Structured Decision Making®
Advanced Trainer Manual

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California
Department of Social Services

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TABLE OF CONTENTS

INTRODUCTION

This series of training modules is designed to increase worker skill at integrating Structured Decision Making® (SDM) assessments into practice. The basic SDM® training is focused on how to complete the assessment forms and basic policy about which tool to do when. Every worker should attend the full training so that the entire model is understood as a whole. These advanced modules, however, focus on work within units, and workers may attend just those modules that apply to their current work assignment. It would be a good idea to have a worker attend an advanced module if he/she is transferred to a new unit that uses different SDM assessments.

These modules are skill-based. While there is some lecture to introduce ideas for strategically integrating SDM assessments into practice, much of the learning will be acquired through individual and group exercises as well as discussion.

These modules introduce concepts such as interviewing skills, engagement skills, safety planning, and case planning. The focus is on integrating these larger skills with SDM assessments. As such, these modules are not substitutes for teaching interviewing, engagement, safety planning, or case planning. Workers should have more extensive training in these areas before and/or after these modules.

Finally, there are some local county policies and/or practices that may be unique and could create tension or conflict with concepts taught. Students should be encouraged to follow local policy, AND trainers should follow up with local management to advise of potential conflict. Students may be operating under "policy mythology," or there may be an area that warrants review by the county.

Support

Trainers should contact Children's Research Center (CRC) if they have any questions about the content or format of the curriculum materials. If questions arise in training that cannot be answered, contact CRC for assistance at 608-831-1180.

Preparation

Each unit has materials that are maintained on the website: https://www.sdmdata.org/ca_curriculum/. The username is "trainer" and the password is "training." The trainer should check the site prior to each session. You may download each time, or at least confirm that your existing copies are the most current. Specific instructions are located at the front of each section.

Class Composition

Participants should be workers who have already completed CORE, including basic SDM training. Ideally, they have been on the job about three to six months prior to taking these advanced modules. More experienced workers will also benefit. Class size should be between

15 and 25. There are advantages to having all workers from the same county, but greater advantages may be found by combining workers from different counties. This will contribute to increased consistency.

Each module will be of interest to different workers, and because each county is organized differently, the choice needs to be based on what assessments the worker uses rather than which unit he/she belongs to. The following breakdown is typical.

- Hotline: All workers whose primary responsibility is hotline/intake; other workers who take night or weekend call.

- Safety assessment/safety planning: All ER workers should attend, as well as FM workers who do safety assessment reviews and are responsible for monitoring existing safety plans. NOTE: FM workers attending the pilot felt a modified version more tailored to safety assessment reviews would be helpful. Current FM workers should not wait for the possibility of a modified version.

- FSNA interviewing/case planning: All FM and FR workers. Also, ER workers and court/DI workers who are responsible for initial case plans.

Supervisors

Concepts taught in these modules will be unfamiliar to supervisors because they would not have had the opportunity to take these courses. This can put supervisors in an uncomfortable position, and if they can't support workers in applying the new techniques, workers will likely revert to previous practice. Therefore, it is highly recommended that supervisors attend the course prior to their workers.

Flexibility

Each unit is designed as a half-day module, except for the case planning module, which is a full day. The two safety assessment modules can be combined into a one-day safety training. Experienced trainers can also spend an entire day on any single module by spending more time in discussions and exercises. This may be a good option if working in a county that has had some struggles in the content area.

Take a break about halfway through each module. Breaks are not mentioned in the text so that you can pick the best time.

ABOUT THIS MANUAL

Throughout this manual you will occasionally see icons on the slides and in the trainer notes. These icons are visual cues, and include the following:

Digging Deeper: When you see this icon, it indicates an opportunity to engage participants in a more in-depth discussion or exploration of a particular issue. These are optional based on your assessment of the participants' level of experience, knowledge, and needs, as well as time constraints.

Orange paper icon: This icon indicates when participants should be referring to a handout.

Purple paper icon: This icon references specific pages in the SDM Policy and Procedures (P&P) Manual.

TRANSFER OF LEARNING[1]

Several times during the training, the trainer should review what is learned and have workers apply it to their jobs. To help them apply what they learn to their job, the trainer can use activities at the end of the class that help them commit to doing something differently.

Here are some transfer of learning ideas:

- Remember and share:
  - » Have them write down one thing they want to either:
    - Remember
    - Was the most important
    - Use tomorrow at work
  - » Then, ask them how they can do it on the job.
    - Turn to the person sitting next to you and say how you would do this in your job or how you can remember this.
    - Each person tells the group what was important to them and then the group chooses the top two to share with the class.
- Ask the group to list everything they can remember from the previous day. The group with the longest list wins. Then have the tables choose the top three ideas to share with the class.
- After a break, review the tools by asking which tool they would use if they were making a particular decision. For example, which tool would they use to decide whether or not to promote a referral?
- At the end of the day, hand out brightly colored paper and ask participants to write down one thing they want to do next week that they learned in the class. Have them write their name and work phone number below what they decided to do. When everyone is done, have them make a paper airplane out of the paper they wrote on. Then have half the class stand on one side of the room and half on the other side. At the count of three everyone throws their airplane and pick up one that someone else threw. Ask them to call that person in one week and ask them how they did on the thing they wrote down.
- At the end of the day, ask them what they remember and what was important to them. Chart their responses on chart paper. Ask them to choose one thing from the list they think is the most important thing to their practice. Then have them pair up and make a plan for how they would do the thing they chose. Help each other come up with ideas. Prizes to the most detailed plan.
- Ask them to write down one thing they want to do within one week on a Post-it. Ask them to open their appointment books and put the Post-it on a date a week from the class.

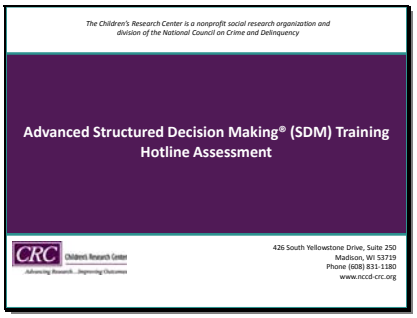
[1] Information provided by Margie Albers from Bay Area Academy.

HOTLINE ASSESSMENT

Materials needed:

- Trainer
  - » This manual
  - » PowerPoint [Hotline.ppt]
- Students
  - » At each seat at start of class:
    - Hotline handout
    - Hotline tool section of P&P Manual (or entire manual)
      NOTE: You can have students bring their own, have copies to hand out and collect at the end of class, or have copies they can take with them.
  - » To hand out during class:
    - Hotline role play
      Print enough so that half of the students will get PERSON A and half will get PERSON B. It may be helpful to print PERSON A on one color of paper and PERSON B on a second color. Print one set of the three-person role-play instructions for classes with an odd number of participants.
- Audio/visual
  - » Laptop/projector/screen
  - » Whiteboard or flipchart is optional

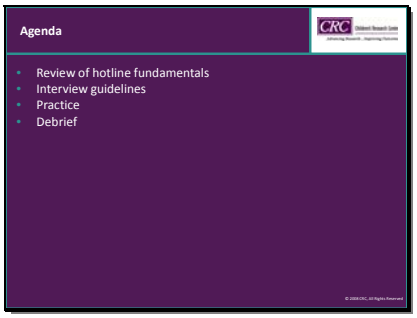
Slide 1



Trainer introduces self and asks participants to do the same. It may be helpful to ask participants to include the amount of time they have been working in intake as part of their introduction.

Trainer introduces the goal of today's session: to practice using good interviewing techniques to gather sufficient information to accurately complete the SDM hotline assessment and priority response assessment.

Slide 2



Today, we will focus on four main activities:

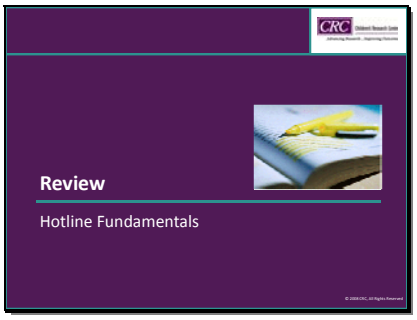
1. We will begin with a review of hotline assessment fundamentals. This will include a brief overview of the two assessments used at hotline, when and how they are completed, and some practice using definitions.

2. Then we will continue with a review of interview guidelines. We are going to remind ourselves of good interviewing practice and how it fits with good usage of the hotline tool.

3. Next, we will break into groups to practice what we've just learned.

4. Finally, we will end the session with a debriefing. We'll share what we learned from our practice with each other.

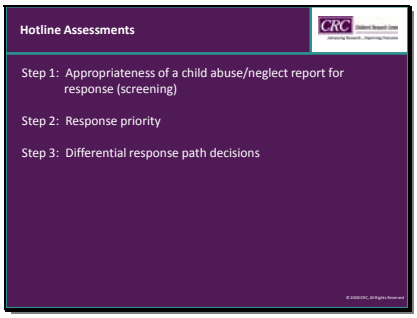
Slide 3



In this room, we represent varying levels of experience with the SDM system and the hotline tools.

Because of this variation, we're going to start this session with a brief review of the hotline assessments, when and how they are used, and some item practice. That way we're all approaching the interviewing section from the same starting point.

Slide 4

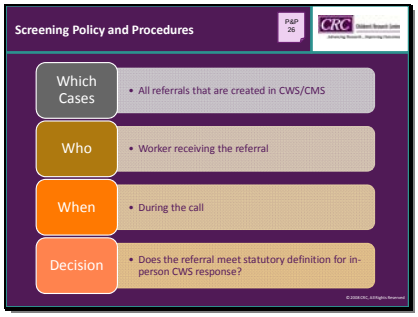


The hotline assessments are divided into three steps. Because not all counties have differential response systems, we're going to focus on Steps 1 and 2 today. All of the principles and techniques that we use today will apply to Step 3 as well, but we won't practice them.

Step 1 is determining whether it is appropriate to respond to the current report. If the answer to Step 1 is "yes," then we will move on to Step 2, response priority, to decide how quickly a response must be initiated.

The purpose of the hotline tools, taken as a system, is to help us make decisions about how to use resources. For example, it wouldn't be efficient or feasible to respond to every call that comes in. Community members are not experts on screening in child maltreatment referrals and may report incidents that require no response. If we investigated each of these reports, it might mean that other reports where maltreatment *has* occurred will not be investigated, or will be investigated at a later time than is appropriate.

Slide 5



The screening assessment, Step 1 of the hotline process, is completed on all referrals created in CWS/CMS.

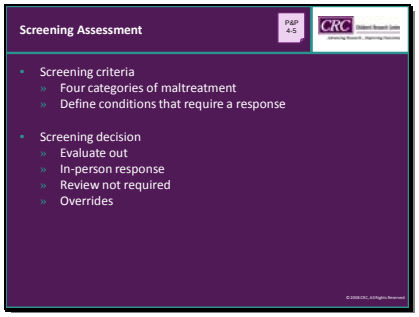
This simple statement implies that one decision has already been made. What decision is that? *(To create a referral.)* What is your county policy for when to create a referral? Case reading suggests that in at least some counties, there is confusion when the call is about an open case. Sometimes the call is just routine information that passes through the hotline because the worker is currently unavailable. These should NOT be made into referrals. Other times, the caller thinks a child is being abused or neglected, and it just happens there is already an open case. These SHOULD be made into referrals.

If the referral does not involve a child under 18, is being referred to another county, or is a duplicate referral, workers may skip to the screening decision and mark "review of criteria not required."

Every referral requires a screening assessment. The screening should be completed by the worker receiving the referral during the call. The policy states that the screening assessment is due "immediately." Sometimes that is interpreted as immediately AFTER the call. But if the first time you look at the definitions is after the caller hangs up, and you discover that there was one more piece of information required, it may be too late. This training will

help illustrate how valuable it can be to have the definitions and decision trees open DURING the call.

Slide 6



The screening assessment has two main sections: screening criteria and the screening decision.

The screening criteria are organized into four categories of maltreatment: physical abuse, emotional abuse, neglect, and sexual abuse. Within these categories are the situations that require a response, and the assessment is supported by definitions that provide details of what conditions must be present for a response to be required.

Review the subcategories and definitions under physical abuse as an example.

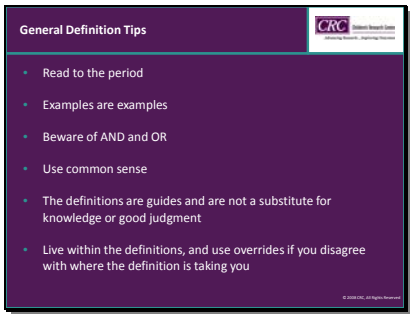
The screening decision is very straightforward: if no elements of maltreatment are marked in the first part, the decision is to evaluate out—essentially, not to investigate. If one or more items are marked, then an in-person response is required and we will complete the priority response assessment.

In some cases, no review will be needed. A legitimate allegation has been made, but the screening criteria do not need to be reviewed. For example, if the report is about a group home, a residential treatment facility, a safely surrendered baby, a duplicate record, or does not involve a child under 18, then the screening assessment is not completed.

Finally, there are circumstances that may allow an override, either changing an evaluate-out decision to in-person response, for example, if law enforcement requested an interview or a response is required by court order; or changing an in-person response to evaluate out—for example, if there is insufficient information to locate the child.

Note to trainer: Review the overrides briefly. In particular, go over override to evaluate out for historical information only.

Slide 7



There are some basic tips to keep in mind.

Click to make each bullet appear.

First, "read to the period" is a way to think about looking at the whole definition. It's about not getting stuck on a word or two in a way that is at odds with the overall theme of the item. This relates particularly to tip #2.

Many definitions provide lists of examples. When examples are provided, they are meant to stimulate your thinking about what could be described by the reporter that would meet the base item and definition. Two errors can be made if we don't "read to the period," and forget that examples are just examples: 1) The caller can be reporting something just as serious, but it wasn't an example provided and we don't mark the item because it wasn't explicitly part of the definition; or 2) The caller reports something that is an example, but does not meet the overall item/definition. For example, look at page 20, the definition for response priority for emotional abuse, question 2. One example is chronic or frequent belittling. Compare that to the other examples and the base item statement. If a caregiver calls child names consistently over time and child is developing some symptoms of emotional harm over time, but is not in any crisis, should that be answered yes or no? *(Correct answer is no—SOMETIMES chronic belittling could meet this definition IF it is so severe that child is in acute distress. It is an example because it COULD meet the overall definition, not because it ALWAYS meets the overall definition.)*

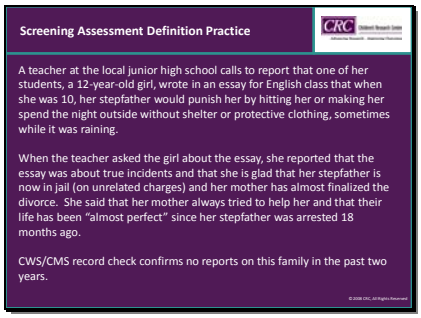
Pay close attention to AND and OR… If the word AND is present, BOTH parts must be true.
You can see that definitions require common sense. If you ever feel that the SDM system is taking you in an absurd direction, it may be that you are applying just a part of a definition instead of the whole thing, or you could be dealing with the 5% that are just too unique to be a good fit.

Likewise, the definitions can't substitute for the vast knowledge needed to be effective in any CPS work, and especially at the hotline. Think of what you have to know: a little law, a little medicine, a little child development, a little substance abuse, mental health, domestic violence, etc. A definition like the one about medical neglect depends on some external knowledge about what would constitute a condition that requires immediate medical attention. You need to have some knowledge, and most importantly, need to know who to call when you need expertise. Often, the definitions

themselves refer to professional opinions of others in helping you reach a decision.

Finally, remember that the definitions ought to lead to good decisions 95% of the time, but there are times you will need to override. It is VITAL that you answer the item based on the definition and then apply an override rather than simply stretching the definition or answering in the way that leads to a result you want. Why is this important? *(Bring out at least these issues: 1) It is the only way to continually evaluate the effectiveness of the tool; 2) It ensures that we aren't just applying our own bias; and 3) It makes our judgment transparent, e.g., downstream area office won't think hotline worker was blatantly wrong.)*

Slide 8

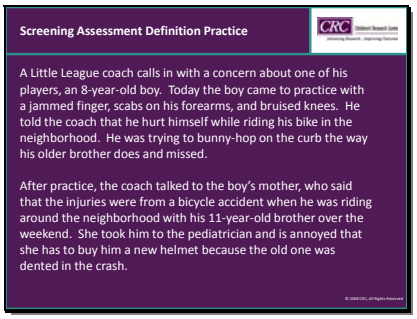


Read the scenario on this slide. How would you complete the screening assessment for this report?

Answer: Evaluate out.

The situation when the child was 10 meets the definition for "physical abuse—cruel or excessive corporal punishment." However, this report meets the FOUR criteria for a historical information override. Review criteria.

Slide 9



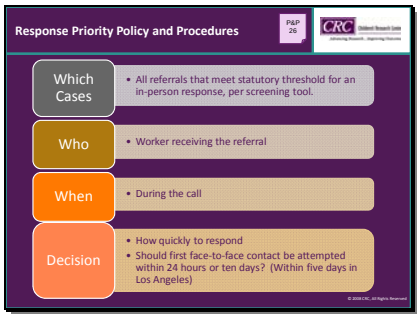
Looking now at this scenario, how would you complete the screening assessment for this report?

Answer: Evaluate out.

Stories and injuries are consistent with accidental injuries and the mom responded appropriately.

Note to trainer: This is one opportunity to discuss educating mandated reporters. Why has the coach called about this incident? Did he think he needed to report all child injuries even if he did not believe that maltreatment was present?

Slide 10

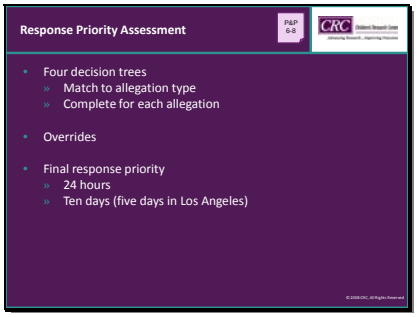


When referrals are determined by the screening tool to require an in-person response, the response priority tool must be completed. Again, the worker receiving the referral should complete the assessment immediately. The decision here is how quickly should we respond, within 24 hours or ten days? In Los Angeles, the decision is between 24 hours and five days.

Note to trainer: You may delete the reference to Los Angeles if you do not have any participants from Los Angeles. If all

participants are from Los Angeles, you may delete the reference to ten days and change it to five days.

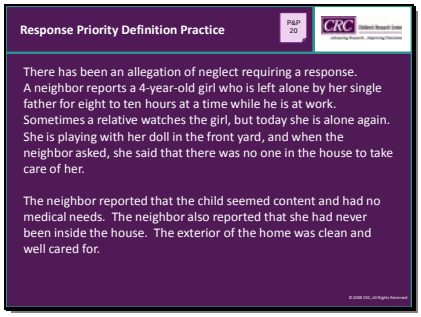
Slide 11



The response priority assessment consists of up to four decision trees, which correspond to the four categories of allegations on the screening tool. Complete a decision tree for each allegation type marked on the screening tool and stop when you have completed all the relevant trees or gotten to a 24-hour response time, whichever comes first. For example, if the caller reported physical abuse, emotional abuse, and neglect, you could begin with the physical abuse decision tree. This might indicate a response time of ten days. You would then continue on to the emotional abuse tree. If this indicated a 24-hour response, you would not need to complete the neglect tree, because the fastest possible response time would already be recommended.

Like all SDM assessments, you also have an opportunity to apply a policy or discretionary override.

Slide 12



Let's look at a response priority scenario. Turn to the neglect decision tree on page 7 of the P&P Manual.

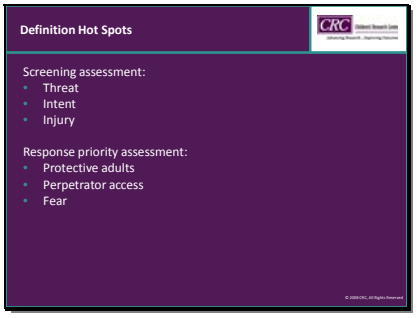
Answer: 24-hour response.

Box 1: No—The child does not appear to need medical or mental health help.

Box 2: No—Although we do not know about conditions inside the house, the exterior is clean and well cared for. There is no indication that we should expect to find hazardous conditions inside the house. Although we should answer protectively in the absence of information, we do have enough information here to reasonably believe that the environment is not hazardous.

Box 3: Yes—The child is currently unsupervised.

Slide 13



A few definitions are worthy of closer examination.

First, let's go back to the screening assessment definitions and look at threats of physical harm (page 11 of your P&P Manual). The operative word is "credible." A credible threat is one that you have reason to believe will be carried out. Though we don't recommend it, many parents say rather threatening things to their children with absolutely no intent to act. Can you think of examples? What could you ask a caller to get at the credibility of the threat? *(Has caregiver ever hurt child before? Does caregiver say things like this*

frequently? How did child react? You can also check CWS/CMS records).

Intent: Some definitions include some intent on caregiver's part. For example, see severe neglect (pages 12–13 of P&P Manual), child's health/safety is endangered. How can you get at whether the caregiver is acting willfully? *(Ask about statements made, pattern of behavior, what else could be causing the concern… for example, a 14-year-old child who developed hypothermia because he stayed out in freezing rain while parents frantically searched for him to get him to come home suggests parents did not act willfully).*

Injury: There are two dimensions of injury relevant to screening: accidental vs. non-accidental and severe vs. other. Any non-accidental injury is screened in. Injuries that are accidental are not. How can you tell over the phone? You don't have to reach a conclusion, just determine if there is a reasonable allegation that it is non-accidental. What can you ask? *(Statements made, sequence of events, use of implement, multiple vs. single contact, prior history, nature of injury, etc.)* Next, is the injury severe or not? Look at the definition for severe. The basic definition is "if left untreated, would cause permanent physical disfigurement, permanent physical disability, or death." The rest are examples. It does not list ruptured spleen, but a ruptured spleen could cause death if untreated.

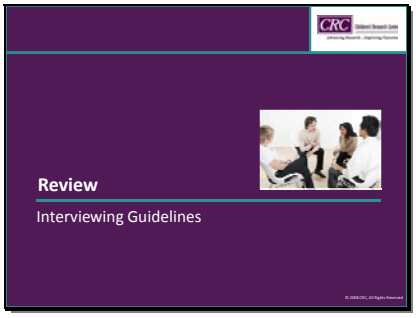
Now let's look at some response priority definitions. Protective adults: See the fourth question under physical abuse (page 19 of your P&P Manual) and the second question under sexual abuse (page 22). Note that for physical abuse, the protective adult can be either the alleged perpetrator (second bullet) or someone other than the alleged perpetrator (first bullet). Let's look at the first bullet. The main definition is that "there is information that he/she is likely to prevent further abuse incidents." The rest of the paragraph gives ideas of the kind of evidence you could listen for. Everything past the first sentence is examples. So, you could have a non-perpetrator parent who is committed to nonviolent parenting BUT has never prevented the other parent from hurting the child. This would NOT be a protective adult. On the other hand, you could have a parent who effectively stepped in to stop the abuse and nothing has happened since, but it was 58 days ago. You could still consider that parent protective even though it's been less than 60 days.

Perpetrator access: See the second question under physical abuse and the third question under sexual abuse. Note that

access is defined differently. For physical abuse, only actual physical contact is considered, while for sexual abuse, we would respond more quickly if there is a likelihood of physical OR verbal or written contact. Why do you suppose there is a difference?

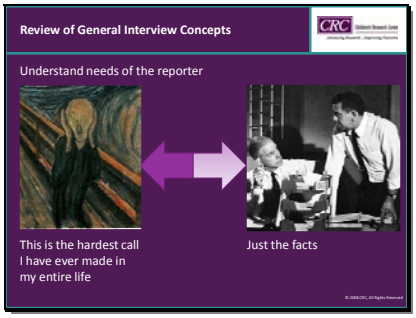
Fear: See third question under physical abuse (pages 18–19 of P&P Manual). The operative word is "credible."

Slide 14



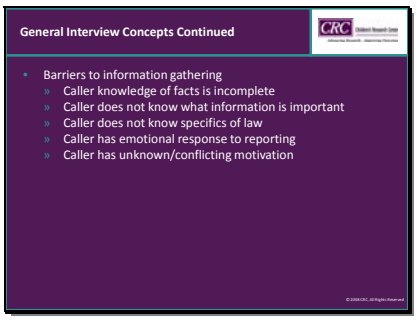
Now we're going to connect what we know about the assessments to what we know about good interviewing practice.

Slide 15



When the phone rings, the person on the other end could fall anywhere along this continuum. On one end is the mandated reporter who has to call frequently and routinely, and has little investment in the call beyond discharging a duty. He/she wants to just give you the facts and be done with it. On the other end is the person who is reporting a family member for the first time in his/her life and is really quite conflicted about it, but deeply worried. This person may want to tell you the entire history of the family, and may need some calming and supportive words to go through with the report. In both cases, you need the same information. In the former, your challenge will be to GET the information you need. In the latter, your challenge will be to FOCUS on the information you need. Either way, opening the SDM items and definitions will give you a road map.

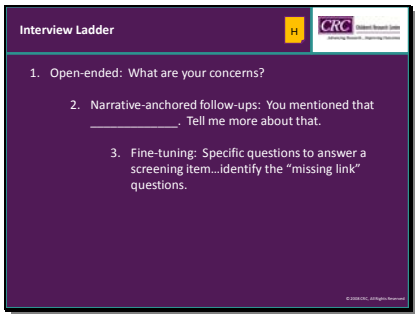
Slide 16



The road map the SDM system provides is essential to good screening. If you relied solely on whatever the caller chose to report, you may end the call without the information you need to make a good decision. There are lots of good reasons callers aren't prepared to tell you what you need to know.

As a screener, it is up to YOU to lead the call in a way that gives you the best chance to get the right information.

Slide 17



Note to trainer: Refer participants to the interviewing handout. When conducting an interview, even a brief one at the hotline, we want to start with open-ended questions and become more specific as we gather more information.

We begin by allowing the caller to tell us what he/she observed. Often, this will give us enough information to determine which category of maltreatment is being reported. As the caller is describing his/her concerns, you should be able to narrow the main categories of maltreatment that may be of concern (i.e., is this about physical abuse, neglect, sexual abuse, emotional abuse, or a combination).

As we narrow down to a category of maltreatment, we might need to ask follow-up questions that anchor on some point of narrative to gather details about the type of maltreatment. For example, "Did you actually see an injury? Can you describe it?"

Finally, we may ask specific questions about the response definitions to determine if what is being reported really fits a definition. As you may have noticed from our practice situations earlier, the easiest way to ensure that you're asking the right fine-tuning question is to have the definition in front of you while you're taking the report.

The same process can be used to determine the response priority, although we might begin at narrative-anchored questions to determine exactly the urgency of the current situation.

In general circumstances, the interview ladder is an appropriate approach. However, it is important to "read" the caller and adjust your approach to the interview style the caller will respond positively to. For example, if a police officer or emergency room worker is calling, they may consider a call to the hotline to be a routine transfer of factual information. With experienced, focused reporters who are familiar with law and policy, it is appropriate to skip to the lower levels of the ladder and ask specific fine-tuning questions. However, if a family member is calling, skipping to a lower level is unlikely to produce a positive response, because he/she may feel that you have not been listening to his/her story and are jumping straight to an interrogation.

Try to stay high on the interview ladder, but adjust your approach if the caller requires it.

Outline for Interviewing

OPEN-ENDED: What are your concerns?

NARRATIVE-ANCHORED FOLLOW-UP: You mentioned _____. Tell me more about that.

FINE-TUNING/MISSING LINK

Interviewing for the Hotline Assessments

1. A concerned person wants to give you information to help a child, but there can still be obstacles and conflicts for this person, such as the following:

- Incomplete information about the incident. The reporter may have observed enough to become concerned, but not enough to meet the threshold for CPS involvement.

- Incomplete knowledge of child maltreatment law. The reporter may have observed an incident that he/she feels requires a response, but an investigation may not be appropriate, given legal thresholds.

- Conflicting loyalties. The reporter may be a close friend or family member concerned that his/her report could "get the caregiver in trouble" or end a relationship with the caregiver.

2. Question types

2.1. The best information is that provided by the reporter in his/her own words in response to the most **open-ended, non-directional questions**.

- What did you observe?

If the caller does not provide enough information to complete the intake tools without further questioning, start with open-ended orienting questions.

- What about this situation concerned you?
- What about the incident caused you to call the hotline?

2.2. If you need additional information, move on to **narrative-anchored follow-up questions**.

- I'm hearing that _____ aspect of the situation concerned you; tell me more about that.

2.3. Finally, try some **fine-tuning questions**. Use your assessment definitions to ask questions that allow you to distinguish among different levels of response. **Use the attached guide for examples**.

Sample Threshold Questions

For each main screening criterion, there are some examples of initial focus questions to help determine whether the reporter is concerned about one of the larger areas. If yes, then look at the questions for the subcategories within the larger category for suggestions for questions to determine whether the subcategory applies. These questions are representative, and not all will be appropriate with each call. There are likely other questions that would be helpful in particular circumstances. These questions do not represent everything that should be asked during a call, but are just suggestions to help determine the screening decision.

MAIN CATEGORY	Narrative-anchored Follow-up	SUBCATEGORY	Sample Fine-tuning "Missing Link" Questions
Physical abuse	• Did you see an injury on the child? • Did the child tell you he/she was injured? • Is the child acting injured (even if you can't see the injury)?	Non-accidental injury	• Did you see how the injury was caused? • Did someone tell you how the injury was caused? (Who?) • From your perspective, was this intentional? What makes you think so? • Did [perpetrator] say anything right before or right after?
		Death of child/another child in home	• Is the cause of death suspected to be abuse? • What other children live in the home?
		Severe	• Has the child received medical treatment? • What would have happened if there had been no treatment? • Describe the injury. • Describe how child reacted immediately following. » Listen for indicators of pain, impaired movement, loss of consciousness, etc.
		Other injury	Describe the injury.
	• What did you see the caregiver do to punish the child? • Did you see the caregiver do something dangerous near the child? • Did you hear the caregiver threaten the child? • What did the child (or someone else) tell you about what the caregiver did to punish the	Cruel or excessive corporal punishment	• What was the caregiver reacting to? • What did the caregiver say? • What were the circumstances when the child was outside (e.g., temperature, time of day, length of time)? What did child do while outside? • How did child react to punishment? • What part of child's body was struck? By what? • What happened to child immediately upon being struck (e.g., fell backward with force, doubled over in pain)?

MAIN CATEGORY	Narrative-anchored Follow-up	SUBCATEGORY	Sample Fine-tuning "Missing Link" Questions
	child?		• How surprised are you that child wasn't injured?
		Threat of physical abuse	NOTE: FOR THE FOLLOWING THERE IS NO INJURY AND NO INCIDENT IN WHICH CAREGIVER HAS ALREADY TAKEN ACTION.
		Threats of physical harm	• Has the caregiver followed through with threats before? • Does the caregiver seem to make threats to scare the children? • Did it appear to be a figure of speech, or a plan? • How did the caregiver and child act following the threat (e.g., it was soon forgotten vs. continuing rage in the caregiver and fear in the child)?
		Dangerous behavior toward the child or in immediate proximity of the child	DOMESTIC VIOLENCE (DV) • What was the nature of the altercation between parents? Was a gun or knife involved? • Where exactly was the child? What was the child doing during the altercation (e.g., intervening, being held by one caregiver)? • Did the parents seem aware of the child's presence? Did the caregivers take any action to protect the child? OTHER • What exactly was the caregiver doing? • What precautions were taken to protect the child? • How close was the child? Was the caregiver aware of child's presence? • How surprised are you that child wasn't injured?
	What happened to the child who died?	Prior death of a child due to abuse or neglect, and there is a new child in home	Was the child living in the home at the time of other child's death?

MAIN CATEGORY	Narrative-anchored Follow-up	SUBCATEGORY	Sample Fine-tuning "Missing Link" Questions
Emotional abuse	• What does the parent do that is upsetting to the child? • How does the child react immediately? • What affect does this have on the child? » Mood » Behavior » Relationships » School	Caregiver actions have led to child's severe anxiety, depression, withdrawal, or aggressive behavior toward self or others	• What is the child's diagnosis? • How long has the child exhibited the symptom (e.g., severe anxiety, depression, withdrawal, or aggressive behavior toward self or others)? • What are the child's specific behaviors? • To what extent have these behaviors affected the child's life? » Expelled? Failing school? » Completely isolated, barely talks to anyone? » Losing or gaining weight, persistent insomnia, sleeping so much that he/she is missing lots of school? » Getting into frequent fights, arrests, injuries? » Suicidal (plan, attempts), self-harming (cutting, etc.)? • How is the caregiver's behavior contributing to the child's condition?
		Threat of emotional abuse	• How long has this been going on? • How does the child react? • To what extent have these behaviors affected the child's life? (*Not REQUIRED to have symptoms, but if there are symptoms, it supports.*)
		Domestic violence	• Does the child see the DV? • How does the child know about DV? • What happens between the caregivers? • Was a caregiver injured? • Are weapons involved? • How often? • Has anyone been injured?
		Bizarre or cruel behavior	• What exactly has the caregiver done? How does the child know about it? • How does the child react? • How often does this happen? How long has it been going on?

MAIN CATEGORY	Narrative-anchored Follow-up	SUBCATEGORY	Sample Fine-tuning "Missing Link" Questions
		Caregiver's mental health concerns	• How long has the caregiver had a substance abuse or mental health concern? • To what extent is the caregiver impaired? • What parenting tasks are not being done due to mental health or substance abuse? • How is the caregiver's behavior affecting child? • How does the child react? • How is the child's life different because of the concern?
Neglect	• What is the caregiver not doing that a caregiver ought to do? • Has the child been injured or become ill as a result? • What is likely to happen to the child if the situation does not change?	Severe neglect	
		Diagnosed malnutrition	• Who diagnosed the malnutrition? • When was the diagnosis made?
		Non-organic failure to thrive	• Who diagnosed non-organic failure to thrive? • When was the diagnosis made? • What is the child's age vs. weight/height? • Has there been a recent change in the relationship of child's age to child's height/weight? • Is the child falling behind on developmental milestones?
		Child's health/safety is endangered	• What injury or illness has the child suffered? • If the situation is not resolved, what is likely to happen to the child? CLOTHING What was the weather like? How long was the child without appropriate clothing? In what way did the caregiver act that caused the child to be without proper clothing? HOUSING CONDITIONS What is the child's lead level? What symptoms does the child have? Has the child required medical care as a result of environment that would not have been required if the child was in a different environment? How did the caregiver contribute to that environment? Did the caregiver understand his/her actions would cause harm?

MAIN CATEGORY	Narrative-anchored Follow-up	SUBCATEGORY	Sample Fine-tuning "Missing Link" Questions
			Can the caregiver control the environmental factors that caused harm? What are the chances the child will need medical care soon if the environment is not corrected? MEDICAL CARE What is the child's condition? What should the caregiver be doing that is not being done? If it is not done, what will happen? How long will it take for that to happen? If the care is provided, how certain is it that the condition will be improved? Does the caregiver know and understand this? KEY: If result will lead to permanent disability, disfigurement, or death, it is SEVERE. If it will result in lesser harm, it is GENERAL. SUPERVISION What is the child's age/developmental status? How long has child been left alone? How often is the child left alone? What are some examples of things that happened when the child was alone? What makes it particularly dangerous for this child to be alone? OTHER • What were the specific conditions? • How surprised are you that the child was not injured? • What could have happened to the child if third party had not intervened? • How much longer could the child have been in that situation before becoming ill/injured/dying?
		Unexplained and/or suspicious death of a child, and there are other children in the home	• What are the circumstances of the child's death? • Who is investigating? • Why is it being considered suspicious? • Who else is in the home?
	Does the child need something that is not being provided?	General neglect	*Understand age/developmental status/vulnerability of children as context for each question:*
		Inadequate food	• What is the child typically eating? • How often is the child going without meals?

MAIN CATEGORY	Narrative-anchored Follow-up	SUBCATEGORY	Sample Fine-tuning "Missing Link" Questions
			• What makes meals inadequate? • Has the child lost weight or failed to gain weight? • Is the child having difficulty in school? • How often does the child go hungry? For how long?
		Inadequate clothing	• What clothing does the child have on when outdoors? What is the weather? How long is the child outdoors? • How many days in a row would the child wear clothes between washing? Is the child avoided or ridiculed at school due to clothing? Does the child avoid leaving the house out of concern for clothing?
		Inadequate/hazardous shelter	• Would the child likely become ill or injured if the situation in the house is not changed? • To what extent is [dirty clothes, rotting food, etc.] present? How long has it been that way? How does it interfere with normal activities? • What items does the child get into his/her hands that are dangerous? • What precautions is the caregiver taking to protect the child? • What actions is the caregiver taking to the correct situation? • In the absence of [utilities/furniture], what is the caregiver doing instead? Does that pose a danger to the child (e.g., lack of bed—does the child have any orthopedic problem as a result, or issue that would make sleeping on a mattress on the floor dangerous?)? • Does the child depend on electricity for a medical device?
		Inadequate supervision	• How long was the child alone? • How often? • What happens when the child is alone? • How has the child been prepared to be on his/her own? • Are there any provisions for supervision?

MAIN CATEGORY	Narrative-anchored Follow-up	SUBCATEGORY	Sample Fine-tuning "Missing Link" Questions
			• When the child begins to do something dangerous, what does the caregiver do? • How do we know the child can't manage on his/her own?
		Inadequate medical/mental health care	• Who indicated the child requires care? • What care is not being provided? • How long has it been that care was not provided? • What has been done to get the caregivers to provide care? • What will happen if care is not provided?
		Child has no parent or guardian capable of providing appropriate care	• Where is the caregiver now? • How long will he/she be there? • What plans, if any, were made for child care? • What happened so that those plans are not working? • What leads us to believe the caregiver is not returning?
		Failure to protect	• What is it about the temporary caregiver that suggests he/she is inappropriate? How has his/her [drinking, young age, mental health, etc.] prevented him/her from providing adequate care? Can you provide an example of that? Has something happened, or nearly happened, while a child was in his/her care? • Who is harming the child? Does the caregiver know? Who all knows? What do you think the caregiver should be doing that he/she is not doing?
		Threat of neglect	
		Prior failed reunification or severe neglect, and new child in household	• How do we know there was a failed reunification or prior substantiation for severe neglect? (Confirm with record check.) • Who is in the house now? Do we know that the child was not there previously?
		Allowing child to use alcohol or other drugs	What did the child consume? How was the caregiver involved? How much did the child consume? How was the child acting afterward? How often does this happen? Was this part of any religious or cultural ceremony?

MAIN CATEGORY	Narrative-anchored Follow-up	SUBCATEGORY	Sample Fine-tuning "Missing Link" Questions
		Prenatal substance use	• Was there a positive toxicology on the mother and/or the child? If not, how do we know the mother used substances prenatally? • What does the mother say about her use? Are there indicators of continuing use (e.g., heard her arranging to get drugs, obvious symptoms of severe dependency)? What drugs does the mother abuse? What is her pattern of use? • How has the mother responded to baby while in hospital? Is she attentive, involved in care? Does she indicate preparations for having baby home? Is she passed out, groggy, inattentive?
		Other high risk birth	How has the caregiver responded to the baby in hospital? In what ways has the caregiver(s) demonstrated inability to provide adequate care? Does the child have special needs? If so, has the caregiver participated in education to learn to provide care? Does the caregiver seem to understand basic information about safely caring for the baby?
Sexual abuse	Are you concerned about someone having sexual contact with the child?	Any sexual act on a child by an adult caregiver or other adult in the household, or unknown perpetrator	• What did the child say happened? Who did the child say did this? Does that person live with the child? How did this happen to come up? • What is it about the child's behavior that has you concerned? How often does the child behave this way? When did it start? Has someone asked the child about this behavior? • Has the child seen a doctor? What do exam/tests show? How significant is that for ruling in or ruling out sexual abuse? • Who saw this happen? What exactly did they see?
		Sexual act(s) among siblings or other children living in the home	• What happens between the children? • What are their ages (Sizes? Cognitive development?)? • Has there been any pressure or coercion for one or more of them to participate?
		Sexual exploitation	• What does the caregiver make the child do?

MAIN CATEGORY	Narrative-anchored Follow-up	SUBCATEGORY	Sample Fine-tuning "Missing Link" Questions
			• How is the caregiver involved?
		Threat of sexual abuse	RULE OUT SEXUAL ACT OR EXPLOITATION FIRST.
		Known or highly suspected sexual abuse perpetrator lives with child	• How do you know the person has a history of sexual abuse? (Confirm with record check.) • How do you know he/she lives with child? (NOTE: If a known or highly suspected sexual abuse perpetrator has contact with the child, but does not live with the child, refer to failure to protect.)
		Severely inappropriate sexual boundaries	• What exactly does the caregiver do? How often does this happen? • How do you know the children are aware? • What do the children say about how it makes them feel? • What happens that makes it seem he/she is doing this on purpose for sexual gratification? • Is there an attempt to do this secretly? • Are the children asked not to talk about it?
Overrides to evaluate out	Is there a reason child protection should not respond?	Insufficient information to locate child/family	FOLLOW COUNTY POLICY FOR EFFORTS TO LOCATE BEFORE MARKING THIS OVERRIDE.
		Another community agency has jurisdiction	• Which agency is going to follow up? • On what basis is there no requirement for child protection involvement?
		Historical information only	• Is the child age 10 or older? AND • Did maltreatment occur at least a year ago? AND • Were there any reports since then? (Confirm with record check.) AND • What was it that contributed to the maltreatment that has changed?

Sample Response Priority Questions

The following are suggestions for questions that can help distinguish yes and no responses to each question box. These are general suggestions. Specific situations may warrant use of other, more individualized questions.

Tree	Box	Question	Sample Questions
Physical abuse	1	Is the child under age 2 (or capability equivalent)?	• How old is the youngest child in the home? (If this child is NOT the victim of the current reported incident, is there reason to believe this child is another potential victim?) • (If over 2) Is there any child who has a severe developmental disability or emotional disability?
		Does the child require immediate medical attention?	• Is the child currently in the hospital, ER, doctor's office for evaluation, or treatment? • Is the child bleeding, burned, unconscious, severely injured, etc.? (Alert 911.)
		Were caregiver actions or threats brutal or extremely dangerous?	• What exactly did the caregiver do to the child? What part of the child's body was injured/hit? What did the caregiver hit the child with? What was the result of impact (e.g., was it forceful enough for child to fall)? • How old is the child? What is the child's size (especially relative to the caregiver)? Is the child able to get away or protect self to any extent? • How surprised are you that the child was not severely injured as a result? • How precarious was the situation? How long was the child exposed to the elements, and what were the conditions? • Had the other party not intervened, or the child not ducked, etc., what would likely have happened? • What kind of force would it have taken to cause an injury like that? What kind of damage can result from an action like that? Does it appear that there has been more than one episode of violence? (for medical professionals)
	2	Does the alleged perpetrator have access to the child within the next ten days?	• Does the alleged perpetrator live with the child? • How much contact does the alleged perpetrator have with the child? • When will the alleged perpetrator next see the child? • Does the alleged perpetrator have contact with the child via email, text, cell phone? • What precautions are in place to prevent contact? • Is the alleged perpetrator able to bail out? • How committed is the caregiver to keeping the alleged perpetrator away from the child?
	3	Is there a prior history of physical abuse?	CWS/CMS record check. Look for investigated physical abuse by any adult caregiver currently in the home.

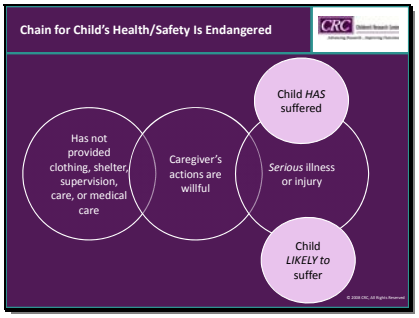
Tree	Box	Question	Sample Questions
		Is there current domestic violence?	• Is there any violence in the home? • Do the caregivers get along? • Any violence with current or former boyfriends/girlfriends? • POLICE RECORD CHECK • CWS/CMS record check
		Is there current caregiver mental health concern?	• Does either caregiver have any mental health concerns? • Does he/she seem in touch with reality? • Is he/she having an unusually hard time coping? • Does he/she seem depressed? • Has he/she been talking about suicide or otherwise hurting self or others? • CWS/CMS record check
		Is there current caregiver substance abuse concern?	• Does anyone in the house abuse drugs or alcohol? • Does he/she get drunk/high?
		Is the child fearful or vulnerable?	• Does the child appear afraid of going/remaining home? • What has the child said? Is the child acting afraid? • Does the child have a way to stay safe if he/she goes/remains home? • Could the child protect self or get away if a problem arises? • Is there reason to suspect another incident tonight or in the next several days? • When are you expecting to see the child again? • Is the child expected to be in school or some other public/planned activity over the next several days? KEEP IN MIND THE SEVERITY OR LACK OF SEVERITY OF THE ALLEGATION. THE GREATER THE SEVERITY, THE MORE VULNERABLE THE CHILD.
	4	Is there a protective adult in the home?	Is there another adult in the home in addition to the alleged perpetrator? If so: • Does he/she know about the alleged incident? If so, what has he/she said or done in response? • Was he/she present for alleged incident? Did he/she do anything to protect the child? • Would he/she be physically and emotionally capable of protecting the child if this happened again? • Is he/she going to be with the child in next several days? • Does he/she use excessive corporal punishment as well? • How much time has gone by since most recent known incident?
			• Was the incident one in a series of concerns, or was it a one-off situation? • How did perpetrator react when it was over? What has he/she said? Does he/she

Tree	Box	Question	Sample Questions
			express regret for incident? • Has he/she apologized, and/or expressed a plan to not harm the child again? If so, has he/she ever made and broken promises like this in the past? • Was the incident an unusual circumstance, or is he/she often volatile/violent/ impulsive/angry?
Emotional abuse	1	Is the child exhibiting behavior that requires immediate mental health evaluation?	• Is the child suicidal (i.e., has attempted, has a current plan, or other indication of significant suicide threat)? • Is the child self-harming? • Has the child recently set fires or been cruel to animals? • Is the child threatening to harm others? Is there a plan? Has the child taken some steps toward harming others? • Does the child seem out of touch with reality? • Is the child so depressed, anxious, or withdrawn that he/she has stopped engaging in daily activities? When did this start? How long has it been going on?
	2	Is the caregiver's behavior cruel, bizarre, or extremely dangerous?	• What exactly has the caregiver done? Whom did the caregiver hurt? How do you know the child saw or was aware? • What exactly has the caregiver said? Does it seem caregiver was making a poor attempt at a joke? Was it a figure of speech? How did the child and others respond? Did they seem shaken? Afraid? • How long did the caregiver make the child [particular action]? How did the child react? How often does this happen? (Consider child's age.) • How does the child respond to violence between the caregivers? Does the child intervene? Has anyone been seriously injured as a result of DV? Has DV involved guns, knives or other weapons? Has the child been directly in the path of DV, even if unharmed?
Neglect	1	Does the child need immediate medical/mental health evaluation?	• Has a doctor, paramedic, nurse, or other medical personnel reported that the child needs immediate medical evaluation? • Has a mental health professional reported that the child needs immediate mental health evaluation? • If the reporter is a non-medical/mental health person, does the child have symptoms of failure to thrive? • What would happen if treatment is not begun in the next five days?
	2	Are the child's physical living conditions *immediately* hazardous to his/her health or safety?	CONSIDER THE CHILD'S AGE/DEVELOPMENTAL STATUS. • What exactly is the hazard? How long has the child been living there with that hazard? (Note: In some instances, longer reduces sense of imminence because it suggests that odds of harm are quite low. In other circumstances, longer will

Tree	Box	Question	Sample Questions
			increase sense of imminence if cumulative harm occurs over time, such as exposure to toxins.) • Is there something about the child's behavior that makes him/her more likely to become ill/injured by this? • Has someone recently been injured/become ill? • How long could a child that age be exposed to that before it causes harm? • How seriously would the child be harmed?
	3	Is the child currently unsupervised?	CONSIDER THE CHILD'S AGE/DEVELOPMENTAL STATUS. • Is the child alone/unattended at this moment? • How recently was the child alone/unattended? • Is there reason to believe the child will again be unattended/alone in the next five days? • Is the person presently caring for the child so impaired/incompetent, etc. that the child has already been injured or nearly injured? • If the child is expected to be left with a concerning caregiver, how often is the caregiver in a condition that he/she can't provide appropriate care? What leads to the conclusion that he/she would be unable to provide care over the next few days? • If the caregiver has disappeared with no apparent intent to return, who is caring for the child now? Is he/she able and willing to do so for a few days?
	4	Is the child a drug-exposed newborn who will be discharged within the next five days?	• What substance showed up in tox screens and/or what has the caregiver admitted to using? • What is the planned discharge date? • Have the caregivers expressed a desire to discharge against medical advice? • Is there an indication that the caregivers are planning to leave without waiting for discharge?
		AND no caregiver appears willing and able to provide for the child upon discharge?	• Has the caregiver used recently? Has caregiver used since birth? Are there indications the caregiver will resume use? • Has the caregiver done what is necessary to prepare to take the child home? CONSIDER ANY SPECIAL NEEDS OF THE CHILD. • If there is a second caregiver, does he/she appear willing and able to help even if birth parent does not? • Has either caregiver ever had an unsuccessful reunification case? RECORD CHECK
Sexual abuse	1	Is there current abuse as evidenced by disclosure?	• If the child disclosed, is the child saying an incident happened recently? Did the child name an alleged perpetrator who lives with the child now? • Is there a recent onset of concerning sexualized behaviors? Is there a recent

Tree	Box	Question	Sample Questions
			significant change in the child's behavior that suggests abuse is current?
		Credible witnessed account?	Did witness see an incident recently?
		Or medical evidence?	Does medical evidence suggest recent sexual activity?
	2	Is the non-offending caregiver willing and able to protect, including seeking medical attention if needed?	• Is there another caregiver in the home who is not alleged as a perpetrator? (If no, the box must be answered no.) • Does the non-offending caregiver know about disclosure/concern? (If no, must be answered no.) • If the non-offending caregiver knows, how has he/she reacted? Is he/she blaming the child, angry at the child? Is he/she threatening the child to not disclose or to cover up? Is he/she coaching the child to disclose things that are NOT true? If a medical exam has been recommended, is the non-offending caregiver cooperative? NOTE: This caregiver does not need to express absolute belief in child's disclosure at this time, but a yes answer indicates he/she is supportive of child and open to hearing the child's account.
	3	Does the perpetrator have access to the child within the next five days?	• If child named an alleged perpetrator(s), does he/she live with the child, or is the alleged perpetrator likely to have contact with the child in next five days? Does the alleged perpetrator have email, text, or phone contact ability with the child? Could he/she contact the child at school, church, or other place? • If the alleged perpetrator is unknown, is there any concern that the alleged perpetrator could be someone who lives with the child or has contact with the child? Has the child provided indicators such as "It happened a long time ago…? I don't see that person anymore," or has the child specifically denied that the alleged perpetrator is someone in his/her home, but not further identified?

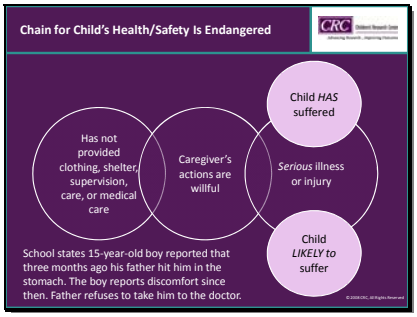
Slide 18



One way to think about the lowest rung on the interview ladder is to visualize each definition as a chain made of links of facts. Here is an example of a definition chain for severe neglect, child's health/safety is endangered. There are three links in this chain. First, there must be some evidence that the child needs something that is not being provided by the caregiver. Second, there must be some indication that caregiver's actions are willful. Finally, the result is, or is LIKELY to be, a SERIOUS illness or injury.

Let's test this.

Slide 19

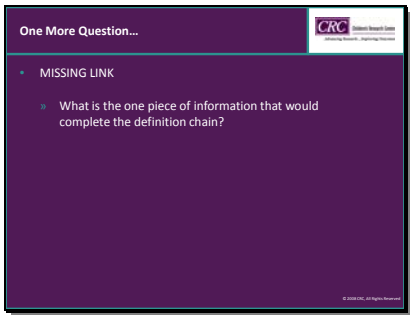


What do we have, and what do we need?

We have: father is refusing to take child to doctor. This is a choice, so it is willful. However, do we know that medical care is needed? Do we know that the refusal has resulted or is likely to result in serious illness or injury?

Note to trainer: We are not dismissing the concerns, just figuring out what we need to know to decide. Even if this definition is not met, we would decide if another definition fits better, or finally, that no definition fits.

Slide 20



One way to think about the final level of questions is to think about the missing link. To meet the entire definition for child's health is endangered, we would need to get some sense of whether medical care is required and the consequences for not getting it. What do we already know?

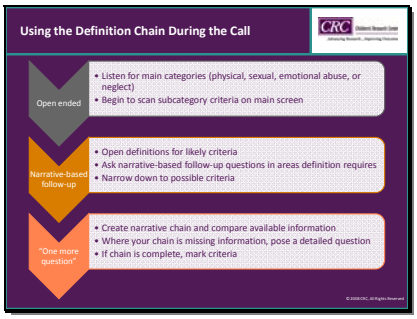
Answer: We know that the boy describes his condition as "discomfort," that the reported incident was three months ago, and that pain has not changed in three months. We can ask if he has missed school, whether he appears to be in pain, whether he has been observed to be in pain, whether the school has alerted the parents to a possible medical concern, whether a school nurse has been consulted.

In an ideal world, a medical person would be at our beck and call to help triage calls related to medical issues. Sometimes, obtaining a collateral opinion will be vital. At other times, our common sense can inform our application of the facts to the definition. What are the chances that a serious injury would be stable over three months and have no impact on the teen other than reported "discomfort?"

We will still consider the call for physical abuse/other injury OR cruel/excessive corporal punishment. But unless the school indicates that the child appears in need of medical

treatment for a serious injury, this definition chain is not met.

Slide 21



So, in most calls, start with open-ended questions and begin to narrow down the main categories.

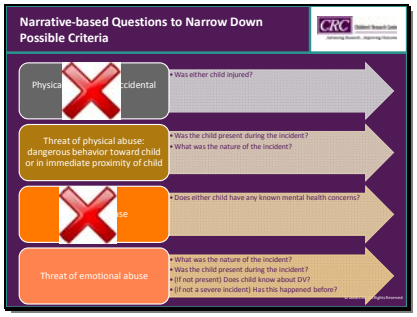
Open the definitions and begin to ask follow-up questions to help narrow down possible criteria.

When you've narrowed down to the most likely category, think of the definition as if it were a chain, and see if you have the facts to connect all the links. If not, use the missing link to select the next question you must ask.

Slide 22

Here's another example.

Slide 23



We could ask if any child was injured. If the officer says no, we can eliminate physical abuse/injury.

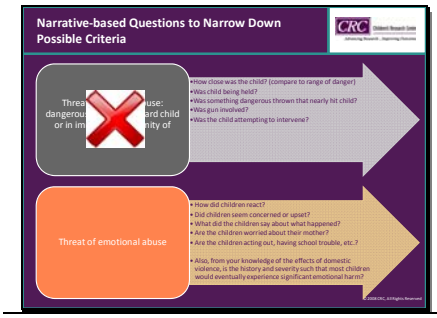
CLICK to bring in the "X."

We could ask if the officer knows of any mental health concerns for the children. If the officer says no, we can eliminate emotional abuse. *NOTE: The officer may not know. We are not ruling this out as an eventual finding, but based on what the officer knows, it is not the basis for our response.*

CLICK to bring in the "X."

We are left with two remaining options: threat of physical abuse and threat of emotional abuse.

Slide 24

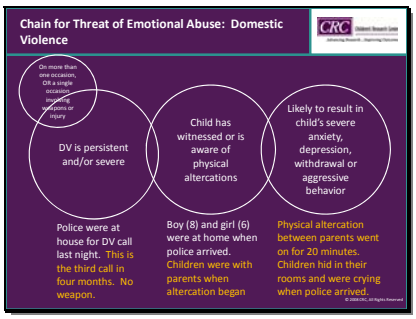


We could ask the officer where the children were when the altercation occurred. Is it reasonable to expect that a law enforcement officer investigating domestic violence would have some information about the events that unfolded? *(Answer: Yes.)* Suppose the officer says that when the parents started to yell, the children ran into their rooms, and stayed there, huddled together and crying, until the police arrived. The altercation went on for more than 20 minutes and police arrived as it ended. No weapons were involved.

CLICK to bring in the "X."

The situation no longer seems to fit threat of physical abuse.

Slide 25



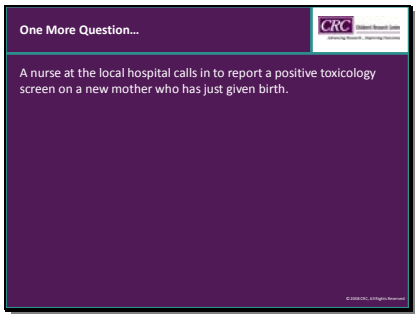
Let's look at the definition chain for threat of emotional abuse. There are three links to this chain. First, we need to know that there is DV that is persistent and/or severe. That means that it happened on more than one occasion OR involved a weapon or injury. Do we have that link yet? *(Answer: Yes, we know this is the third incident in four months.)*

Next, we need to know that the child witnessed or is aware of physical altercations. Do we have that link yet? *(Answer: No, we only know the children were there when police arrived, but don't know if they witnessed event.)*

Finally, we need to know that for these children, it is likely to result in severe anxiety, depression, withdrawal, or aggressive behavior. Since we don't know about the extent of abuse or children's knowledge, we don't know this. From the research, what DO we know about the circumstances which increase the likelihood of these results from children's exposure to violence? *(Answer: The younger the child, the more extensive the exposure; the more violent the exposure, the more likely…we can also find out if children are developing early indicators, or if they appeared traumatized by the known incident[s].)*

Digging Deeper: *Domestic violence can take many forms and may have diverse effects on children. This is why domestic violence situations are included on the screening tool in multiple categories of maltreatment. What is the county's general approach to domestic violence? In the hotline tool, the SDM system focuses on the child's response to the situation to determine what the CPS response should be.*

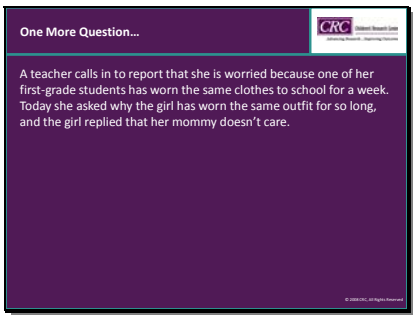
Slide 26



Exercise: Given the example, what question would you need to ask to be able to determine if the situation meets the threshold for a response or not?

Answer: We need to know if there's any indication that the mother will continue to use to the extent that her ability to care for the child is compromised. If the nurse doesn't know, can the doctor provide any information? Are other family members present? What can they tell us about her history, parenting planning, and skills?

Slide 27

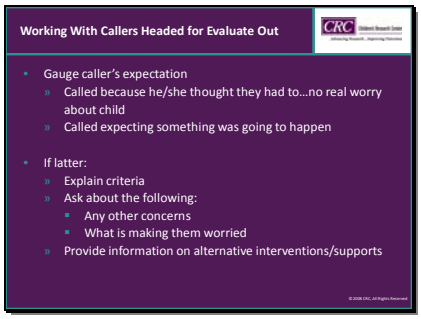


Exercise: Given the example, what question would you need to ask to be able to determine if the situation meets the threshold for a response or not?

Answer: Was the outfit weather-appropriate? Does the child appear to have asked to wear the outfit repeatedly? Are there other indicators that mother might be neglecting the child (e.g., sending the child to school without lunch or means to procure lunch, evidence of lack of bathing, injury to the child)?

Additionally, the teacher is a mandated reporter. Why does she think that this situation requires a CPS response? Is she a new teacher? If this situation does not meet the threshold for a response, you might discuss the threshold with the teacher so that she can make a better reporting decision in the future.

Slide 28



Before moving on to response priority, there are a couple of final considerations. Your position is part of customer service. You are the public voice of the agency. Every contact with a caller is an opportunity to educate and motivate callers about what they should call in and what they should not. It is also your opportunity to have that person hang up and think about the positive experience he/she just had.

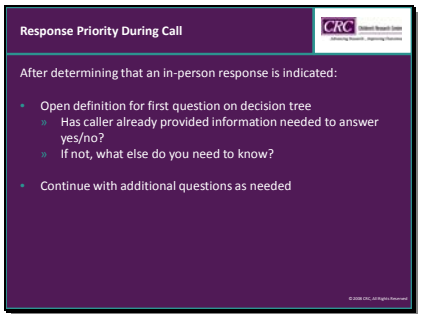
If you are about to tell the caller that you will not be sending someone out to respond to the caller's concerns, it's important to think about downstream consequences. Will this news contribute to the caller's negative view of the agency? Will she not call the next time, and will that leave a child in danger? Or will she continue to call about frivolous concerns because you take the call each time so she figures she is on target?

Step one is to get a sense of the caller's expectations. It's entirely possible she was only calling because she thought it was required. In these circumstances, you can thank her for

the concern, and provide some guidance about the appropriate threshold for making a referral. Reporters may think they need to call in about every bruise they see. We often make clear to mandated reporters that they don't need to investigate, but some interpret that so broadly, they think they have to call first before making even reasonable layperson inquiry about a fairly innocuous statement, symptom, or observation.

On the other hand, a caller may feel strongly that the department ought to do something. Some reporters will never be satisfied with a decision to not respond, but many will understand if you take a moment to explain the potential downside to responding. This could be related to the impact on the family; the intrusion into private life, which is reserved for pretty serious concerns; or the deployment of staff away from very dangerous situations. Help the caller to know where the threshold is so that if things do get worse, he or she knows when to call back. Always ask about any additional concerns. If the caller's statement seems to fall quite short of a screening threshold, ask the caller what makes him worried about this child. It may be that there is good cause for concern, but the caller is not able to clearly articulate it. Finally, if the caller seems committed to finding help for a child/family and it's clear that the concern is for a need, not abuse or neglect, provide the caller with alternative resources.

Slide 29

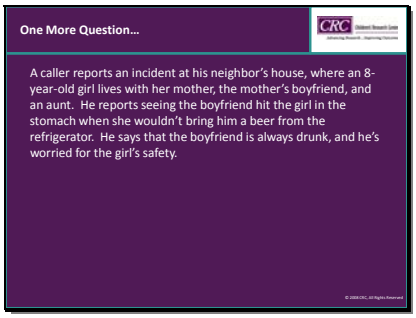


If the referral is screened in, open the definition for the first box on the first applicable decision tree (or skip to a different decision tree if there is more than one and you think a different allegation is more serious). With the definition open, see if what you already know leads to a yes/no answer. If it does, you move to either a termination point or another question. If the definition is unclear, use the definition to shape the question you ask the caller. Be sure you think about the definition chain, and don't leave any missing links!

Continue in this way until you reach a decision. Having the definitions open as you go will assure that you get the information you need.

With some callers, it may be important to point out that it looks like you will probably respond, but need to ask a few more questions to help decide how quickly. Otherwise, callers may be frustrated that you keep asking questions.

Slide 30



Exercise: Given the example, what question would you need to ask to be able to determine if the situation requires an immediate or ten-day response (five-day in Los Angeles County)?

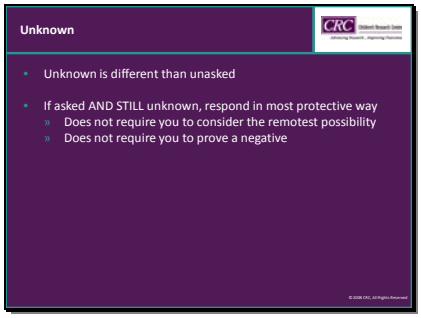
Answer 1: Response priority physical abuse decision tree. Need to get at whether the child requires immediate medical evaluation OR whether hit to abdomen was with substantial force. When did this happen? How did the girl respond (e.g., double over, fall down,)?

Answer 2: Already know alleged perpetrator lives in home. May want to verify that he is still living there.

Answer 3: Would be a "yes" if the statement about being always drunk holds up. It would be good to ask for a little more detail…Can you tell me as much as you know about his drinking? How often is he drunk? How drunk does he get? If caller's additional detail is weak (e.g., well, he drinks a couple of beers every now and then), you may need to explore prior CPS history, whether there are physical altercations among adults, or whether 8-year-old is afraid or has any special needs.

Answer 4: What did mother do? What did aunt do? Has this ever happened before?

Slide 31



Before we do some practicing, we have to address the reality that even asking the best questions won't always get you all the information you need. Sometimes the caller simply does not have a vital piece of information. In general, the SDM policy is that when faced with unknown information we must respond in the most protective way. While that is true, common sense is needed!

First, unknown is different than unasked. Just because the caller doesn't mention an important piece of information does not mean we apply the most protective response. Ask the question. And that doesn't mean to ask the caller the question on the SDM tool…ask it in a way THIS caller is likely to understand. For example, if caller is a grandmother with a high school education, don't ask, "Does the baby have indicators of failure to thrive?" Ask about the child's size compared to other grandchildren at that age, has baby been growing, is baby active, does baby cry, how is baby eating?

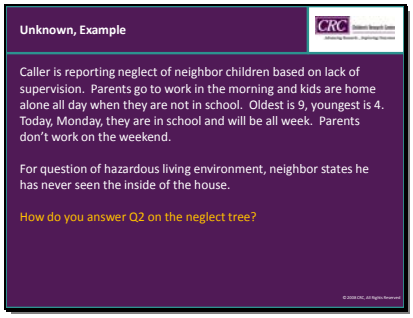
If the caller STILL does not know, remember that you do NOT have to do the following:

- Consider the remotest possibility. Yes, a 2-year-old was in the car alone for a minute while mother got out to mail a letter. Yes, it was 85 degrees AND the dog could have locked the door AND the car could have run out of gas causing the air conditioning to go off AND AAA could have been backed up AND dad lost the spare key AND a bad thing could have happened. But odds are this is really, really unlikely.

- In thinking about whether the child is vulnerable (page 19 of P&P Manual), the child is scheduled to be in school the rest of the week and has a good attendance record. But you can't tell the future, so you don't KNOW the child will be in school, and there is a chance that lightning will strike the school and it will burn down. But this is really, really unlikely.

- You do not have to prove a negative. The caller reports physical abuse. You don't ALSO mark sexual abuse just because the caller can't confirm that there is no sexual abuse. For neglect, "does the child need immediate medical/mental health evaluation?", you don't need to get a doctor on the phone to tell you the child does not need evaluation.

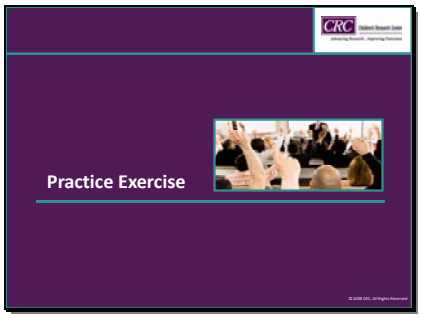
Slide 32



Here is another example. In this situation, how would you deal with missing information?

(Answer: The caller can tell you about the absence of hazards outside; whether the caller can see/smell any indicators of hazards from outside; whether caller has seen illness/injury that would be a likely result if there were hazards inside; etc.)

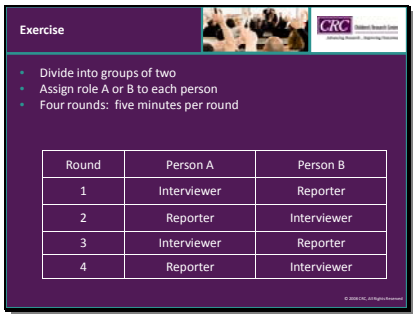
Slide 33



Now we're going to put everything we've reviewed into practice.

Note to trainer: There are a set of instructions on page 41 of this manual that describe how to do this exercise if you have a group of three people.

Slide 34



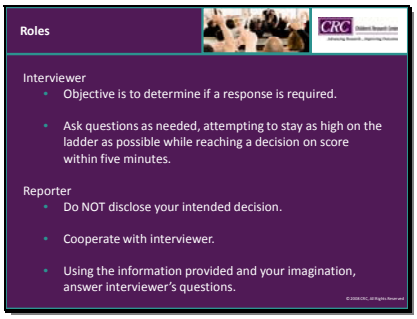
In our pairs, we're going to take turns being each half of the reporter-hotline worker interview.

There will be four rounds of five minutes each. In your groups, each choose letter A or B. Each person will take on each role for five minutes. Take a few minutes before each round to review the scenarios.

Each of you will have two reporting scenarios. Use this time to review the relevant definitions, decide what additional details you might need to add to your story, and generally prepare for the interview.

If at any point during the role play you need to step out of your role, raise your hand. That will indicate to me and to your partner that you're going to start a non-role play discussion.

Slide 35



Your role as interviewer is to use what we've learned today to gather enough information to score the hotline tool while keeping your questions as open-ended as possible.

When you are the reporter, your role is to cooperate with the interviewer by answering his/her questions using the information I will pass out and your imagination. Do not reveal your intended score.

Both the interviewer and the reporter should have the hotline tool definitions out so that they can refer to the standards given. This will help the reporter keep any information he/she adds to the scenario within the definition for the letter on their role assignment. It will also help the interviewer craft follow-up questions.

Person A: Interviewing Exercise

Break into groups of two. In each group, one person is "A" and one is "B." Take a few moments and review the definitions related to your scenarios. Think about what you need to know as an interviewer. Also think about your role and how you will answer questions based on your scenario. ***Do not disclose the item score you will represent.***

There will be four rounds of the exercise, with each person rotating through each role twice. Each round will include five minutes for interviewing, and we will begin each round with two minutes of preparation time.

Round	Person A	Person B
1	Interviewer	Reporter
2	Reporter	Interviewer
3	Interviewer	Reporter
4	Reporter	Interviewer

Scenario for Round 2

You are an emergency room worker calling to report concerns about an 8-year-old girl. The incident fits within the guidelines for severe neglect, and does require a response.

Imagine that a child has been brought in by mother with a broken arm. Mother is currently without a fixed address, and they have been staying with relatives. For the past few days, they have been staying at the grandmother's house, and mother left her daughter in grandmother's care while she went out for a few hours to look for a job. When she got home, the girl had a broken arm because she had fallen from the roof of the house.

If you are asked open-ended questions or general questions about the child's situation, you may offer some information unrelated to the allegation, but should also include some information related to possible neglect.

Scenario for Round 4

You are a family member calling to report an incident that you believe requires a response. The incident approaches the threshold for physical abuse or neglect. However, no response is required.

Imagine that at a recent family gathering, father was playing with his daughter and tossing her up in the air. He threw his daughter into a moving ceiling fan, and she now has bruising on her face and wide parallel cuts on her face and head.

Person B: Interviewing Exercise

Break into groups of two. In each group, one person is "A" and one is "B." Take a few moments and review the definitions related to your scenarios. Think about what you need to know as an interviewer. Also think about your role and how you will answer questions based on your scenario. ***Do not disclose the item score you will represent.***

There will be four rounds of the exercise, with each person rotating through each role twice. Each round will include five minutes for interviewing, and we will begin each round with two minutes of preparation time.

Round	Person A	Person B
1	Interviewer	Reporter
2	Reporter	Interviewer
3	Interviewer	Reporter
4	Reporter	Interviewer

Scenario for Round 1

You are a babysitter calling to report concerns about a 5-year-old boy. The incident approaches the threshold for emotional abuse, but does not require a response.

Imagine that you have arrived for a babysitting job for a family you sit for frequently. You are five minutes late, and the parents are somewhat rushed getting out the door because they are worried that they will miss the start of their movie. The only child in your charge is a 5-year-old boy who bursts into tears when you ask him how he is. He says that he wants to run away because his father killed his dog. He wants to run away and live with his grandfather. He insists that he will never speak to his father ever again. You have never noticed any inappropriate or abusive behaviors by the boy's father in the past and the family has always seemed happy and functional to you. The dog was a 15-year-old mutt, had gone blind, and had been having difficulties with mobility lately. The family has not discussed it with you, but it's reasonable to ask if the dog was put to sleep for veterinary reasons.

Scenario for Round 3

You are a neighbor calling to report concerns about a 6-year-old girl. The incident fits within the guidelines for physical abuse and non-accidental injury, and does require a response.

Imagine that your next-door neighbors are a family (mother and father) with two children. One is a girl about 6 years old who walks past your house each day on her way to school. The other child is a boy of about 15 or 16. He does not appear to be home very much and never stops to talk on his way past. When the girl came home from school yesterday afternoon, she looked fine, but this morning she had a large bruise on her arm.

If you are asked open-ended questions or general questions about the child's situation, you may offer some information unrelated to the allegation, but should also include some information related to possible physical abuse.

Interviewing Exercise—for a group of three
Person A

Use these instructions only if you are part of a group of three. One person is "A," one is "B," and one is "C." Take a few moments and review the definitions related to your scenarios. Think about what you need to know as an interviewer. Also think about your role and how you will answer questions based on your scenario. ***Do not disclose the item score you will represent.***

There will be four rounds of the exercise, with each person rotating through each role twice. Each round will include five minutes for interviewing, and we will begin each round with two minutes of preparation time.

Round	Person A	Person B	Person C
1	Interviewer	Reporter	
2		Interviewer	Reporter
3	Reporter		Interviewer
4	Interviewer	Reporter	

Scenario for Round 3
You are a neighbor calling to report concerns about a 6-year-old girl. The incident fits within the guidelines for physical abuse and non-accidental injury, and does require a response.

Imagine that your next-door neighbors are a family (mother and father) with two children. One is a girl about 6 years old who walks past your house each day on her way to school. The other child is a boy of about 15 or 16. He does not appear to be home very much and never stops to talk on his way past. When the girl came home from school yesterday afternoon, she looked fine, but this morning she had a large bruise on her arm.

If you are asked open-ended questions or general questions about the child's situation, you may offer some information unrelated to the allegation, but should also include some information related to possible physical abuse.

Interviewing Exercise—for a group of three
Person B

Use these instructions only if you are part of a group of three. One person is "A," one is "B," and one is "C." Take a few moments and review the definitions related to your scenarios. Think about what you need to know as an interviewer. Also, think about your role and how you will answer questions based on your scenario. ***Do not disclose the item score you will represent.***

There will be four rounds of the exercise, with each person rotating through each role twice. Each round will include five minutes for interviewing, and we will begin each round with two minutes of preparation time.

Round	Person A	Person B	Person C
1	Interviewer	Reporter	
2		Interviewer	Reporter
3	Reporter		Interviewer
4	Interviewer	Reporter	

Scenario 1
You are a family member calling to report what you believe to be abuse and what may approach the threshold for neglect. It does not fit the definition of either and does not require a response.

Imagine that after many years of living on the east coast, you have returned to California to find that your sister is raising her three children (two girls, ages 8 and 9, and a boy, age 12) as vegans. Even their dog is vegan. You are sure that such a diet cannot be sufficient to the needs of growing children. You don't care what your sister has to say about tofu and beans. And all the children clearly have hygiene issues—even the boy has long hair (no matting, looks like he combs it at least once a day).

Scenario 4
You are a teacher calling to report concerns about a child in your class. The incident approaches the threshold for neglect, but does not require a response.

Imagine that the child, who is 10 years old and in the fifth grade, told his friends that he was given alcohol at a family birthday party for his grandmother last month. During a lunchroom discussion, he says that he is often given wine at family gatherings and eggnog at Thanksgiving. He brags to his friends that he is allowed to drink because his family is cooler than theirs.

If you are asked open-ended questions or general questions about the child's situation, you may offer some information unrelated to the allegation, but should also include some information related to possible neglect.

Interviewing Exercise—for a group of three
Person C

Use these instructions only if you are part of a group of three. One person is "A," one is "B," and one is "C." Take a few moments and review the definitions related to your scenarios. Think about what you need to know as an interviewer. Also, think about your role and how you will answer questions based on your scenario. ***Do not disclose the item score you will represent.***

There will be four rounds of the exercise, with each person rotating through each role twice. Each round will include five minutes for interviewing, and we will begin each round with two minutes of preparation time.

Round	Person A	Person B	Person C
1	Interviewer	Reporter	
2		Interviewer	Reporter
3	Reporter		Interviewer
4	Interviewer	Reporter	

Scenario for Round 2
You are a babysitter calling to report concerns about a 5-year-old boy. The incident approaches the threshold for emotional abuse, but does not require a response.

Imagine that you have arrived for a babysitting job for a family you sit for frequently. You are five minutes late, and the parents are somewhat rushed getting out the door because they are worried that they will miss the start of their movie. The only child in your charge is a 5-year-old boy who bursts into tears when you ask him how he is. He says that he wants to run away because his father killed his dog. He wants to run away and live with his grandfather. He insists that he will never speak to his father ever again. You have never noticed any inappropriate or abusive behaviors by the boy's father in the past, and the family has always seemed happy and functional to you. The dog was a 15-year-old mutt, had gone blind, and had been having difficulties with mobility lately. The family has not discussed it with you, but it's reasonable to ask if the dog was put to sleep for veterinary reasons.

Slide 36

Note to trainer: Invite groups to report on their experiences.

Slide 37

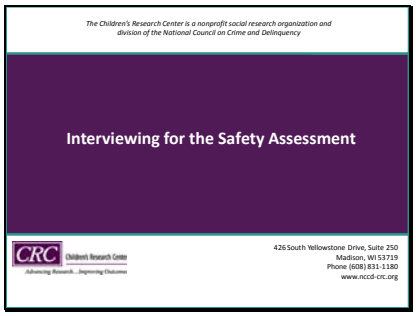
Note to trainer: Conclude by asking every person to describe one new idea or skill that they will begin to use as soon as they return to work.

SAFETY ASSESSMENT

Materials needed:

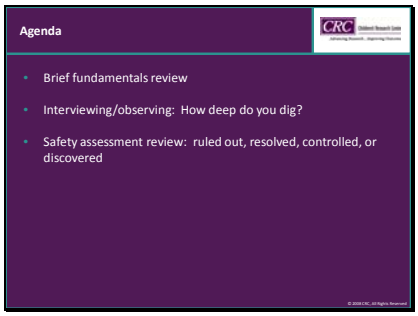
- Trainer
  - » This manual
  - » PowerPoint [Safety Interviewing.ppt]
- Students
  - » At each seat at start of class:
    - Safety assessment handout
    - Safety assessment exercises 1 (as a single sheet), 2 (as its own packet), and 3 (as a single sheet)
    - Safety assessment section of P&P Manual (or entire manual)
      NOTE: You can have students bring their own, have copies to handout and collect at the end of class, or have copies they can take with them.
- Audio/visual
  - » Laptop/projector/screen
  - » Whiteboard or flipchart is optional

Slide 1



Trainer may start with an introductory exercise of his/her choice.

Slide 2



We will begin with a brief review of the fundamentals of the SDM safety assessment.

The main concept we'll work with today is the question of how deeply you have to dig in each safety threat item before reaching a conclusion as to whether it applies or not. As we do that, we'll get ideas for various ways to use interviewing and observation to rule in or rule out each safety threat. We'll do some brief exercises to try out the conceptual approach we'll be learning today.

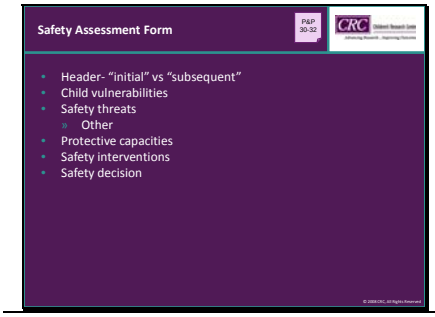
Toward the end, we will also discuss the issue of safety reassessment: once a safety threat has been identified, how do you know when it's gone? We'll talk about four possibilities for change at safety assessment review: ruled out, resolved, controlled, or discovered.

Slide 3

First the review. The purpose of the safety assessment is to identify children who are in imminent danger of serious harm. The two key words are imminent and serious.

Because the safety assessment identifies **imminent** danger of **serious** harm, it forms the basis for protective placement. When there is at least one safety threat and there are insufficient protective capacities to mitigate that threat, conditions exist to make an immediate removal. There should never be a removal by a child protection worker without a court order UNLESS the safety assessment supports it.

Slide 4



Let's look at the assessment together. Please look on page 30 of your P&P Manual.

Often we're tempted to skip right past the header, but let's stop and spend some time here. When we complete the header, we need to indicate if this safety assessment is the "initial" assessment, completed at the first face-to-face contact, or a "subsequent" assessment. Before the end of the day, we'll learn more about conducting subsequent safety

assessments.

The first section after the header is child vulnerabilities. How is this used in safety assessment? *(Answer: Each item is considered based on the most vulnerable child. This helps remind us of a particular vulnerability).* Next are the safety threats. These are 12 things that every worker is responsible for examining on every visit. These are things that, if present, would create imminent danger of serious harm. On the assessment, you have only two options, either yes or no for each one. At the conclusion of a safety assessment, you need to mark each one yes or no. Today we'll talk about the process of getting to the yes or the no.

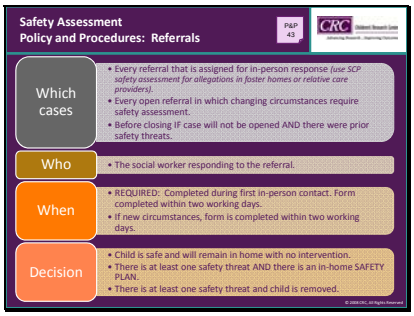
Item 13 is "other." We know that not every possible threat will fit into the 12 categories, and we trust your clinical judgment to identify a unique threat. Be sure that if you use "other," it is something that doesn't fit in an existing category, but is as imminent and serious as the things that are there.

The next section will look at the safety assessment at the point of protective capacities, but we'll walk through the fundamentals now. If there are no safety threats, you are finished. There is no need to search for capacities to mitigate threats if there are no threats. There is no need for interventions, and the decision is complete: it will be safety decision #1.

If you identified at least one threat, your next task will be to determine whether you can work with the family to develop a safety plan. That task begins with identifying protective capacities the family already has. You have to get something to work immediately, so this is not about BUILDING capacity, it is about USING existing capacity. If you can't identify protective capacities, you won't be able to develop a safety plan. The work toward determining whether existing capacities can be used to build a safety plan is the work we will discuss in the next module.

After you have walked through these steps, the safety decision is automatically marked in webSDM. This may feel as if the SDM system is making the decision for you, but all it is doing is reflecting your decision. You make the decision to mark a safety item yes or no. You make the decision about whether there are protective capacities. You decide whether the safety plan is sufficient or not. Based on your input, webSDM simply presents the logical result.

Slide 5



The policy and procedures for safety assessment are pretty similar whether you are working on a referral or on an open case, but we'll talk about them separately. First, for referrals: every referral assigned for in-person response should have at least one safety assessment. The first safety assessment on a referral is marked "initial." Note that there is now a version of the safety assessment called SCP safety assessment that you should use if you are investigating allegations of maltreatment by a substitute care provider (SCP).

There are a couple of logical exceptions to the "every open referral" guideline: If you can't locate the family despite following all county policies for locating a family (note that this is different from a family that is avoiding you…that is probably a safety threat itself); or if the assignment is based on something other than an allegation of abuse or neglect (e.g., courtesy home visit).

Note to trainer: If the allegation relates to a substitute care provider (SCP), the worker should use the SCP safety assessment.

The initial safety assessment is always done during the first in-person contact. The first in-person contact may involve more than one interview at more than one location, but always ends the same day it started. Even if you still have more questions you need to ask, more places you need to see, even if you think you'll get more information the next day, you have to make a safety decision before you end the day because you are either taking the child with you or not.

So what are you basing that on?

Mark what you know, and act on what you know before you leave the home. The documentation is officially due within two working days, but it's best practice to document immediately. If anything happens to you or the child that night, your best bet is to have a documented safety assessment. It's very quick to do while the information is fresh in your mind. If you DID the assessment in the field, recording it in the office will only take a couple of minutes. If you wait, you may forget details. Because safety is a volatile concept that can change rapidly, the longer you wait, the harder it will be to remember what you knew at different times.

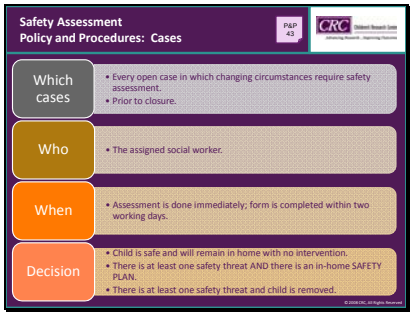
You also need to do a review/update if conditions change while the referral is open. If you become aware of a change in safety, you should assess the change right away and document

within two days. Again, the sooner the better.

Finally, if you are closing the referral and not promoting it to a case, you must do a closing safety assessment IF the most recent safety assessment shows that there was a safety threat. This makes sense: we would not walk away from a family knowing that a child was in imminent danger of serious harm.

The decision will be either no safety plan is needed; OR a safety plan is required; OR the child is going to be placed on an emergency basis.

Slide 6

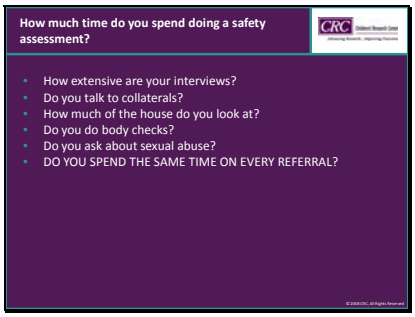


If you are assigned a case, the first thing you ought to do is look at the safety status of that case. Are there any threats now? Is there a safety plan that you just assumed responsibility to monitor? You need to know the current safety status of every one of your cases. During the life of a case, there will be times when everything is safe. There may also be times when you may need to temporarily introduce some safety interventions, or even times you need to make an emergency removal because things changed so fast you don't have time to go to court. You need a safety assessment review/update. When conditions change, you have two days to document, but you will want to document as soon as possible.

Finally, if you are considering closing a case, you must do a closing safety assessment. This assessment must show that there are no safety threats. If it does not, closing the case is probably not an option.

The decisions are the same as for safety plans during referrals.

Slide 7

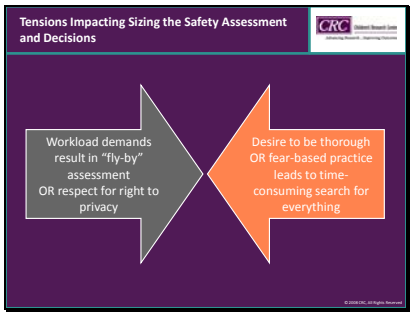


Think about the last 10–20 safety assessments you did.

Note to trainer: Title will appear first. Click to reveal each bullet. Ask questions one by one and generate several responses from participants.

In doing case reading over the years, it's clear that some safety assessments are done very quickly, and others take much more time. That makes sense. The question is, do we spend the right amount of time on each safety assessment? Case reading sometimes reveals safety assessments that were done too hastily, and others that used time that wasn't needed. How do you know how much time to spend? Let's think of the pressures on you at the point of safety assessment.

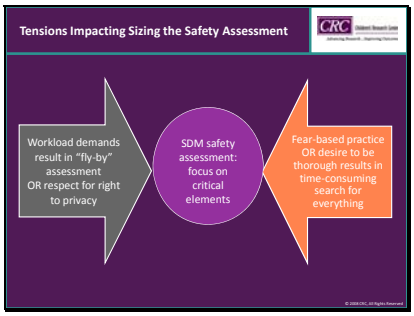
Slide 8



On one hand, you want to be thorough. Every worker is committed to keeping children safe, and we don't want to go home at night thinking we might have missed something. Alternatively, we can get into fear-based practice, especially after headlines or other critical events. These pressures can leave us afraid to stop looking for fear that we'll overlook some critical piece of information.

On the other hand, while we are doing one home visit, how many are lined up waiting for us? We can get tempted to make decisions very quickly, operating on the first impression because we have time for only one impression. Also pushing on us from this side is the need to respect the family's right to privacy.

Slide 9



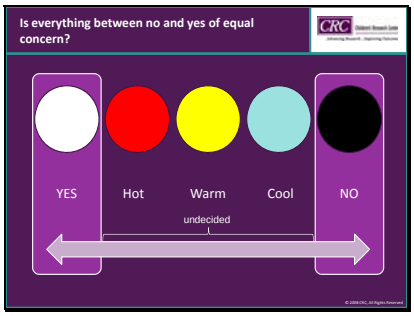
One value of the SDM safety assessment is that it mediates between these competing tensions by helping us know where to focus. You don't have a blank page to write on, so that if something goes wrong—whatever you write—the next person can always find one more thing you should have thought about. Instead, here is the list. Here are the things. Take the time you need to answer these things—no more, no less.

Slide 10

But, even with the SDM system's focus on the 12 safety threats, how do you know when this safety assessment is complete? The short answer is that it is complete when all 12 items are sorted into either yes or no. The harder question is what is between yes and no?

Safety assessment as a "process" is never complete. However, an individual safety assessment FORM needs to be completed at specific points.

Slide 11



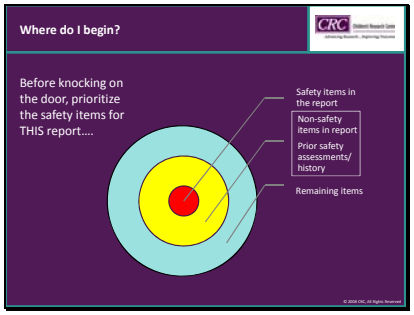
When you first knock on the door, all 12 items are between the yes and the no. They are undecided. Until you interview and observe, you can't rule any item out or in. However, going straight down that list of 12 items and giving equal emphasis to each is an inefficient use of your time. A better approach would be to prioritize.

Today we'll learn a simple three-level triage system for the undecided items that will inform the question of how much time you need to spend on each item before moving it to the yes or the no. For simplicity, we'll refer to these undecided categories as hot, warm, and cool. It's important to note that this is all conceptual. There is no such thing on the safety

assessment. We can't stop on hot, warm or cool. We have to get to yes or no. But you may find it helpful to sort items into these categories to help prioritize your assessment and help to know when you have enough information.

Note to trainer: It may be useful to reiterate that hot items are not Yes. Cool items are not No. This system is just an approach to help us prioritize our time.

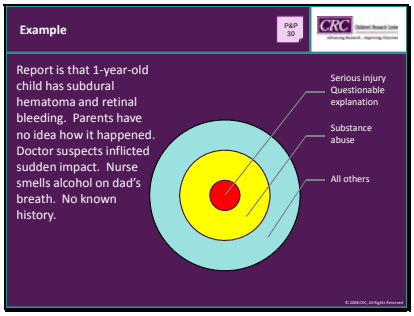
Slide 12



Now we're going to look at some of the facts from a referral. An actual referral narrative would have more information than you have here, but we're going to try to make some initial sorting decisions based on just this information.

Let's start before you even knock at the door. Look at the screener narrative. What is being alleged? Is there anything in the report that, if true, meets the definition for a safety threat? If so, consider that a HOT item. Is there anything in the report that doesn't really meet the safety threshold but is in the area of a safety threat (for example, the caller mentions domestic violence, but doesn't have enough detail to qualify as a safety threat)? This would be a WARM item. Other WARM items would be items that this family previously had as safety threats or in their readily available history. For example, you check webSDM and see that on a previous referral, the safety assessment had item #9 marked. Item #9 would be WARM in this referral. All other items would be COOL.

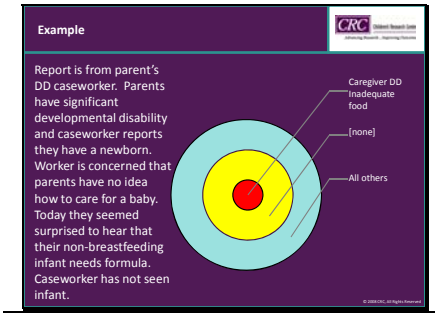
Slide 13



Let's try this example. Which items are HOT? WARM? COOL?

Note to trainer: Use mouse or keyboard arrow to reveal answers on the slide.

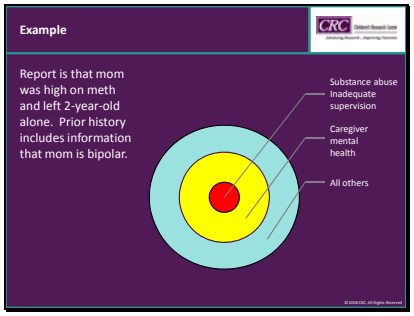
Slide 14



Try this one. Which items are HOT? WARM? COOL?

Note to trainer: Use mouse or keyboard arrow to reveal answers on the slide.

Slide 15



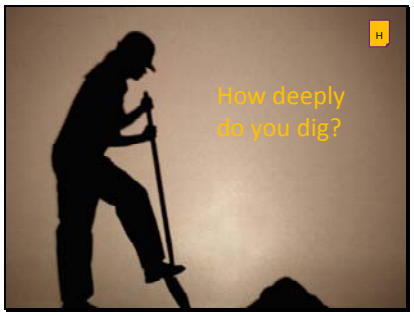
And this one? HOT? WARM? COOL?

Note to trainer: Use mouse or keyboard arrow to reveal answers on the slide.

It's important to emphasize that we are not answering YES or NO to anything yet. We are still undecided. But we are triaging the 12 safety threats so that we know where to start, and…*(next slide).*

Note to trainer: As you transition to the next slide, refer participants to the safety handout.

Slide 16



How deeply do you dig? Look at the handout. Notice that each safety threat has ideas for how much you need to do if that threat comes in as HOT, WARM, or COOL.

There are some important caveats to this handout. First, this is not a complete list. It is just to give you ideas of the general level of inquiry appropriate for different safety threats based on what we already know about that safety threat. Second, some of the ideas, especially for HOT items, require discussion with your supervisor, and possibly counsel, before you proceed.

You can take a look at these items while we describe the general ideas for depth of assessment for COOL, WARM, and HOT items.

Safety Assessment Interviewing and Observation

1. The extent of assessment per item may vary depending on the initial report, family history, and information emerging during the assessment.

1.1. Confirmed "yes": Worker has facts that meet the threshold of safety item based on what is currently known.

1.2. Uncertain

1.2.1. "Hot": The item is mentioned in the referral in a way that, if confirmed, constitutes a safety threat; OR, during assessment, information emerges that is likely to be a safety threat, but is not quite confirmed.
1.2.2. "Warm": The subject of an item is mentioned in the referral, but the allegation is less serious than a safety threat OR there is a family history in the area of a safety threat OR information emerges that suggests a possible safety threat, but the information is ambiguous.
1.2.3. "Cool": The item is not mentioned in the referral and no information emerges that suggests the safety threat is present. ALSO includes items that were HOT or WARM that have been nearly ruled out, but final confirmation is needed.

1.3. Confirmed "no": Worker has facts that rule out the presence of the safety item based on what is currently known.

2. A safety assessment is "complete" when all items have been assessed at the appropriate level and are confirmed as either "yes" or "no."

2.1. If worker is at the end of shift or there are other logistical barriers to completing a safety assessment the same day it began (e.g., caregiver is unreachable), worker should discuss with supervisor.

2.1.1. Any already identified safety threats must be addressed immediately. This requires either a safety plan or a protective placement.
2.1.2. If there are no confirmed safety threats but there are "hot" items, account for child safety while assessment is continuing. Involving another shift, law enforcement, or overtime may be necessary to complete the safety assessment promptly. Completion of this safety assessment is a top priority.

3. Pursuit of safety items at various level of uncertainty. See handout.

4. Items may increase or decrease in priority as information emerges, until item is confirmed "yes" or "no."

5. Interview styles will vary depending on the nature of the referral and the style of the family.

5.1. When referral does not contain safety threat allegations AND family is more open, interview style may be more open-ended and start with more general questions.

5.2. When the referral contains allegations that would constitute a safety threat AND/OR family seems less open to general conversation, interview style will be highly focused on reported issues and safety threats.

6. Worker should systematically work through safety assessment, starting with hottest items.

6.1. Assess for any "hot" items.

6.1.1. If present, determine whether to proceed immediately to the safety plan or if the safety assessment can be completed before starting the plan.

6.2. Assess for any "warm" items.

6.2.1. If any "warm" items increase to "hot" as a result of interviews/ observations, go back to 6.1.

6.3. Assess remaining "cool" items.

6.3.1. After all items are confirmed either "yes" or "no," complete safety plan if needed (and not already done).
6.3.1. Proceed to risk assessment if needed.

7. Safety reassessment

7.1. Ruled out. On a previous safety assessment, a safety threat was marked based on information available at the time. New information has emerged that confirms the threat never existed in the first place. Complete a new safety assessment showing the item now confirmed as "no." (Do not revise the previous safety assessment, because it accurately reflects what was known at the time.)

7.2. Resolved. On a previous safety assessment, a safety threat was marked. Since that time, the safety threat has been resolved and it is likely that the threat will not re-emerge in the immediate future. Complete a new safety assessment showing the item now confirmed as "no."

7.3. Controlled. On a previous safety assessment, a safety threat was marked. A safety plan was put into place and is working. The plan is necessary to keep the threat from re-emerging. No safety assessment is required.

7.3.1. Uncontrolled. On a previous safety assessment, a safety threat was marked. A safety plan was put into place. The plan is no longer working and the threat remains. A new safety assessment and new safety plan is needed, or a protective placement is made.

7.4. Discovered. A safety threat that was not present previously is now confirmed. A new safety assessment and safety plan or protective placement is required.

Safety Assessment: How deeply do I dig?
Ideas for Pursuing Undecided Safety Items

NOTE: That an area of questioning or observing is mentioned below does not confer the legal authority to pursue it. Be sure to know the legal issues in your jurisdiction. If needed, seek legal consultation. This table is meant as general guidance and is not an exhaustive list of assessment questions or observations. These suggestions are examples and are not intended as a comprehensive list.

Safety Item	Hot	Warm	Cool
Serious harm	• Observe injury, check for other injuries • Medical reports, medical opinion, medical exam • Forensic interview of child victim, all caregivers, all witnesses (coordinate with law enforcement)	• Questions about reacting to particularly stressful situations • Questions about beliefs regarding discipline • Ask child about injuries to self or siblings • Tell me how that happened	• Observe for visible injuries, implements used for discipline • During interviews, listen for spontaneous reports about injuries, dangerous discipline techniques • General question about discipline
Sexual abuse	• Forensic interview (coordinate with law enforcement) • Medical exam if needed • Detailed questions about non-abusing caregiver's belief, willingness to protect child • Child's perception of safety • Location of perpetrator, ability to access child	• Ask child age-appropriate, non-leading questions about touching, grooming behaviors • Ask caregiver about change in behaviors, sexualized behaviors, contact with persons of concern	• During interviews, listen for spontaneous reports about sexual touch, sexual behavior, discomfort/ fear related to a person, etc. • General question about anyone who makes child uncomfortable, any worries, anything child would like help with
Unable to protect	• Detailed questions about caregiver's knowledge of harm/potential harm to child • Detailed questions about caregiver's recent protective behaviors • Detailed questions about caregiver's plans for protecting child in immediate future and capacity to carry out plans	• Ask child about who helps keep him/her safe • Ask child how caregiver responded when child told • Ask caregiver about plans for protecting child	• During interviews, listen for spontaneous reports about harm by a third party • General question about child's perception of safety, who keeps him/her safe • If there is no report or concern of child being harmed by someone other than the caregiver, no further inquiry is needed
Questionable explanation	• In individual interviews, gather each witness's detailed account of incident (including child and alleged perpetrator; coordinate with law	• General question to child, caregiver about how injury occurred • Observation of plausibility of explanation and/or conflicting accounts	If no injury/illness, no further inquiry is needed

Safety Item	Hot	Warm	Cool
	enforcement if needed) • At least one medical opinion about cause and potential for injury to have been caused as reported • May require physical evidence (generally handled by law enforcement, but be aware of avoiding contamination of evidence)		
Refuses access/flee	• Specific location of child. Verify. • Determine whether access is being refused entirely or if agreeable arrangements can be made to see child • If access is refused, consult legal authority • Detailed inquiry of where caregiver will be/ how caregiver can be reached. Verify. • In some instances, immediate protective order, security plan may be needed (e.g., threat to remove very ill child from hospital AMA)	• Questions about where family members can be reached in next several days • If indicators of impending flight or refusal of access were observed, ask for explanation	• Are you able to complete interviews as needed? • During interviews, listen for spontaneous statements suggesting flight or intent to avoid further access • Observe for indicators that family may be preparing to leave
Immediate needs unmet* *See appendix for more detailed description of each type of need	• Detailed questions (of child, caregiver, others) about the presence or absence of specific need • Detailed questions about efforts to meet need in recent past • Detailed questions about plans to meet need in immediate future • Detailed questions about impact of unmet need on child. May require medical and/or mental health professional input.	• Questions about how caregiver is meeting child needs* • Ask child about his/her experience specific to concern*	• During interviews, listen for spontaneous reports* • Observe for indicators of unmet needs*

Safety Item	Hot	Warm	Cool
Hazardous living conditions	• Detailed questions about how long the condition has existed • Detailed questions about efforts to resolve condition • Detailed questions about efforts to protect child from condition • Detailed questions about injuries/illnesses to any household member as a result of condition • Detailed plans for resolving condition • What harm could come to child as a result and what is the likelihood of that harm (i.e., a child will likely sustain a very minor injury vs. a severe injury could result but it's highly unlikely vs. a severe injury is likely)?	• For interviews outside the home, follow up on any spontaneous statements or observed illness or injury with general questions (e.g., how did you get so many bug bites?) • For interviews outside the home where history has raised the item to middle priority, ask about whether prior concerns are present now (e.g., tell me what it's like inside your house now? What would I see if I walked in your front door?) • In home, ask to see operation of utility in question (e.g., turn on lights, look for stopped-up sinks or inoperable toilets) • To follow up on observed potential hazard, ask about how long it's been that way, whether anyone has been injured, how he/she is protecting child from hazard	• For interviews outside the home, listen for spontaneous reports of hazardous conditions or harm resulting from hazardous conditions • For interviews outside the home, observe for signs of illness or injury resulting from hazards • When in the home, observe for hazards, operating utilities
Caregiver substance use	• It is NOT necessary to have a diagnosis of substance abuse • Observe level of incapacity (e.g., balance, speech, judgment, volatility) • Establish child's age/developmental status/maturity/vulnerability to determine self-care ability while caregiver is under the influence • If caregiver is not obviously under the influence during interview: » Detailed questions about use—what is used, how often, how much » Detailed questions about incidents during intoxication in which child was injured, unattended » Use pattern, plan to use in the near future	• For historical information, ask caregiver how he/she is doing since last contact; any treatment he/she has completed; support groups he/she is attending; any use • Ask child how caregiver has been doing, whether child is concerned that use has resumed • To follow up on observed signs of intoxication or use, state observation and ask caregiver's explanation • If use is established but safety is uncertain, ask about effect on child, where is child during use	• During interviews, listen for spontaneous reports • For young children, listen for knowledge of using behavior • Observe caregiver for signs of intoxication • Observe residence for signs of drug/alcohol abuse

Safety Item	Hot	Warm	Cool
Domestic violence NOTE: If there is any indication of domestic violence, interview separately.	• Detailed questions about violent incidents/ threats including frequency, severity, injuries, use of weapons • Location/involvement of children • Impact on child. What does child do when it happens? After it happens? • Police record checks	• Questions about how decisions are made/ conflict is handled • Questions about freedom (e.g., can one parent go out, make phone calls, spend money without fear?) • Questions about how you are getting along with partner • Do you ever feel afraid of your partner? Have you ever been struck in anger?	• During interviews, listen for spontaneous reports of violence and/or power/control in caregiver relationship • Observe signs of violent behavior, such as damage to walls, doors, injuries on caregiver
Emotional harm	• Specific details of frequency of incidents, child's reaction to incidents • Specific details about child's emotional status (how long, how severe, behavioral indicators) • Child suicidal/self-harm behavior detail	• Questions about caregiver's view of child/behavior toward child • Questions about child's emotional/ behavioral status	• During interview, listen for spontaneous reports about caregiver behavior toward child/child's emotional status • Observe child for indicators of severe emotional distress
Caregiver mental health, cognitive ability	• Questions about specific existing diagnosis/ assessment (who, when, what, prescribed treatment) • Questions about existing treatment/support plan and extent to which it is being followed • Questions about impact on child	• Ask caregiver to describe his/her understanding of pertinent caregiving responsibilities. • Ask caregiver and/or child to describe typical day, who does what • Ask caregiver about how he/she is coping	• During interview, listen for caregiver content suggesting lack of understanding for basic caregiving responsibilities, loss of touch with reality, mention of incapacitating depression, etc. • During interview, watch for affect or behavior that might indicate mental health or cognitive deficit • Observe for unmet child needs

APPENDIX: BASIC NEEDS IN DETAIL

Basic Need	Hot	Warm	Cool
Supervision	• Establish age/developmental status/maturity/special needs of child: How capable is child of self-supervision? • Detailed questions about recent times child was alone: How long? Under what circumstances? Include whether child is currently home alone. • Detailed questions about caregiver's plans to provide supervision in the immediate future: Who will watch child when caregiver is away? What do we know about that person? • Interview caregiver, child, and perhaps others about any incidents that occurred while child was alone, such as accidents, poor judgment/decisions. NOTE: Same type of question applies if concern is that caregiver is present but inattentive.	• Questions about whether child is ever home alone (or unsupervised in other circumstances) and if so, how long? • Observe extent to which caregiver attends to child during interview • Ask child known to be alone at times how he/she would handle various situations; how safe he/she feels	• During interviews, listen for spontaneous reports • Was young child home alone on arrival?
Food	• Medical opinion/diagnosis • Presence/absence of food in home • Size and appearance of child • Detailed questions of child related to recent food intake, feelings of hunger • Detailed questions of caregiver related to recent feeding, availability of food, ability to secure food • In some instances, beliefs about feeding	• Ask child about food likes/dislikes; what he/she has eaten in last day; who fixes meals; whether child is hungry (if so, describe more to distinguish from normal hunger) • Ask parents to talk about typical meals, whether it's easy or hard to provide enough food for family • Ask to see refrigerator and cupboards	• During interviews, listen for spontaneous reports of going without food, withholding food • Does child appear strikingly underweight, listless, or have other signs of possible malnutrition or failure to thrive?
Clothing	• Medical opinion regarding existing or potential hypothermia, frostbite, sunburn, sunstroke, etc. • Determine why clothing being worn was worn (for example, child may be diagnosed with frostbite, but parent had provided gloves to child in the morning and child lost them)	• Ask about whether child has more appropriate clothing	• During interviews, listen for spontaneous reports of dangerously inappropriate clothing • During interview, is child's clothing appropriate to weather?
Medical	• Medical consultation regarding child's	• Ask caregiver about how he/she is	• During interviews, listen for

Basic Need	Hot	Warm	Cool
	condition. May require second opinion. Be specific about the following: » What will happen if treatment is not provided (include timeframes) » What treatment would accomplish if provided » Details of prior attempts to get treatment to child • Caregiver's understanding of child's condition and treatment plan options	addressing child's medical need, and whether there are any difficulties accessing health care or following prescribed treatment plan • Ask child about trips to doctor, medicines taken, how caregiver helps him/her with illness/injury/condition	spontaneous reports of missed medical appointments, untreated medical conditions, treatment plans that are not followed • Observe for general wellness—does child appear ill or does condition appear untreated?
Mental health	• Determine acuity and severity of mental health situation. Is child psychotic? Does child have suicide plan? Does child's depression result in child not getting to school? • Determine specific efforts caregiver has made to provide treatment/support. Was caregiver aware? • Determine caregiver's plans to provide treatment in the immediate future • If child is suicidal, determine plan to provide safety	• Ask child age-appropriate questions about mental health • Ask caregiver about child's mental mood, symptoms • Ask caregiver about any barriers to getting help/support for child	• During interviews, listen for spontaneous reports of missed mental health appointments, suicide threats that were not responded to, psychotropic medication that is not provided, etc. • Observe child for affect, behavioral indicators of mental health concerns

References

Bragg, H. Lien. (2003). *Child protection in families experiencing domestic violence*. U.S. Department of Health and Social Services, User Manual Series. http://www.childwelfare.gov/pubs/usermanuals/domesticviolence/domesticviolence.pdf

Slide 17

Remember that cool items are those that were not mentioned in the report or the history. Cool items can't be overlooked, but don't require extensive assessment before it's reasonable to conclude that they are not present.

You can probably think of referrals that had most items start out COOL, and maybe one WARM item that was quickly ruled out. These safety assessments can be done rather quickly, and you can move on to risk assessment.

Slide 18

WARM items are also not specifically alleged as safety threats, but the report contains information in the areas of the safety threat. You might think of these as safety threats for which some, but not all, elements of the definition are present. For example, the call is about physical abuse, but the reported injury is not serious. You'd consider safety #1 warm to start. A WARM item is also an item that you find historical information about. You won't be reading volumes of past history, but a quick look in webSDM can let you know if this family has had any prior safety threats.

HINT: For SafeMeasures counties, you can search for the current referral, which will bring you to the history page. The history page will list any associated referrals. You can search for each associated referral you find and see the SDM assessments that have been completed for each. For each safety assessment completed, the safety decision will be displayed. If the safety decision was safe, you know there were no safety threats, so you don't have to open the assessment. If the safety decision was conditionally safe or unsafe, you can copy and paste the specific referral number into the search field in webSDM to view the safety assessment. Be sure that if it is still in editable mode you don't click on anything!

An alternative method is to copy/paste prior referral numbers that come up in CWS/CMS into the referral search function in webSDM and see if any safety assessments were completed.

An item can become WARM during the assessment if new information emerges. A cool item can become warm if you observe or hear something that is an indicator of a condition that MIGHT be a safety threat. For example, you see lots of empty beer cans and maybe an ashtray with a roach clip. This warrants further inquiry, but is not in and of itself a safety threat. You'll need to do more assessment.

An item can become WARM if it started as HOT, and as you

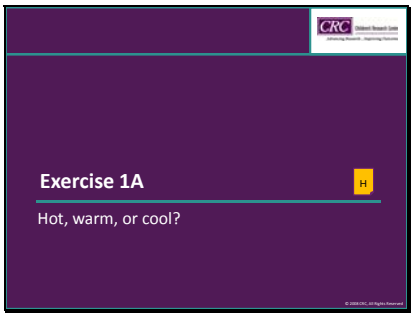
begin your assessment the early information argues against confirming the threat as a YES, and it's beginning to stack up more toward a NO, but you don't have all of the pieces yet.

Slide 19

Finally, HOT items are those that were alleged in the report in such a way that if what the reporter says is true, it is a safety threat. Many 24-hour responses will have at least one HOT item.

An item will become HOT during the assessment if new information arises that would be a safety threat if confirmed. The difference between a HOT item and a YES answer is evidence.

Slide 20



Let's try a quick exercise. For each of the six scenarios, mark whether you think the item is HOT, WARM, or COOL. Assume that you don't have enough information do decide YES or NO. Leave the last column blank.

Note to trainer: Allow a few moments for participants to complete each scenario, then ask for responses. Address any responses that suggest the concept is not fully understood. If the worker has a good reason for marking something other than the suggested response, that is fine. Even if there are differences, point out that this is a concept, not a defined final decision. While presented as three discrete categories, it is really more of a continuum. If a supervisor thinks an item is warm and a worker thinks it is cool, ask questions that are a little more than general and a little less than very specific!

EXERCISE #1A
(Answer Key)

Hot, Warm, Cool

In each of the following situations, there were no indicators of safety threats in the referral information and no history of safety threats. During early in-person contact, the indicated information emerges. Check whether the information constitutes a hot, warm, or cool item. (Next steps will be completed later.)

New Information	Yes	Undecided			No	Next Steps
		Hot	Warm	Cool		
1. During the course of interviewing the child at school, she mentions that her dad can get pretty mad if she doesn't bring home good grades.				**X**		
2. During the course of interviewing the child at school, she mentions that her dad can get pretty mad if she doesn't bring home good grades. Later, you ask what it's like when he dad gets mad. She says he has spanked her pretty hard.			**X**			
3. During the course of interviewing the child at school, she mentions that her dad can get pretty mad if she doesn't bring home good grades. Later, you ask what it's like when her dad gets mad. She says he has spanked her pretty hard. You notice she is sitting gingerly and grimacing occasionally.		**X**				
4. As you are talking to the mother, she seems very nervous and frequently mentions needing to check with her husband. She denies any problems at home. You learn they moved here from several states away. She knows no one and seems to spend all day in the house.			**X**			
5. As you are talking to the mother she explains that they have a traditional view of marriage. Father works outside the home and is considered the head of the household. Mother is not happy about being reported. She appears confident and talks about activities she participates in.				**X**		
6. As you are talking to the mother, she seems very nervous and frequently mentions needing to check with her husband. She denies any problems at home. You learn they moved here from several states away. She knows no one and seems to spend all day in the house. You notice small bruises on both of her upper arms. She admits that her husband took her by the arms and shook her, and that her 8-year-old was present at the time. She says this happened just once, and he had been under a great deal of stress.		**X**				

Slide 21

Cool items should not be overlooked, but they don't require extensive assessment before it's reasonable to conclude that they are not present. You should have your eyes open for indicators of these items, and listen for spontaneous statements. You should ask some very general questions that would get at these areas, but if nothing emerges, you don't have to dig deeper and deeper. You can move that undecided safety threat into the NO column.

If observations, general questions, or spontaneous statements provide some indicator of a possible safety threat, the COOL item heats up. How much it heats up depends on what you observe.

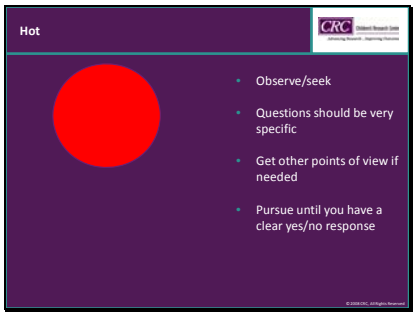
Note to trainer: Read through a few examples of cool item actions from the handout.

Slide 22

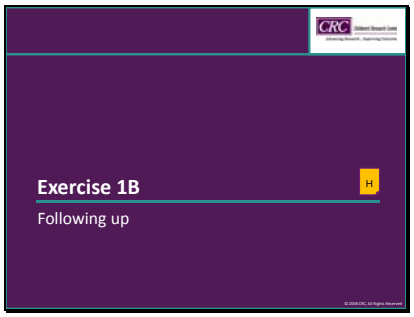
For WARM items, you will observe. You will use interviewing, but rather than general questions, you'll ask more specific and detailed questions. You'll want to ask in more than one way.

Note to trainer: Read through several examples of warm item actions from the handout.

Slide 23



When you have a HOT safety item, you must be assertive. You cannot let go of this item until you either rule it in or out as a safety threat. You will not only observe; you will seek. Your questioning must become very specific. You will often need additional points of view, such as medical or mental health opinions. You will often be working jointly with law enforcement and/or children's advocacy centers. Sometimes even a HOT item will be ruled out quickly. When you arrive and discover that the reporter was clearly and completely mistaken, you will go quickly from HOT to COOL and then to NO. At other times, the decision to go from HOT to YES will be complicated and may require hours. If you are at the end of your shift, you need to consult with your supervisor. If there is an unresolved HOT item, you have to make a plan. If you already have a different safety threat, make a safety plan for that threat (or pursue placement). If there are no other safety threats, you and your supervisor must decide to either 1) work overtime, 2) have the next shift take over, or 3) complete the safety assessment based on what you know now, which is that you do NOT have a safety threat. Double check your facts—are you certain that you do not have a safety threat? The amount of evidence you need is at the

	"reasonable" level, not the "beyond a reasonable doubt" level.
Slide 24 	Return to the Exercise 1 handout. Based on whether an item is HOT, WARM, or COOL, list ideas in the "Next Steps" column for interview questions, collateral contacts, observations, etc., that could help move toward a clear yes/no answer. Use the safety handout for ideas. *Note to trainer: Allow a few moments to complete, then process. Note that, based on specifics of situation, ideas for follow-up will go beyond what is in the handout. Just help workers keep within the appropriate range of follow up for the hot, warm, or cool items.*

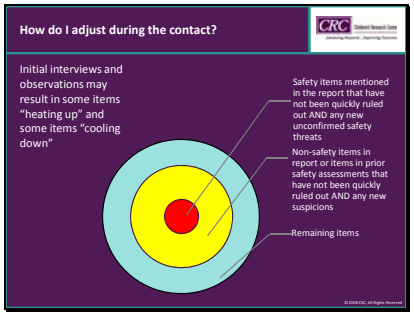
EXERCISE #1B
(Answer Key)

Hot, Warm, Cool

In each of the following situations, there were no indicators of safety threats in the referral information and no history of safety threats. During early in-person contact, the indicated information emerges. Check whether the information constitutes a hot, warm, or cool item. Then fill in some follow-up questions or investigation strategies in the Next Steps area.

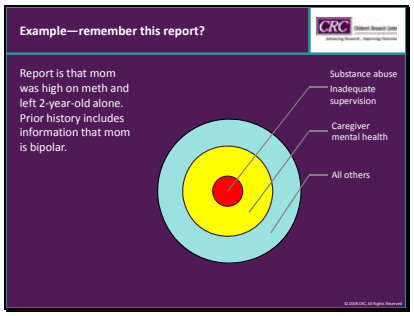
New Information	Yes	Undecided			No	Next Steps
		Hot	Warm	Cool		
1. During course of interviewing child at school, she mentions that her dad can get pretty mad if she doesn't bring home good grades.				X		**What happens when dad gets mad? How do you feel when dad gets mad? What else makes dad mad?**
2. During course of interviewing child at school, she mentions that her dad can get pretty mad if she doesn't bring home good grades. Later, you ask what it's like when dad gets mad. She says he has spanked her pretty hard.			X			**What does dad spank with? Does dad spank a lot? When was the last time dad spanked? Has dad ever spanked so hard that it was hard to sit down after?**
3. During course of interviewing child at school, she mentions that her dad can get pretty mad if she doesn't bring home good grades. Later, you ask what it's like when dad gets mad. She says he has spanked her pretty hard. You notice she is sitting gingerly and grimacing occasionally.		X				**Does it hurt you right now to sit? What happened? Observe for marks/bruises as appropriate.**
4. As you are talking to the mother, she seems very nervous and frequently mentions needing to check with her husband. She denies any problems at home. You learn they moved here from several states away. She knows no one and seems to spend all day in the house.			X			**You seem a little on edge—are you worried about something? How has it been for you since moving here? What was the reason for your move? History check from other state.**
5. As you are talking to the mother, she explains that they have a traditional view of marriage. Father works outside the home and is considered the head of the household. Mother is not happy about being reported. She appears confident and talks about activities she participates in.				X		**What types of activities are you involved in? How do you define a traditional marriage? How does that view translate to your approach to parenting?**
6. As you are talking to the mother, she seems very nervous and frequently mentions needing to check with her husband. She denies any problems at home. You learn they moved here from several states away. She knows no one and seems to spend all day in the house. You notice small bruises on both of her upper arms. She admits that her husband took her by the arms and shook her, and that her 8-year-old was present at the time. She says this happened just once, and he had been under a great deal of stress.			X			**Ask the mother to talk about what happened. Get criminal history check from previous state. Ask mother to discuss the stress her husband is under and how she might handle things if he were to grab her again. How were the children impacted?**

Slide 25



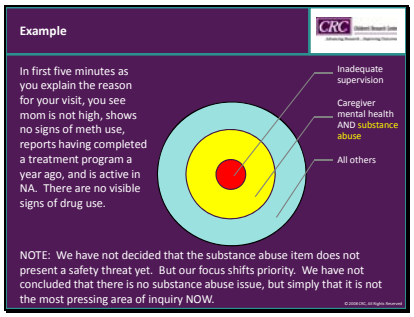
We mentioned that information that emerges during the assessment can turn up the heat on an item or cool it off.

Slide 26



Let's go back to this report. This is where we started.

Slide 27

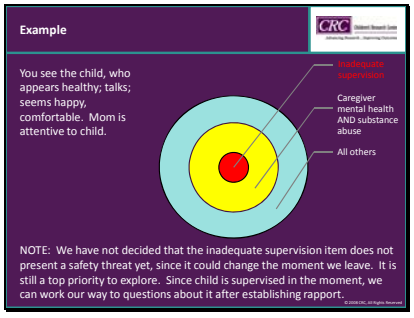


Suppose that you learn this information. Now, what is HOT? WARM? COOL?

Note to trainer: Ask the class what they think. Use the mouse or keyboard arrows to reveal answers on the slide.

It's important to note that we "cooled off" substance abuse. Mom is not high right now. Why have I not just marked it NO? *(Answer: Will need more information to be confident that mom is not likely to use again in the near future.)* We are not assessing risk or needs, only safety, which is imminent danger of serious harm.

Slide 28

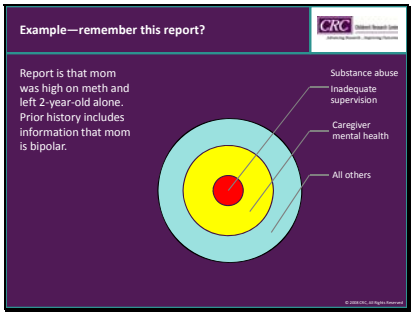


Here is what happens next. Now what is HOT? WARM? COOL?

Note to trainer: Use mouse or keyboard arrow to reveal answers on the slide.

We have learned that the child is currently with mother. Why did we not cool off the inadequate supervision item? *(Answer: We haven't determined that it didn't happen recently or that it is unlikely to happen imminently.)*

Slide 29

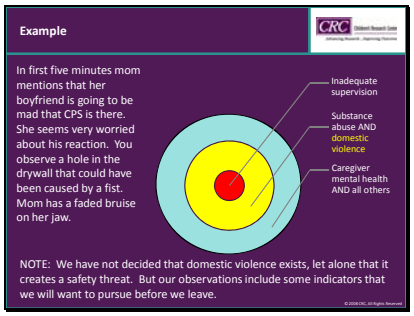


Now what? HOT? WARM? COOL?

Note to trainer: Use mouse or keyboard arrow to reveal answers on the slide.

Remember that mental health issues were not mentioned at all in the current report. Our only basis for having it WARM to start with was prior history, and we are seeing that there is no indication of current mental health issues. Why is it COOL and not NO at this point? *(Answer: We are only going on observation. It still warrants at least general inquiry in interview with mom before ruling out as a safety threat.)*

Slide 30



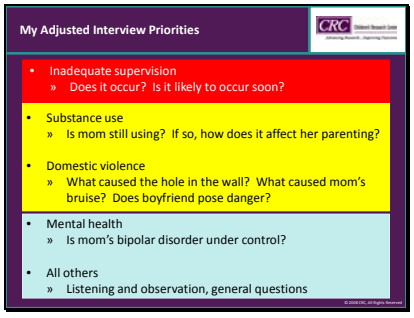
Finally, what now? HOT? WARM? COOL?

Note to trainer: Use mouse or keyboard arrow to reveal answers on the slide.

What else could these observations mean? *(Answer: Moving furniture, mom hit by her drug dealer, etc.)* We should have an index of suspicion for domestic violence when we see these things, but can't conclude that there is DV, let alone that it reaches a safety threat threshold at this time.

What kind of observations or spontaneous statements would result in a HOT DV item? *(Answer: Child says daddy hurt mommy last night. Follow up by asking why that would not be a YES. Some things the class mentions might be sufficient to rate a yes. Compare to definition and amount of evidence. In this example, we'd want some verification and would need to know how it poses a safety threat to child.)*

Slide 31



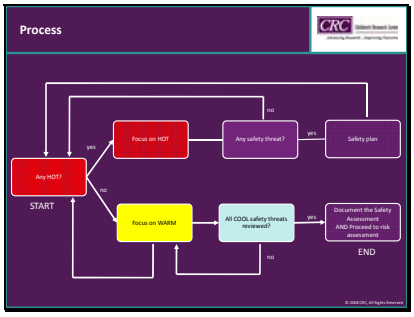
So, in our example, we have shuffled the items around a bit in the first five minutes, and we are left with this triage order.

Slide 32

Knowing the triage order before you knock on the door and adjusting as you go can really help you focus on the most critical information first. This session is not about getting into interviewing style or family engagement approaches. These are important and are covered more completely in other training. To put our safety assessment triage approach in context, let's notice that every interview will fall somewhere on this continuum. There are good reasons to try to start with general conversation and open-ended questions. This is a good approach to build rapport by letting the family know you are interested in knowing both the positive and negative, letting you get a sense of what is important to the family, and more. The fact that the SDM system begins with a safety assessment doesn't preclude this open, general approach. You have to discern clinically, however, when you need to be at the other end of this continuum. You need to focus quickly and directly on safety threats when necessary. Having HOT items would be a good time to be more focused on safety threats.

Note to trainer: Our focus on being open-ended does not begin literally from the moment we knock on the door. We will begin the contact by respectfully explaining why we are there (i.e., the allegation) and what we hope to accomplish during the visit. Open-ended questions may begin as we investigate possible safety threats.

Slide 33



Let's put it all together in a sort of road map. When you begin, ask yourself if you have any HOT items. If so, focus on your first HOT item. Interview, observe, get collateral information. Reach a conclusion. Is it a safety threat? If YES, you know you need a safety plan (you'll work on deciding whether this will be an in-home safety plan or a removal). If the danger is immediate, you can act immediately on that one safety threat. Get the child protected. You can return to reviewing the remaining items later. If the threat is not as pressing, you can hold on to that safety threat and finish the assessment, taking all possible safety threats into account. Is there another HOT ITEM? If yes, you will repeat this process. (NOTE: This is a schematic, and does not mean you can't investigate more than one HOT item at a time).

If there are no HOT items, your focus turns to any WARM items. WARM items will move in one of two directions. If the WARM item gets HOT, you go back to the beginning and focus on the item that is now HOT. If the item gets COOL, you finish any other WARM items, then go through the COOL items. When you've covered all the items, you can go

on to the risk assessment (either that day or another day).

Slide 34

Turn to Exercise 2 in your handout. You will see referral information. Based on the referral information, which items are HOT, WARM, and COOL? At several points you get new information and can adjust which items are HOT, WARM, and COOL. You may have enough information to rate some items YES or NO as you go. By the end, complete the safety threats by answering all items YES or NO.

Note to trainer: Allow time to complete, then process. If time is short, process final safety items only.

Answers: See answer key on following pages.

EXERCISE #2

Read the following vignette. Where prompted, indicate which safety threats are at hot, warm, and cool. Conclude by indicating which safety threats are present.

Referral Information: Day 1

Hospital reports birth of a child five days ago with prenatal drug exposure. The mother tested positive for opiates and admits to using drugs during pregnancy. She relapsed a few times and smoked crack cocaine. The baby's tox screen results are pending. The mother's tests have been sent to an outside lab for confirmation. She was on methadone during pregnancy. She may have tested for something else in addition to opiates, but results will not be back for 48 hours. Mother has a history of heroin addiction.

The baby is in the NICU. He was born a little premature. He has withdrawal symptoms. He is jittery and irritable. He is also having feeding problems and will not be discharged for at least five days. He is being given small doses of methadone. He weighed 5 pounds, 14 ounces at birth, and is 18.5 inches long. His APGAR scores were 7 and 9.

The mother had sporadic prenatal care, which she started in the second trimester. About four months ago she indicated interest in putting this baby up for adoption, but changed her mind. The baby's father pushed her to have the baby, and he does not want to lose the baby.

Mother was discharged yesterday. She has three adult children. She also has an 8-year-old who lives out of state with grandparents and a teenager who was adopted by other relatives. The 8-year-old's arrangement is informal.

SCENE 1

Yes	Hot	Warm	Cool	No
	#9: Substance abuse #1: Serious physical harm	#2: Prior history	All others	

Evidence for hot items:

#9: Mother has admitted to drug use during pregnancy. If true, this is inappropriate prenatal care for the child, and we have concerns about her care for the child going forward.

#1: A drug-exposed infant would meet the criteria for marking this item.

Evidence for warm items:

#2: We do not yet know why her 8-year-old and teenager are living with other relatives. Given that information in the referral, if true, would be a serious current child maltreatment concern, we would want to further investigate the reasons these children live elsewhere.

Record Review: Day 3

Review of prior CPS records indicates a long history of CPS referrals for neglect, dating back at least 20 years. Many of the older records were not readily available, but records in the past five years were available electronically. There were no referrals in the past two years, following the decision that the mother made to let her youngest (then age 6) go stay with his grandparents. Prior SDM risk assessments were always very high risk. Prior safety assessments related to the 6-year-old always indicated substance abuse and domestic violence as safety threats. The teenager who was adopted by relatives had been removed five years ago following a neglect referral. Mother was using heroin and had left the child unattended for days at a time. Reunification efforts failed and mother eventually agreed to a termination of parental rights.

SCENE 2

Yes	Hot	Warm	Cool	No
	#9: Substance abuse #2: Prior history #1: Serious physical harm	#10: Domestic violence	All others	

Evidence for changes:

#2: Now that we have more information about prior history, we have the part of the definition about previous child maltreatment and the caregiver's response.

#10: Domestic violence is added as a warm item because it was a safety threat in a previous investigation.

Hospital Visit: Day 3

On arrival you learn the baby is doing better, but is still in the NICU and still on low-dose methadone. Baby is not feeding well, and has lost more than usual weight. Doctor believes this will probably resolve in next several days. The tests for mother and child came back positive for both methadone and heroin. Baby may be ready for discharge in three to five days. He will have to be on an apnea monitor at night due to some respiratory difficulty that will eventually clear up.

You review chart and talk to nursing staff, and note that since being discharged, mother has not been to the hospital. Father has visited twice, but has not participated in any care or teaching. He brought a plastic toy truck. There have been no other visitors. According to the chart, mother and father live together. This father is not the father of any of the older children.

SCENE 3

Yes	Hot	Warm	Cool	No
	#7: Ability to meet medical needs/supervision #1: Serious physical harm #9: Substance abuse #2: Prior history	Domestic violence	All others	

Evidence for changes:

#7: Mom hasn't been to the hospital yet and has made no apparent effort to learn about her child's care needs after discharge.

Although #9 and #1 are likely confirmed at this time, we do not mark an item yes or no until we have had our first face-to-face with the caregiver.

Home Visit: Day 3

You arrive at the parents' home. As you approach the home, you note that it is a unit in an old house that has been converted to four apartments. Parents live in the upper rear apartment. The property is not well maintained but is habitable. Mother comes down to let you in. You walk up a dark staircase with no handrail. Mother says the light bulb is out, but when you enter the house you note that no electronic displays on the TV or cable box are lit. You notice the mother has a black eye and slightly swollen lip.

The apartment has one bedroom. There is a table in the kitchen, as well as an electric stove, a microwave, and a refrigerator. You see a few roaches. There are ashtrays filled with cigarette butts and a strong cigarette odor. In the living room is one couch, which is pretty tattered. It is an overstuffed couch, and in places the stuffing is coming out of fabric tears. There are three big cushions that are distorted from use, leaving large gaps between cushions. There are two plastic chairs and a television on a bookcase that is pretty wobbly. Father works odd jobs and has a toolbox in the living room with many of the tools spread around the living room. There is no crib, bassinet, or any baby-related items.

Mother appears drowsy at 2:00 p.m. She is wearing shorts and a t-shirt that look like they've been worn for several days. Her hair is uncombed. As you begin speaking with her, she does not always track your conversation.

You ask mother about the baby, and she says the baby is doing great and she can't wait for him to come home. You ask when mother expects that to happen, and she says maybe tomorrow. You ask what mother needs to do to prepare for the baby, and she says she is ready anytime. You mention that mother looks tired. She says she is fine. You ask her to tell you a little about how she has prepared for the baby. Mother starts to tell you about her adult children and how helpful they are going to be. She then seems to doze off for a minute or so before continuing.

You ask mother about her methadone, and she states that after the birth of the baby, she stopped taking methadone. She said it just wasn't as good as heroin. She admits that she has been

smoking heroin since being discharged from the hospital (as well as several times in the last weeks of pregnancy).

Mother grows impatient with talking. You ask if she can tell you how to get hold of father so you can talk to him. She tells you she threw that bum out last night and he isn't the father anyway. You ask what happened and she tells you he stole money from her, and when she confronted him, he got mad and started whupping on her. The neighbors called the police and he was arrested. She says she's not letting him back in.

SCENE 4

Yes	Hot	Warm	Cool	No
#9: Substance abuse #1: Serious physical harm #7: Ability to meet medical needs/supervision #2: Prior history	#8: Hazardous living conditions #10: Domestic violence			

Evidence for changes:

We have met the mother and have no new information to contradict the evidence we've gathered about her substance abuse, prior history, or lack of ability to meet the child's needs.

In addition, we have concerns about bringing the child into a home with roaches, cigarette smoke, and an apparent lack of electricity. We have confirmed some domestic violence, but we don't know if the father will return or not.

Phone call with doctor from your car, immediately after leaving mother's house

You describe smoky room, lack of electricity, and mother's state of mind to doctor. Doctor states that without electricity, apnea monitor can't operate and that would be too dangerous. They would also not be able to warm baby's bottle. Child's compromised respiratory system could not manage a smoky environment, and letting child go there would risk respiratory distress and failure.

Phone call with law enforcement from your car, immediately after calling doctor

Police have no record of a domestic dispute at this address and no record of arrest of anyone by father's name last night.

COMPLETE SAFETY THREAT SECTION OF SAFETY ASSESSMENT.

CALIFORNIA
SAFETY ASSESSMENT

r: 10-07

Referral Name: _____ **Referral #:** _____

County: _____ **Worker:** _____

Date of Assessment: ____/____/____

Assessment Type: ☐ Initial ☐ Subsequent (mark one): ☐ review/update ☐ referral/case closing

_____ _____

_____ _____

_____ _____

Household Name: _____ **Were there allegations in this household?** ☐ 1. Yes ☐ 2. No

Factors Influencing Child Vulnerability (conditions resulting in child's inability to protect self; mark all that apply to any child):

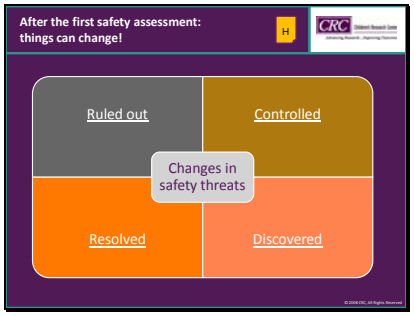
☑ Age 0-5 years
☑ Significant diagnosed medical or mental disorder
☐ School age, but not attending school
☐ Diminished mental capacity (e.g., developmental delay, non-verbal)
☐ Diminished physical capacity (e.g., non-ambulatory, limited use of limbs)

SECTION 1A: SAFETY THREATS

Assess household for each of the following safety threats. Indicate whether currently available information results in reason to believe safety threat is present. Mark all that apply.

Yes	No		
☑	☐	1.	Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by: ☐ Serious injury or abuse to the child other than accidental. ☐ Caregiver fears he/she will maltreat the child. ☐ Threat to cause harm or retaliate against the child. ☐ Excessive discipline or physical force. ☑ Drug-exposed infant.
☑	☐	2.	Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident.
☐	☑	3.	Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern.
☐	☑	4.	Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.
☐	☑	5.	Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.
☐	☑	6.	The family refuses access to the child, or there is reason to believe that the family is about to flee.
☑	☐	7.	Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.
☑	☐	8.	The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
☑	☐	9.	Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.
☐	☑	10.	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
☐	☑	11.	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
☐	☑	12.	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.
☐	☑	13.	Other (specify): _____

Slide 35



Now we've completed an initial safety assessment. Note that if you end up answering NO but had some HOT items, your narrative should reflect why you selected NO. You also want to alert a downstream worker (FM or FR or the next ER worker who gets a referral on the family) that you had information about possible safety threats that either was confirmed but just fell short of the threshold in the definition, or would have met the definition, but you lacked evidence. If the case is opened, the FM or FR worker should keep an eye out for new information that may result in confirming a safety threat.

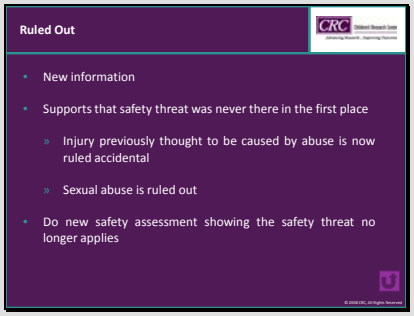
Most counties have done a very good job of getting initial safety assessments completed. But when safety changes, there are not always safety reviews/updates, and safety is not always being done at case closure. One barrier may be confusion over how to treat changes in safety items over time. Today we'll talk about four possible changes to safety threats and what you need to do in each circumstance.

Note to trainer: Refer participants to the Ruled Out, Resolved, Controlled, Or Discovered? table in the Safety Interviewing Exercises handout. Click on each hyperlink one at a time, starting with Ruled out, then Resolved, then Controlled, then Discovered.

RULED OUT, RESOLVED, CONTROLLED, OR DISCOVERED?

	Description	New Safety Assessment?
Ruled out	New information supports that safety threat was never there in the first place.	Yes
Resolved	Situation was present initially but is no longer present AND no longer relies on external intervention to maintain safety.	Yes
Controlled	• Safety threat remains but is being controlled by interventions in safety plan; OR • Safety threat is temporarily resolved, but continued intervention is required to prevent imminent reappearance of safety threat.	No
Discovered	A safety threat that was not previously marked is now confirmed as present.	Yes

Slide 36



The first option is ruled out. You were right to mark the safety threat in the first place, based on information available at the time. But new information suggests that the threat was never there in the first place.

Example #1: Child is rushed to emergency room and initial exam reveals multiple broken bones. Doctor states, "This is consistent with abuse." You mark safety threat #1.

Day 2. Orthopedic surgeon is consulted and determines child has osteogenesis imperfecta. While this does not rule out abuse, you gather interviews and confirm parents' accounts, and the injuries are all confirmed accidental.

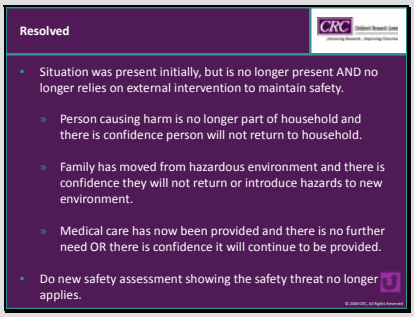
Example #2: Child made some very concerning but inconclusive statements during an interview that led everyone to suspect sexual abuse by the father. Exam was normal, but that does not rule out abuse.

Day 2. Further interviewing provides explanation for initial statements that rules out sexual abuse.

If you rule out a safety threat, you need to do a new safety assessment to show that this threat no longer applies. If you simply close the referral and something happens later, it will look like you walked away knowing there was a threat.

CLICK THE HYPERLINK TO RETURN TO SLIDE 35.

Slide 37



The second possibility is that the threat was present to start, but after a while the threat is resolved. Consider it resolved ONLY if it is not only gone for the moment, but even if you took away the safety plan, the threat would not likely return immediately.

Example #1: The person who posed the threat is gone and not likely to return. Be very careful. What is keeping the person away? If the person died, you can be pretty certain he/she won't return. Short of that, you need to use your clinical judgment about likelihood. It may require the family demonstrating success at keeping that person away. You don't have to be absolutely certain (e.g., dad is in prison for 20 years, BUT he could escape one day, so it's not resolved!). You don't have to reach certainty, but reasonable probability.

Example #2: The safety threat was hazardous living environment, and they have now moved and the new environment is not hazardous. The threat is resolved if you are reasonably confident that even if you removed the safety

plan, they would not quickly recreate the hazard.

Example #3: The threat was about failure to provide medical care. Once the care has been provided, if the situation itself is resolved (e.g., broken bone is healed), or it's a more chronic condition but you have reason to believe the parents will continue to provide care even if you withdraw the safety plan, then it is resolved.

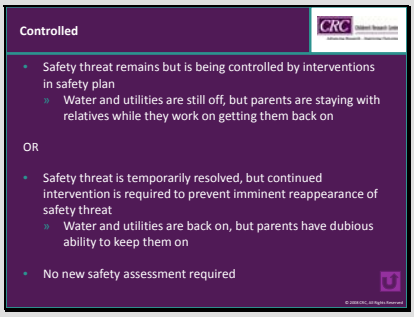
With some families, you may gain confidence that they will continue on their own by observing a few days of success. With others, you may need a few weeks or months before they demonstrate ability and willingness to do what they need to do.

NOTE: Withdrawing the safety plan doesn't mean the family stops all services. It's just that they don't need CPS to keep a safety plan that they are monitoring.

If a threat is resolved, you need to complete a new safety assessment to show it is resolved. Again, failing to do so and closing a referral or case creates a document trail that suggests you perceived a child to be in imminent danger and walked away.

CLICK THE HYPERLINK TO RETURN TO SLIDE 35.

Slide 38



A controlled safety threat is one that is present but is mitigated for now. For example, there is still a threat of domestic violence, but dad is in jail and mom and the kids went to shelter. Or the water and utilities are still off, but parents are staying with relatives.

Alternatively, the threat is temporarily resolved, but unless you have a safety plan in place and CPS is monitoring it, the threat is likely to return. For example, there was DV, but mom kicked the boyfriend out. He has no legal right to be there. Mom has kicked him out before and let him back, and it's only been one day. OR the water and utilities are back on for now and the family is back in the house, but in the past, the utilities have been shut off every couple of months because parents don't pay their bills.

You do not need to do a new safety assessment because the threat has not changed. You may update the safety plan if the plan changes.

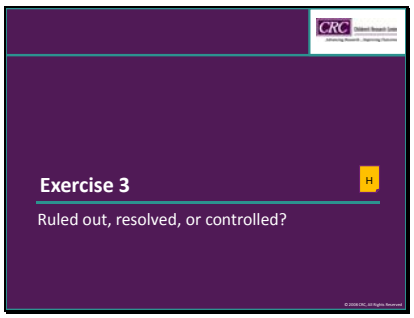
CLICK THE HYPERLINK TO RETURN TO SLIDE 35.

Slide 39

Finally, you may discover a threat at any time during a referral or a case. You need to do a new safety assessment AND you need to take action. This may mean creating a safety plan if you didn't have one already, or adding to an existing safety plan. It could also mean making an emergency removal.

CLICK THE HYPERLINK TO RETURN TO SLIDE 35.

Slide 40



Refer to Exercise 3 in your handout. For each circumstance, indicate whether safety threat is ruled out, resolved, or controlled.

EXERCISE #3

For each circumstance, indicate whether safety threat is ruled out, resolved, or controlled.

Circumstance	Answer
Safety threat #1 was originally marked based on excessive discipline or physical force. Alleged perpetrator, father, is still in the home. He maintains that corporal punishment is good and that is all he did. Child had multiple bruises on buttock, lower back, upper thighs, and one arm. Safety plan was that father would not be alone with child and mother would handle discipline. Father reluctantly agreed. Two weeks later, risk assessment is moderate. Father has spanked child once, but did not cause any injury.	❑ Ruled out ❑ Resolved ☑ Controlled
Safety threat #3 was originally marked based on mother's concern for sexual abuse by father during visits (they are divorced). Child is 3 years old. Suspicion was based on mother's report of hypersexual behavior; redness in genital area; and child stating daddy touches her there, pointing to vaginal area. Initial assessment at child advocacy center was inconclusive; there was redness and swelling, but it was non-specific. Forensic interview included some statements by child that could point to abuse, but there was no clear disclosure. Father denied abuse. Two weeks later, tests came back normal, child continues to have redness and swelling despite absence of father, and it is determined to not indicate sexual abuse. Further interviewing of child and mother lead all (except mother) to believe child is not abused.	☑ Ruled out ❑ Resolved ❑ Controlled
Safety threat #5 was originally marked because mother was denying knowledge of how child was injured. Child had spiral fracture of femur. By day two, mother revealed that her boyfriend caused the injury. She did not reveal initially because she was afraid her boyfriend would hurt her other children if he got mad, and she needed time to think things through. She has now made a statement to police and he has been arrested. He is not a legal parent to any of her children. She is convincingly committed to protecting her children.	❑ Ruled out ☑ Resolved ❑ Controlled
Safety threat #7 was originally marked because 3-year-old child was found wandering alone on the street and could not lead passersby or, later, police to his home. CPS was called and child was placed in a foster home while search for his parent continued. It was not until the next day that mother was found. She had been walking with the child in a park when she had a seizure. She had never had seizures before. Child wandered off before a passerby found mother and called ambulance. Mother was medically unable to communicate for several hours, and when she could, she had a hard time getting people to listen to her pleas to find her son. Eventually the worker connected with the mother. She helped contact her mother, who can watch the child until mother is medically cleared.	❑ Ruled out ☑ Resolved ❑ Controlled *Explanation: The safety threat was that the mother was incapable of providing appropriate supervision (#7). Her intent was not the issue. She has now resolved that threat by working with her mother and medical personnel (to manage her seizures in the future).*

Slide 41

Note to trainer: Conclude by asking each person for one idea or skill they learned that they will begin using as soon as they return to work.

If the safety planning session is not taking place in the afternoon, encourage participants to sign up for that session as soon as they can.

Slide 42

SAFETY PLANNING

Materials needed:

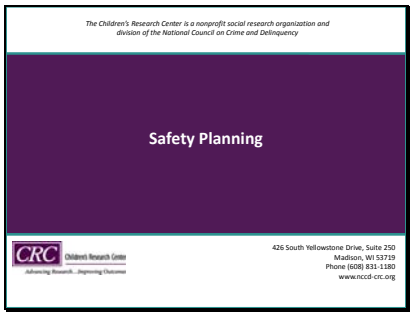
- Trainer
  - » This manual
  - » PowerPoint [Safety Planning.ppt]
- Students
  - » At each seat at start of class:
    - Safety planning handout
    - Safety assessment section of P&P Manual (or entire manual)
      NOTE: You can have students bring their own, have copies to hand out and collect at the end of class, or have copies they can take with them.
  - » To hand out during class:
    - Exercise 1: Safety Plan vs. Case Plan
      There are two versions of this exercise available. One has a list of general safety items, and one has a safety threat scenario for each safety item. Some classes will be comfortable drafting safety plan and case plan items based on a safety item, and others will require more information to complete the exercise. Select one version of this exercise and make enough copies for each member of the class. Do not print this handout double-sided.
    - Exercise 2: Safety Planning Role Play
      The class will be asked to divide into groups of two to four, and each group will be given one exercise handout. The safety planning role play document contains enough scenarios for ten groups. Make four copies of each page in the document (as a single sheet). Do not print this handout double-sided.
- Audio/visual
  - » Laptop/projector/screen
  - » Whiteboard or flipchart is optional

ADVANCE PREPARATION

Determine whether county has a specific safety plan document. (They should.) You may choose to have blank copies of the county safety plan documents available for the exercise. Alternatively, you can use blank paper. It would also be helpful to speak with a manager in advance to learn how the county approaches the transition between safety plan and case plan. If

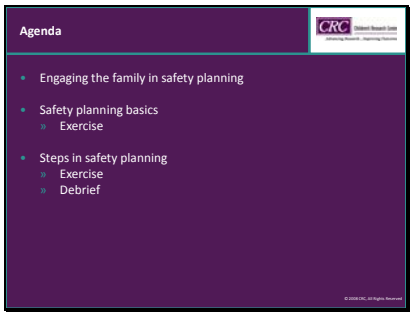
it is different than what is contained in this unit, ask the manager whether he/she will allow workers to operate according to the guidance in this curriculum, or whether the trainer will need to modify the advice. Specifically, this module teaches that safety plans and case plans are for two different purposes. The safety plan is short-term and addresses an imminent threat, while the case plan is long-term and seeks change in underlying dynamics. The safety plan can overlap with a case plan. There will always be a case plan, while safety plans may be intermittent.

Slide 1



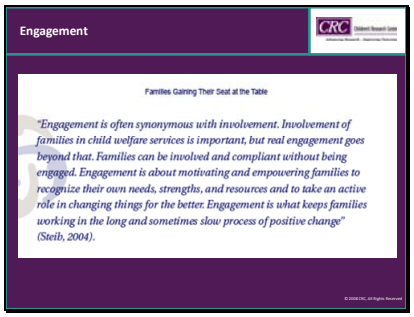
Trainer may start with an introductory exercise of their choice.

Slide 2



This unit will focus on creating safety plans that are effective and are created WITH the family. You should have already completed the unit on safety assessment. A review of SDM safety assessment fundamentals was included in that unit and will not be repeated here. We will spend a little time anchoring our thinking in basic engagement concepts. We won't be TEACHING engagement—that would be a course itself, and then some. But we do want to revisit basic principles of engagement to be sure we are all on the same page. We'll go over some basics about safety planning and do one short exercise. Then we'll lay out a step-by-step process for creating a safety plan and provide an opportunity for you to practice here in the classroom.

Slide 3



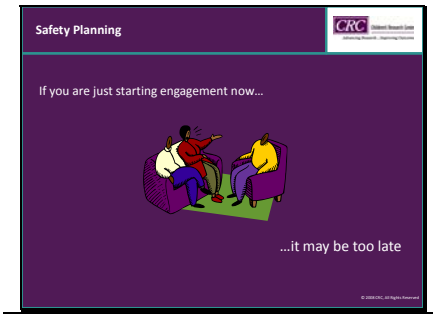
Take a moment to read this.

What are your reactions? Does it describe the kind of work you want to do?

We are about to talk about safety planning. Most counties have a safety plan document that requires parent signatures. This class will go beyond the notion that getting a signature at the end is engagement. Instead, we will work with the family every step of the way, to the extent they will let us. We can't wait for the family to engage; we have to lead them into engagement. Their prior experiences may have taught them that we will do TO them. We have to extend ourselves to convince them that we want to work WITH them. As we do this, we can't lose sight of child safety.

Cited in http://www.americanhumane.org/site/DocServer/CFSR-PIP-Review-Family-Engagement.pdf?docID=6782

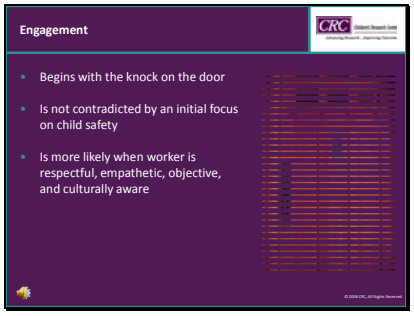
Slide 4



We did not talk about engagement in the safety assessment unit. But that doesn't mean engagement doesn't start until planning.

Click to make "…it may be too late" appear.

Slide 5



CLICK MOUSE TO ACTIVATE SOUND OR KNOCK ON THE TABLE.

From the moment you knock on the door, the family develops impressions of how you will be working with them. Engagement begins with the knock on the door. The way you approach the family and ask questions during the safety assessment communicates to the family whether you are interested in them as a family and whether they will be given a voice. This does not mean that you abdicate responsibility for child safety. It is possible to engage the family AND focus on child safety. Even in circumstances with several HOT safety threats, you can be respectful, empathetic, objective, and culturally aware. Engagement does NOT mean ignoring danger.

Note to trainer: Refer participants to handout.

Safety Planning

1. Effective safety planning depends on effective family engagement.

    1.1. Engagement is more than mere involvement.

    1.2. Engagement begins with the knock on the door.

    1.3. It is possible to be clear and objective about child safety AND practice family engagement.

    1.4. Worker actions/characteristics that support engagement include being respectful, empathetic, objective, and culturally aware.

    1.5. Introduce the concept of safety planning to family.

        1.5.1. Be clear that plan is necessary for child to remain home.
        1.5.2. Clearly explain the concern(s) with specifics for THIS family at THIS time. Write this on safety plan document as you do so. Acknowledge different points of view.
        1.5.3. Ask family who should be part of safety planning (be aware of time needed).

2. Basic safety planning concepts

    2.1. Elements of safety plan

        2.1.1. Description of safety concerns
        2.1.2. Family-friendly description of facts that create safety concern(s)
        2.1.3. Detailed information for each planned intervention (who will do what, when, for how long, how will it get done, etc.)
        2.1.4. How plan will be monitored
        2.1.5. Signatures

    2.2. Safety planning over time. Often, safety plans will need to be adjusted. For example:

        2.2.1. During first visit there was no chance to develop a safety plan and child was protectively placed. A safety planning meeting in the next day or so could potentially result in a plan, and the child can return home with plan in place.
        2.2.2. During first visit you may be unable to confirm availability of elements of a plan that would last for weeks, but you can confirm a safety plan that would last overnight. Create that short-term plan, have a safety planning meeting the next day and revise the plan.
        2.2.3. During the first visit only one caregiver was available. Develop a plan with that caregiver. If the second caregiver is necessary for the plan to work, meet with that caregiver as soon as possible to confirm participation, or modify plan or decision.

2.2.4. Plan was created, but after days or weeks plan is no longer working for any reason. Hold a safety planning meeting to modify plan or decision.

2.3. Special considerations when domestic violence is a safety threat or has not been ruled out as a safety threat.

2.3.1. Discuss safety planning with the adult victim alone.
2.3.2. Only involve and/or discuss safety plan with alleged perpetrator if victim consents AND your professional judgment is that it would be safe to do so.
2.3.3. Some parts of safety plan should never be shared with alleged perpetrator (e.g., escape plans).

2.4. Safety plan vs. case plan

2.4.1. Safety plan begins NOW and is designed to control the specific, immediate safety threat.
2.4.2. Case plan activities are selected after comprehensive assessment; they address underlying dynamics and promote long-term change.

3. Steps. Note that different families and circumstances will require more or less leadership from the worker. Engage the family to the extent that the family is willing and able.

3.1. Identify protective capacities. Protective capacities are skills, abilities, or resources the family already has that can directly mitigate the specific safety threat.

3.1.1. Incorporate what you already know.
3.1.2. Start discussion by telling family about a protective capacity you have already observed, if possible. (If not, describe something that could be a protective capacity if you learned more about family.)
3.1.3. Ask family additional questions as needed. See Table 1.

3.2. Generate ideas. NOTE: Some families will appreciate the ability to put ideas on the table and discuss them. Others will be less likely to engage in this step. Whenever possible, present family with at least one choice between two options that you would support. See Table 2.

3.2.1. When appropriate, ask family first.
3.2.2. When you introduce ideas, generally present them as options rather than requirements at this point.

3.3. Test ideas. Generating and testing ideas is not necessarily a linear sequence.

3.3.1. Restate the safety threat(s) and evaluate available ideas to be sure that, if selected, they would adequately mitigate the threat.

3.4. Finalize written plan

3.4.1. Agree on elements. Be specific about who will do what, by when, for how long, where, etc. These should be concrete actions that can be observed.

3.4.2. Agree on monitoring. For each part of safety plan, be clear about how worker will know that it is being carried out and is working. See Table 3.

4. Additional considerations

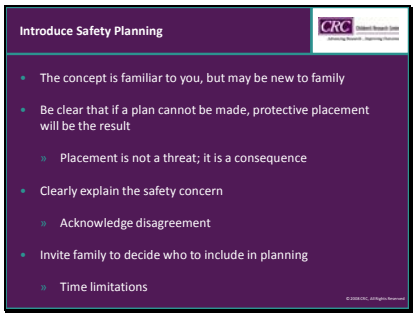
4.1. What if worker and family do not agree? Worker is ultimately responsible for child safety.

4.1.1. Exercise professional judgment to determine whether compromising on an element of the safety plan would compromise child safety.
4.1.2. Exercise professional judgment to determine how far to go in encouraging family to accept plan. Are you achieving involvement or engagement?

4.2. What if family agrees but you doubt their willingness/ability to follow through?

4.1.1. Consider incorporating additional monitoring. Check more often, have more monitors involved. Would that increase likelihood of plan working?
4.1.2. If removal is necessary, consider creating opportunities for family to begin implementing part of plan immediately after placement to demonstrate their ability. If successful, return home could be made quickly.

Slide 6



So you've now completed your assessment and there is at least one safety threat confirmed. You have to address that threat right now, before you do anything else. You need to get the family engaged in safety planning.

Click to make each bullet appear.

If you begin by telling the family you are now going to work together on a safety plan, chances are the family will not know what you mean. In our business, we use the term "safety plan" routinely and it means something to us. The words alone are not technical, so we may think it's obvious. The family may think it's obvious. But there may be large or small misperceptions about what safety planning is about that could lead to problems down the road. So take a moment to explain what a safety plan is, what it is designed to do, what it is NOT designed to do, how long it will last, and what will happen if it doesn't work.

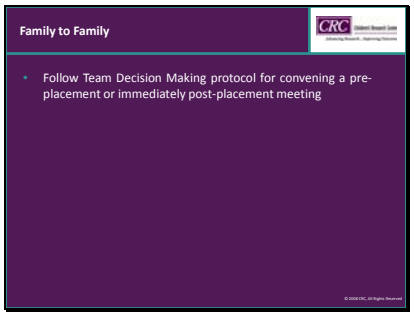
It's really important that the family understand the consequences of not agreeing on a plan. Assuming you followed the definitions in deciding a safety threat existed, the threat is imminent and serious, and if you can't agree on a plan, you have a basis for emergency detention. Removing the child from the home should not be presented as a threat, but as a consequence. Don't present emergency placement as a possible consequence if you were stretching a definition. If you can't legitimately make an emergency placement and have a reasonable expectation of county counsel carrying through with a detention petition, don't use a safety plan as a way to get the family to agree to services they don't want.

Take a moment to lay out the specific safety threat, including the evidence you are relying on to conclude that the threat is present. Use family-friendly language here. This can be written right on the safety plan document. If the family disagrees with you, then make a note that the family disagrees. If you believe the evidence supports the presence of the threat, the threat is present. Engaging the family means listening to their point of view and giving it weight, but not replacing every other perspective with that of the family. Your professional responsibility is to weigh all perspectives and make your decision.

Finally, ask the family if they want others to help them develop a safety plan. This could be a friend, neighbor, relative, minister, therapist, etc. Keep in mind that the initial

safety plan needs to be put in place quickly. There may not be time to gather folks. You may need to make a temporary plan to get to a family meeting and then make a more complete plan at a meeting.

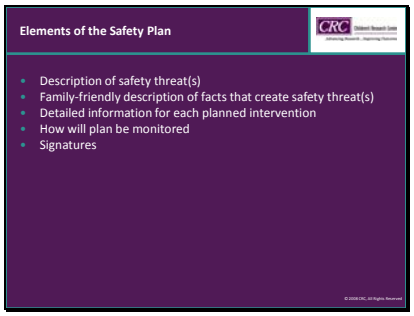
Slide 7



Note to trainer: Hide this slide if county does not use Family to Family.

As a Family to Family county, you have specific protocols for conducting placement TDMs. Follow those protocols. They are consistent with the SDM system. For example, if you have the opportunity to convene a TDM after identifying a safety threat but before making a safety decision, use the TDM process to do everything we are about to discuss. Think about doing a bridge safety plan, such as having grandma come to babysit the children for a few hours while you organize a TDM. If you can't get a TDM before making a decision, do the safety planning with the caregiver(s), but try to organize a TDM the next day. You will go into the TDM with information about what the safety threat was yesterday. The first question should be whether the threat is ruled out, resolved, controlled, or whether there are any discovered safety threats. If it turns out there are no more safety threats, the child will go home and you'll move on to risk assessment. If one or more safety threats remain, use the TDM to identify protective capacities and see if the family can come up with a workable plan so the child can go home. DO A NEW SAFETY ASSESSMENT FOLLOWING THE TDM IF ANYTHING HAS CHANGED.

Slide 8



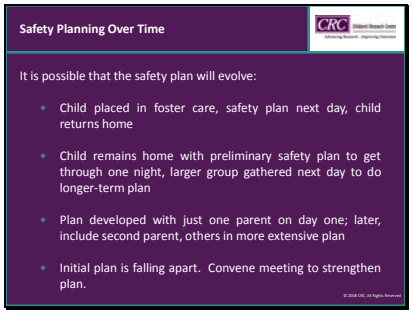
The safety plan document varies from county to county, but must contain these elements. The description of the safety threat could be just the number of safety threats present, or the name, or it could have a place to mark the box of the safety threat present. It is for you to know which safety item you marked. The next part is for the family. As mentioned previously, this is where you spell out exactly what the threat is in family-friendly language, using specifics of this incident. For example, safety threat #1 might be "Dad hit Bobby in the head and Bobby has a concussion." If dad denies, you could add, "Dad denies that he hit Bobby," but state why you believe it, "…but Bobby was diagnosed with a concussion by Dr. Niam Cray. Bobby said his dad hit him and provided a credible account, and dad was the only person alone with Bobby during the time the incident occurred. The matter will continue to be investigated."

Next are the two things we focus on in this session: detailed information for each planned intervention and how the plan

will be monitored.

Signatures should be obtained from at least one parent, children old enough to understand, and any party who you will rely on to be part of the plan.

Slide 9



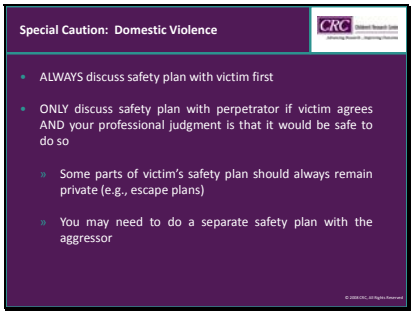
It's important to view the safety plan as a dynamic document. It's not even logical to think that a safety plan created one day will be the same plan the family needs a week later or a month later. Let's talk about different situations in which the plan might change.

Click to make bullets appear. (Bullets are self-explanatory.)

Note to trainer: The safety assessment does not need to be redone unless information on the document changes; for example, if there is a change in safety threats, protective capacities, interventions, or the decision. If the worker is making changes WITHIN an existing safety assessment, only the plan needs to be updated. For example, if the threat remains; there is no change in protective capacities; and the interventions were already marked as intervention #2, but the plan will change so that a different person assumes responsibility for child care, only the plan needs to change. But if they are going to add that child care will now be provided by a community agency and intervention #3 was not previously marked, they should update the safety assessment.

Possible discussion scenario: You have developed a safety plan with the family. As you monitor the safety plan, you realize that it is not working. If you're willing to renegotiate the safety plan, will the family think this means they can "call your bluff" and not follow the new safety plan either? (The discussion might include trying to determine why the family did not follow the original safety plan. Did they completely disregard it? Did they try to follow the plan but meet with unexpected obstacles? It might be that the only solution is to remove the child. In such cases, it is important to emphasize to the family that this is not about punishment; sometimes a lack of safety can't be resolved in the short term.)

Slide 10



Some families will have domestic violence issues co-occurring with child maltreatment. Whether the DV is at the level of a safety threat or not, when DV is present the worker needs to be aware of family safety even while focusing on child safety. There are a few special considerations. Though not always, there is usually one caregiver who is in a victim role and one who is in an aggressor role. The intervention of CPS, no matter how necessary, can increase the danger to the victim. Of course, you would have already conducted a private interview with the apparent adult victim. Likewise, you should discuss safety planning with the adult victim (with or without support people of his/her choosing). Do not include the aggressor in these first discussions. Why? *(Answer: If done jointly, aggressor will influence plan to his/her advantage AND/OR will not be able to include elements to keep victim safe).*

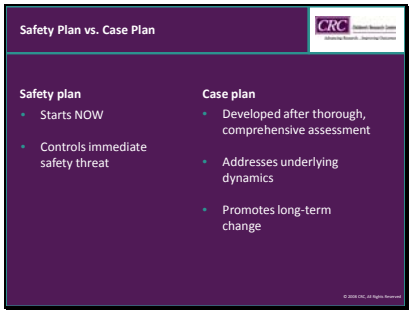
In some instances, where the violence/power imbalance has been minor and brief, the victim may be willing to develop a joint safety plan. Use your professional judgment. Is the victim in denial about the danger? Is the victim feeling coerced into sharing the plan? If so, don't do it. If you do a shared plan, work separately with the victim for a personal safety plan, just in case.

In other instances, you may need to have a safety plan with the aggressor AND a safety plan with the victim.

Be careful about copies of written safety plans that contain information the aggressor should not see, such as escape plans.

Note to trainer: The handout on safety plan ideas includes a website reference for ideas for safety planning related to domestic violence.

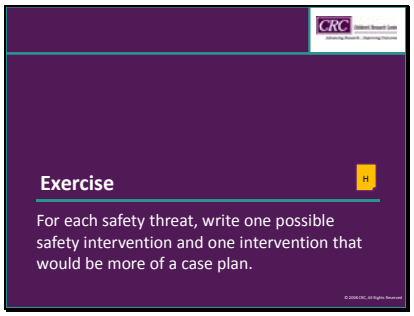
Slide 11



Let's start thinking about what goes into a safety plan. The first important notion is that a safety plan is not a case plan. Key distinctions are that a safety plan starts NOW. It is addressing imminent danger of serious harm. It can't rely on objectives or actions that won't begin for days or weeks. It can't rely on waiting to understand the underlying dynamics, let alone waiting for fundamental life changes to take hold.

The safety plan is straight forward and blunt. It is not subtle or nuanced. It is "Here is the danger…here is how we will keep the child safe right now."

Slide 12



In your exercise, on page 1, you see several safety threats listed. Take a moment and jot down at least one idea for a possible safety intervention; then think about what underlying dynamics may be, and write at least one intervention that could later become part of a case plan.

Note to trainer: Two versions of Exercise 1 are available. In the A version, only the general safety item is given. In the B version, a mini-scenario describing the safety threat is included. Select a version for your class based on your preferences and the level of abstraction the group is comfortable with.

Allow time to complete, and then discuss.

EXERCISE 1: SAFETY PLAN VS. CASE PLAN

Example:

Safety Item (general title)	Safety Intervention Idea	More Like a Case Plan: DO NOT USE IN A SAFETY PLAN
Sexual abuse	Dad will stay with his friend until investigation is concluded. He will have no contact with [child] in person, by phone, mail, email, text, or third party.	Dad will successfully complete sexual perpetrator therapy.

Safety Item (general title)	Safety Intervention Idea	More Like a Case Plan: DO NOT USE IN A SAFETY PLAN
Unable to protect		
Refuses access/ flee		
Hazardous living conditions		
Caregiver substance use		
Emotional harm		
Supervision: Failure to protect		
Medical: Failure to provide		

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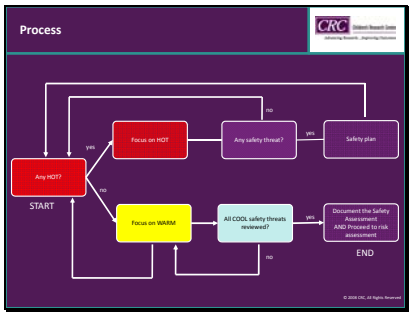
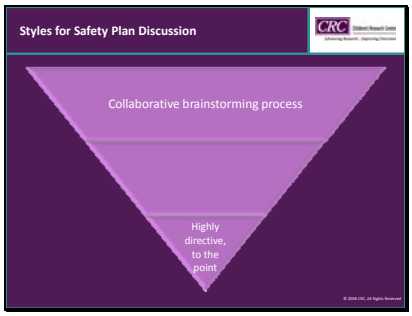
Safety Item (general title)	Safety Intervention Idea	More Like a Case Plan: DO NOT USE IN A SAFETY PLAN
Unable to protect: Maternal grandfather regularly uses inappropriate physical discipline on the children. Mother relies on grandfather for child care every weekday afternoon.		
Refuses access/flee: Father has been observed telling the child that she must be confused about what happened, and urging her to "stop saying that Daddy hurt her or she'll go to bed without dinner."		
Hazardous living conditions: The home has no electricity, heat, or running water because parents have been unable to pay their utility bills.		
Caregiver substance use: Mother admits to a history of alcohol abuse, and children (aged 2, 4, and 6) report that she often drinks to the point of passing out in the evenings. There is no secondary caregiver.		
Emotional harm: Father repeatedly blames and punishes daughter for rule breaking by sons. Daughter is withdrawn and shows signs of depression.		
Supervision: Failure to protect: Mother's boyfriend is in the central registry for previous child maltreatment, and mother routinely leaves him alone with her children.		
Medical: Failure to provide: Father refuses to monitor child's diabetes because he "doesn't like needles."		

Slide 13



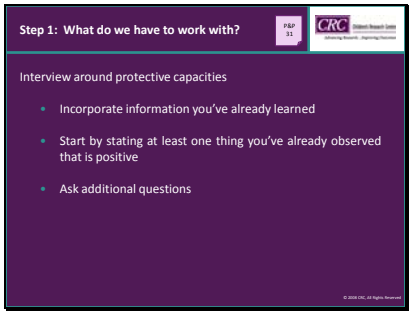
Remember this schematic? Safety planning may start the moment you have identified one safety threat, or may come after you've reviewed all safety threats and identified one or more. If the first safety threat is very serious and immediate, you need to begin to plan right away rather than taking time to see if there are additional threats. In most instances, however, "imminent" means danger in the next hours to days, not seconds or minutes, and you will have a complete assessment of the threats in this family at this time.

Slide 14



We will go through a step-by-step process for considering possible safety interventions. As we do this, we'll keep in mind a parallel notion to the continuum of styles we talked about for safety assessment. Each family will be different and each circumstance will be different. Ideally, you want to be in a collaborative brainstorming process as you begin safety planning. The steps we will discuss reflect this ideal. We realize that in some instances, the danger will be so immediate or the family so unwilling/unable/unready to engage in a collaborative process that you simply have to take more control. The point is that you should do so only when necessary, only for as long as necessary, and you should be very deliberate about your choice of style. For example, some families may themselves be highly directive and move immediately to a to-the-point approach. You may need to help such families adopt a more collaborative approach to avoid becoming deadlocked.

Slide 15



Let's assume you have a reasonably cooperative family, and the danger is not so immediate that it precludes working your way through this process.

The first step is to identify what the family has to build on. We are looking for protective capacities. Protective capacity is not a synonym for strength. It is a specific, immediately available skill or characteristic that can directly mitigate the existing safety threat. Take a look at the list of protective capacities on the tool.

Note to trainer: Review several, including their definitions.

We are still on the question of safety, so we are not talking about having a psychological assessment scheduled in four weeks to find out if these capacities are present. If you have evidence of its presence, mark it. If not, leave it blank. There is not a NO option here because not marking it doesn't necessarily mean that the family doesn't have that capacity, only that you don't have information yet and so won't be able

to rely on it as you think about safety planning. So, how can you quickly review protective capacities?

Remember that you've already done some interviewing and observing to determine if there were safety threats. Along the way, you may have already discovered some protective capacities. Go ahead and mark (or if you don't have the form, mentally mark) any you already know. Tell the family any that you've already observed. By starting with a statement to the family that you notice something positive about them, you can help them realize you aren't just "out to get them." Use the definitions to ask additional questions. Turn to page 4 of your handout. Here are some examples of ways you can ask a few simple questions to uncover potential protective capacities.

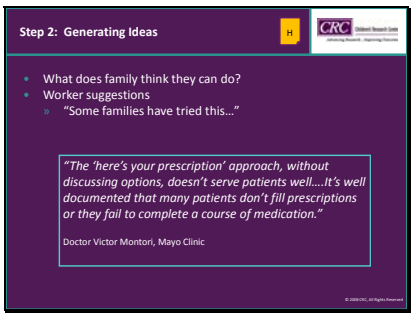
Note to trainer: Take a moment to go through a few examples.

If you cannot identify any protective capacities, either because the caregivers can't be located or won't cooperate at all, you can't build an in-home safety plan. If you don't have protective capacity #2, it's pretty hard to imagine how you could build a plan unless you bring in outside individuals to completely protect the child. An example might be a caregiver who is temporarily incapacitated in coma in hospital, but likely to recover.

Note to trainer: The other pressure on moving to the other end of the continuum is worker convenience/workload. That is not a good reason to rush. You might get a safety plan done quickly, but if the plan does not have buy-in, it is more likely to fail and result in the need for placement. That is time-consuming and costly. Rushing through safety planning is a false economy that costs more in the long run. Engaging the family in safety planning also sets the stage for longer-term planning.

Table 1: Protective Capacities	
Protective Capacity (general title)	**Question and Observation Ideas**
Child	• How has [child] avoided being hurt before? • Does [child] know how to call 911? • Does child seem calm or distressed? Developmentally on target? How large is child? Any disability?
Caregiver	Has caregiver been communicating effectively to suggest reasonable cognitive ability? (Beware of mistaking non-English speaker as having cognitive difficulty.) Is caregiver calm or distressed? Any disability? Does he/she look physically capable of protecting against alleged perpetrator?
Willingness to recognize problem	• How does caregiver react to description of safety threat? Does he/she acknowledge threat or deny/minimize it? • Do you understand why [child] is in danger because of [safety threat]?
Ability to access resources	Does family have phone? Car or other transportation? Do they have financial means to pay for needed intervention? (Family does not need unlimited means, just the means to access the kind of intervention that will be necessary. If they do not have the means, it does not necessarily mean removal is the only option, but another option for developing the interventions will need to be found.)
Supportive relationships	• Who could help you right now? Is there someone you'd like to call to come over right now to help us plan? What do you think he/she could do to help? • Who could get together with us tomorrow (or the next day) to come up with a plan? What do you think he/she could do to help? • If [friend/relative] offered to help, would that be okay with you?
Willing/able to protect	• What would you be willing to do to protect [child]? • How would you imagine you would be able to prevent [alleged perpetrator] from harming child again? Have you ever prevented him/her from harming child in the past? Can you tell me about that? • Consider current incident. Did caregiver attempt to intervene? Was he/she successful? NOTE: Attempting to intervene and failing may be less hopeful, since it directly suggests inability despite willingness. Ask how caregiver believes he/she will be successful next time and what help he/she may need to be successful.
Healthy relationship	• Observe interactions. • Listen for how caregiver describes child. NOTE: If this is the only protective capacity, it may not be sufficient for a plan.
Committed to meeting child needs	• What would you say [child] needs right now to be safe? • How far are you willing to go to meet [child's] needs?
Problem solving	Have you ever been in a situation like this before? How did you solve it?

Slide 16



Next, remind the family of the specific threat or threats that must be addressed and what they have to work with, and ask them what they think they could do or arrange to assure child is protected from danger. Asking the family first doesn't mean you'll accept their suggestion—you'll see that in the next step. But asking them first implies that you are willing to listen, that you are willing to see their capability, and they may have a great idea. If they have no ideas or limited, unlikely ideas, you can offer suggestions. But make them suggestions at this point.

CLICK

The medical field is learning that if you really want patients to follow medical plans, you can't just say, "Here's your prescription." Instead, patients of doctors who explain available options, pros and cons, and ask patients how likely they will be to follow a plan—and help resolve barriers to following a plan—have better results.

One starter phrase is "Some families have tried this…" What are some other options? *("I heard about…" "What would you think of….?")*

In your handout on pages 5–7 are some ideas for safety plan interventions. For each safety threat there are several suggestions.

Note to trainer: Review a few. Note the mix of formal and informal activities.

Table 2: Safety Intervention Ideas

Safety Item (general title)	Safety Intervention Ideas
Serious harm	• Alleged perpetrator is arrested • Alleged perpetrator agrees to remain outside the home until investigation concludes • Non-suspected parent will not let alleged perpetrator into house until investigation concludes • Child will remain in hospital • Caregivers agree to not use corporal punishment for the next 30 days • Non-suspected parent will obtain a temporary restraining order
Sexual abuse	• Alleged perpetrator is arrested • Alleged perpetrator agrees to remain outside the home until investigation concludes • Non-suspected parent will not let alleged perpetrator into house or have any contact with child until investigation concludes • Non-suspected parent will take child for forensic interview and medical exam • Caregivers will not question child or attempt to influence his/her statement either way • Caregiver will not challenge child's story while investigation continues
Unable to protect	• Caregiver will not let alleged perpetrator into house or have any contact with child until investigation concludes • [Relative/friend] will be available for mother to call if she is tempted to allow alleged perpetrator back home
Questionable explanation	• Alleged perpetrator is arrested • Alleged perpetrator agrees to remain outside the home until investigation concludes • Non-suspected caregiver will not let alleged perpetrator into house until investigation concludes • [Relative/friend] will stay in the home and be with child at all times until investigation concludes
Refuses access/ flee	• Caregiver will permit worker to see child • Child will attend school every day • [Relative/friend] will stay in the home and be with child at all times until investigation

Table 2: Safety Intervention Ideas	
Safety Item (general title)	**Safety Intervention Ideas**
	concludes • Caregiver will provide names and contact information for at least three employers/teachers/pastors/friends/relatives to worker, and worker will confirm identity and willingness to provide new phone/address from family • Caregiver will sign a release of information with [DMV/CalWORKs/probation agent, etc.] to obtain new contact information if family moves
Immediate needs unmet	*See appendix for more detailed description of each type of need.*
Hazardous living conditions	• Child will stay with [approved relative] until hazard is removed • Family will stay with [friend/relative] until hazard is removed • Family will stay in homeless shelter until hazard is removed • Worker will help advocate for landlord to remove hazard • Agency will assist in removing hazard • [Relatives/friends] will help remove hazard • Caregivers will remove hazard
Caregiver substance use	• Using caregiver will go to detox • Using caregiver will stay with [relative/friend] until clean/sober • Using caregiver will not be responsible for child care while under the influence • Non-using caregiver will provide all child care and will protect child from using caregiver • [Relative/friend] will stay in home until using caregiver is clean/sober and will provide all child care • Child has a safe place to go if caregiver begins drinking [neighbor/friend]
Domestic violence	Excellent resource for developing a safety plan for a domestic violence victim: http://www.aardvarc.org/dv/plan.shtml • Victim caregiver will go to shelter with children • Victim caregiver will go to [relative/friend] with children • Victim caregiver will develop and implement a safety plan for domestic violence • Alleged perpetrator caregiver is arrested • Alleged perpetrator caregiver remains out of the home while investigation continues • Caregivers assure that children are out of the home or in safe location in the home if caregivers begin to argue • Child (if older) will not intervene if parents begin to fight. (May leave home and go to neighbor/call 911.)
Emotional harm	• Child will have immediate mental health evaluation • Child will stay in shelter/with approved relative/friend for tonight • Caregiver will refrain from [behavior/threats] for 30 days • Non-suspected caregiver will stay with child at all times child is not in school
Caregiver mental health, cognitive ability	• Caregiver will have immediate mental health evaluation • Caregiver will resume prescribed medication • Non-affected caregiver will provide all child care and will be with child at all times while child is not in school • [Relative/friend] will stay in home and provide [all or specific] child care while investigation continues • Public health nurse will provide instructions for caregivers and caregivers will follow

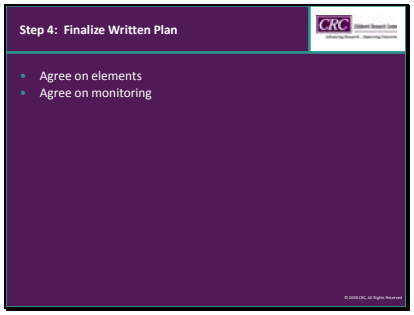
APPENDIX

Safety Item (general title)	Safety Intervention Ideas
Supervision	• Worker provides information on certified daycare providers • Worker assists family with application for child care funding • [Relative/friend] will stay with child [define times/locations] • Caregiver does not leave home to [do voluntary activity] until appropriate child care is in place • Caregiver's alternate will provide child care for two hours per day so caregiver can leave for personal time
Food	• Worker provides groceries • Worker assists family in applying for emergency food stamps • Worker provides information on food pantries • [Relatives/friends] provide money or food • Caregiver provides meals for child (define meal based on child age)
Clothing	• Worker provides voucher for necessary clothing • Worker provides information on clothing resources • Caregiver ensures that child is dressed for weather • Caregiver ensures that child has clean clothes • Worker provides voucher for laundromat • [Relative/friend] allows family to wash clothes in their machine for next two weeks
Medical	• Caregiver makes and keeps appointment • Caregiver fills prescription and provides medicine to child • Caregiver follows medical recommendations while investigation continues • Worker assists family in applying for [medical, SSI, etc.] • Hospital/provider agrees to let family have service and arrange payment plan • [Agency] provides medicine/medical equipment
Mental health	• Caregiver will remove guns from home • Caregiver will stay with child at all times • [Relatives/friends] will help caregiver provide 24-hour observation of child • Caregiver will obtain/provide prescribed medication • Caregiver will take child for immediate mental health evaluation • Caregiver will allow child to begin/resume therapy with [provider]

Slide 17

Ideally, get all the ideas on the table first. This is just basic brainstorming technique. If we start to critique ideas as they are presented, it tends to stifle ideas. But again, remember that in some situations you have to press forward faster because of the immediacy of the danger. Some families aren't going to participate in a "kumbaya" moment with you. When you can, wait until a number of ideas are on the table before proceeding to testing the ideas. Don't skip this step! Not all good ideas will work. Ask how each proposed idea will directly protect the child from the specific threat. Ask what could go wrong. Use this information to develop contingencies so that the plan is detailed and complete. Some ideas will be rejected because during this step you'll realize they're not feasible, won't be robust enough protection, or have some other limitation.

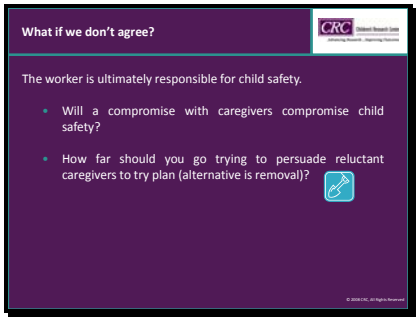
Slide 18



Now you can assemble your final plan. Write it on the safety plan document. Be specific about who will do what, and when.

A most vital component of the plan is monitoring. How will you know the plan is being carried out and is protecting the child? For each plan element, ask, "How will the worker know this is being done?" For the overall plan, ask "How will the worker know the child is safe?"

Slide 19



Before we practice developing a safety plan, there are a few final considerations. We've already said that if the worker and the family disagree on whether the threat is present, the worker marks the threat as present AND gives voice to the family's perspective by noting their point of view. What if they disagree with the only plan the worker thinks is viable?

The fundamental principal is that at this point the worker is ultimately responsible for child safety. We cannot abdicate our professional responsibility by simply saying the family was unwilling so we will close the case or accept a plan we doubt will work. But we don't have to be rigid either. Ask the family what they would be willing to do—how could this plan be acceptable to them? Ask yourself if their amendment would really compromise child safety. Sometimes it won't. For example, they prefer dad's brother to be the child's safe place rather than mom's sister. Unless you have reason to think the paternal uncle would not be safe, there's no reason to object. (If the family was engaged along the way, you might not even get to this point, but the family may have been reluctant to express concerns previously). There is no point in getting into an unnecessary power struggle. But if the uncle is

a previous perpetrator, or if this is a DV situation and the uncle may side with dad over mom and keep mom from access to the child, then you should not compromise.

Conversely, knowing that if the family won't agree to a plan the child will go into foster care, and the plan could be so simple, you can't understand why the parents won't just say yes…How hard should you try to persuade them?

It is necessary to ensure that you aren't being coercive when presenting/developing the safety plan. Parents have to see and understand safety plans as a voluntary agreement that they are entering into and that interventions are time-limited. There was a recent case in the Illinois State Supreme Court (*Dupuy v. Samuels*) that challenged the constitutionality of safety plans. While the court ultimately supported the practice of safety plans in CPS, it did prompt several clarifications on practice expectations by the agency.

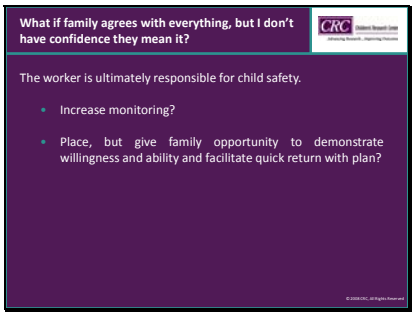
There is no substitute for good clinical judgment here. You want to be sure they understand how easy the plan would be, and how much even one night in foster care will affect their child. See if you can figure out what hook will work best, and use it. But if you feel you are pushing them to just say yes when they mean no, and they aren't really buying into the plan, then it's best to not push too hard or you may just be setting up a safety plan failure.

Safety plans must be clear, voluntary, time-limited, and not coercive. Removal is a potential consequence of failure to comply with safety planning, not presented as a threat.

Dupuy v. Samuels is a case brought in 1997 in Illinois by 150,000 residents of that state. For purposes of safety planning, the crucial portion of the case concerned parents' allegations that they were illegally and unconstitutionally forced to comply with safety plans under threat of child removal. This issue was considered in the "Dupuy II" claim brought in 2002, in which the court found that safety plans that last more than "a few days" violate families' rights to due process. "A few days" was further defined as requiring a safety plan review after 14 days. A 2006 appeal of the decision found that safety plans must be uniformly voluntary, and criticized coercive practices (e.g., threatening families with foster care placement)

that the court found to be common in safety planning. The issue remains subject to appeal, but clear, voluntary, time-limited, non-coercive safety plans remain good practice.

Slide 20



Finally, you've probably been in situations where the family says yes to everything. They are the most agreeable family ever. Problem is, that the moment you leave, they do everything BUT what they just agreed to. If you have good reason to doubt that the family will really act to protect the child, the same principle applies: you are ultimately responsible at this point. It's not enough to just walk away and accept at face value when your professional judgment is sound and telling you the child will not be safe. You have two choices:

1. Consider whether increasing the monitoring would provide the assurance that the family really is doing what they say they will. Are they agreeable to unannounced visits? Can child call in every daytime hour for first 48 hours? Can grandma move in for the weekend?

   Note to trainer: Open up discussion on the issues around involving the child in the safety plan. What is the difference between creating a safety net for the child vs. making the child responsible for his/her safety?

2. Let family know that you are not convinced they will be able to carry out the plan. Be careful! Don't frame this as malicious intent—it may not be, and probably isn't. Explain that the danger is so great and the plan so difficult that you will have the child in a safe place for the first few days WHILE the family begins to put the plan in place. You can use this time to let the family demonstrate their follow-through. If possible, the child may go home quickly. If the family does not follow through, the placement was clearly necessary and remains so. *(If an example of how this might work is needed, consider the following hypothetical situation: There is a safety threat related to domestic violence. The safety plan is for mom to ask her boyfriend to leave the home and not let him return. However, mom has a history of allowing this boyfriend to return to the home. You might discuss mom's previous history with her and suggest a temporary placement for the child so that she can demonstrate her ability to keep the boyfriend*

away from the home. You would then set a timeline and a monitoring plan with meaningful indicators.

Note to trainer: Refer to Table 3: Monitoring in the Safety Plan Exercise handout.

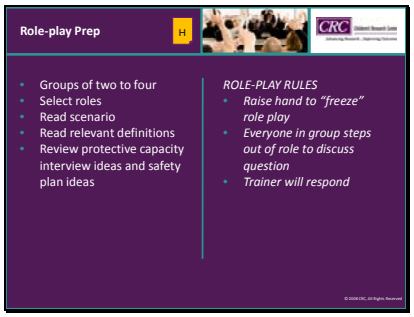
Table 3: Monitoring	
Issue	**Monitoring Ideas**
Monitoring	• Worker will check on child [daily/weekly/at least twice] • Worker will call [collateral] to confirm that… • [Collateral] will call worker if caregiver is not following plan • Child will have worker's number plus a 24/7 number and can call any time

Slide 21

Now we'll put it all together and give you an opportunity to build a safety plan.

Note to trainer: Explain that for each safety threat, there are some ideas for safety interventions—use those as ideas, or come up with your own.

Slide 22



Organize into groups of two, three, or four. In each group, one person is a caregiver, one person is a worker, and the other one or two, if present, are secondary caregivers, children, or collaterals.

Note to trainer: Hand out one role-play scenario to each group. Let them pick blindly from available scenarios for the group size (two, three, or four).

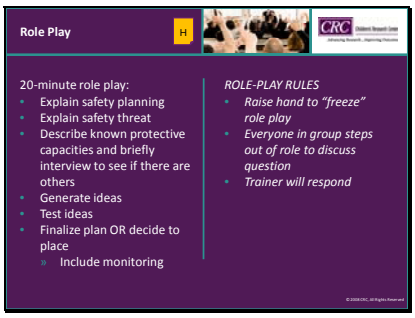
Take a moment to read through the scenario. Each group has the safety threat related to domestic violence. They differ in terms of the specific circumstances that met the threshold; whether or not there are other safety threats; what protective capacities are available; and family constellation, socioeconomics, culture, and location. Decide who will play which role.

Take a moment to read through the definitions for the safety threats and protective capacities for your family.

Take a moment to read through safety plan ideas for DV and any other threat that is present.

Note to trainer: Ask if group members have selected their roles. If any group has not selected roles yet, you should assign.

Slide 23



Now that you are almost ready, take out [blank sheet of paper OR county safety plan document]. Worker, it is your responsibility to lead a discussion of safety planning. Start by explaining what you are going to do, describing the safety threat and known protective capacities. Interview a bit more to see if you have any other protective capacities. Then generate possible safety interventions. Test those ideas. Finally, create a written plan that includes monitoring OR decide to place.

Note to trainer: It may be necessary to tell participants that writing a full safety plan may take more than 20 minutes, but they should get as far as they can.

SAFETY PLANNING EXERCISE

Group 1

Safety threats	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
Details	Altercation between caregivers last night resulted in mother having facial bruising and a sprained wrist. Oldest child was present and attempted to intervene, but was not injured. Police were called but did not arrest. There is a history of similar violence between caregivers.
Caregivers	Mother, age 35. Father, age 38. Married five years.
Children	Twelve-year-old male from mother's previous marriage. Four-year-old from current marriage.
Protective capacities	Child has the cognitive, physical, and emotional capacity to participate in safety interventions. Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions. Caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment.
Education	High school graduates
Income	Father unemployed, high family debt, unemployment benefits run out next month. Mother does not work. One older car in need of major repair. Live in apartment and behind on rent.
Culture	White, northern European, multigeneration American
Community	Extended family out of state. Suburban neighborhood.
Roles for role play	1. Mother 2. Father (mother was interviewed first and agreed to plan jointly) 3. Twelve-year-old 4. Worker

SAFETY PLANNING EXERCISE

Group 2

Safety threats	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child. Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.
Details	Altercation between caregivers last night resulted in mother having facial bruising and a sprained wrist. Oldest child was present and attempted to intervene, but was not injured. Police were called but did not arrest. There is a history of similar violence between caregivers. Physical violence most often occurs when father is drinking heavily. He was drunk last night when incident occurred. Mother states he is becoming increasingly violent when he drinks. He has gone after oldest child when drunk, yelling that he's going to beat him silly. Child has been able to run away.
Caregivers	Mother, age 45. Father, age 45. Married 20 years.
Children	Seventeen-year-old male Twelve-year-old male Eight-year-old female, all from current marriage.
Protective capacities	Child has the cognitive, physical, and emotional capacity to participate in safety interventions. Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions. At least one caregiver in the home is willing and able to take action to protect the child, including asking offending caregiver to leave.
Education	Mother, high school; father, some college.
Income	Both work steadily in lower-paying jobs. Own small home. Two cars in reasonable condition.
Culture	Hispanic (Mexican), second generation.
Community	Extensive extended family in area. Rural. No shelter or DV program within hour's drive.
Roles for role play	1. Worker 2. Mother 3. Seventeen-year-old 4. Maternal grandmother

SAFETY PLANNING EXERCISE

Group 3

Safety threats	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
Details	Altercation between caregivers last night resulted in mother having facial bruising and a sprained wrist. Child was present and attempted to intervene, but was not injured. Police were called but did not arrest. There is a history of similar violence between caregivers.
Caregivers	Mother, age 25. Mother's live-in boyfriend, age 21. He's lived there one year.
Children	Eight-year-old male; mother had him as teenager; unknown father.
Protective capacities	Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions. Caregiver has the ability to access resources to provide necessary safety interventions. Caregiver is aware of and committed to meeting the needs of the child.
Education	Mother, GED; boyfriend, high school.
Income	Both have minimum-wage jobs with no benefits. He controls finances. One car; he has keys. She does not have driver's license. Live in rental property in his name only.
Culture	African American, multigeneration.
Community	She has extended family in area, but strained relationships. He has extensive family. Urban, but few resources in immediate neighborhood.
Roles for role play	1. Worker 2. Mother

SAFETY PLANNING EXERCISE

Group 4

Safety threats	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child. Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation as indicated by serious injury or abuse to the child other than accidental.
Details	Altercation between caregivers last night resulted in mother having facial bruising and a sprained wrist. Oldest child was present and attempted to intervene. Boyfriend swung fist at mother, missed, and hit child. Child suffered a broken nose. Police were called and boyfriend was arrested and bailed out. There is a history of similar violence between caregivers.
Caregivers	Mother, age 28. Mother's boyfriend; does not live in the home, but stays over many nights.
Children	Nine-year-old male from previous relationship. Father is out of state. Two-year-old female from current relationship.
Protective capacities	Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions. Caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment. Caregiver is aware of and committed to meeting the needs of the child.
Education	Both dropped out of high school; no GED.
Income	She is on CalWORKs. Has already been sanctioned once. No car.
Culture	Native American
Community	Close connections with extended family and tribe. Outskirts of urban area. Numerous community organizations in area.
Roles for role play	1. Worker 2. Mother 3. Tribal elder (whom mother called) 4. Maternal aunt (mother is very close to her)

SAFETY PLANNING EXERCISE

Group 5

Safety threats	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
Details	Altercation between caregivers last night resulted in mother having facial bruising and a sprained wrist. Oldest child was present and attempted to intervene, but was not injured. Police were called but did not arrest. There is a history of similar violence between caregivers.
Caregivers	Mother, age 31. Father, age 38, has lived in apartment for past two months. They are separated, pondering divorce, but have not filed papers. He comes over two nights a week to visit children and they go to spend weekends with him.
Children	Ten-year-old male Eight-year-old female, both from this marriage.
Protective capacities	Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions. Caregiver has the ability to access resources to provide necessary safety interventions. At least one caregiver in the home is willing and able to take action to protect the child, including asking the offending caregiver to leave.
Education	Both college graduates
Income	Middle income from father's employment. Live in own modest home. One car.
Culture	White
Community	Rural; home is distant from any community. He has some family in state; hers are all out of state.
Roles for role play	1. Worker 2. Mother 3. Father (she was interviewed separately first and agreed to plan jointly)

SAFETY PLANNING EXERCISE

Group 6

Safety threats	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child. Caregiver fails to protect the child from serious harm or threatened harm by others.
Details	Altercation between caregivers last night resulted in mother having facial bruising and a sprained wrist. Oldest child was present and attempted to intervene, but was not injured. There is a history of similar violence between caregivers. Both mother and father are violent toward each other and children are often present. Neither caregiver calls the police. Police were not there last night, but a neighbor called CPS. Mother, interviewed separately, was angry at neighbor for getting CPS involved: "This is just how we work out our differences."
Caregivers	Mother, age 28. Father, age 31. Not married, but live together.
Children	Ten-year-old male Five-year-old female One-year-old female, all from this relationship.
Protective capacities	Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions. There is evidence of a healthy relationship between caregiver and child. Caregiver has a history of effective problem solving.
Education	Both high school graduates
Income	Both work and have living wages. He has a car in his name. She uses bus. Live in rental in both names.
Culture	Mother, White; Father, African American.
Community	Urban, many resources, some extended family nearby.
Roles for role play	1. Worker 2. Mother 3. Maternal grandmother 4. Maternal grandfather

SAFETY PLANNING EXERCISE

Group 7

Safety threats	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
Details	Altercation between caregivers last night resulted in mother having facial bruising and a sprained wrist. Child was present and attempted to intervene, but was not injured. Police were called but did not arrest. There is a history of similar violence between caregivers.
Caregivers	Birth mother, age 31. Mother's female partner, age 25. No marriage or domestic partnership. Have lived together three years.
Children	Nine-year-old male born to single mother (insemination).
Protective capacities	Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions. Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning AND caregiver is willing and able to accept their assistance.
Education	Mother, college graduate; partner, some college.
Income	Mother makes average wage and owns home they live in (in her name only). Partner is unemployed and lives on mother's wages.
Culture	Mother, Latina; partner, White.
Community	Mother has close family members and friends. Partner is independent and has lost contact with family and has few friends. There is a DV program in area.
Roles for role play	1. Worker 2. Mother 3. Partner (mother agreed after being interviewed privately)

SAFETY PLANNING EXERCISE

Group 8

Safety threats	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child. Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.
Details	Altercation between caregivers last night resulted in mother having facial bruising and a sprained wrist. Oldest child was present and attempted to intervene, but was not injured. Police were called but did not arrest. There is a history of similar violence between caregivers. Father gets very paranoid about mother's behavior and thinks she is part of a conspiracy against the government. Fights often emerge from this delusional thinking. He is diagnosed with schizophrenia and does well on meds, but has not been taking them lately.
Caregivers	Mother, age 35. Father, age 36. Married 15 years.
Children	Fifteen-year-old male Thirteen-year-old female, both from this marriage.
Protective capacities	Child has the cognitive, physical, and emotional capacity to participate in safety interventions. Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions. Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning AND caregiver is willing and able to accept their assistance.
Education	Mother, high school; father, college graduate.
Income	Father on SSI-D. Mother works part-time at minimum wage. Uses medical to insure children. One car that is in reasonable condition.
Culture	White, second-generation Eastern European.
Community	Urban; many resources nearby, but he resists using help. She has supportive extended family, but has lost touch with friends.
Roles for role play	1. Worker 2. Mother 3. Fifteen-year-old 4. Paternal uncle (at mother's request)

SAFETY PLANNING EXERCISE

Group 9

	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
Details	Altercation between caregivers last night resulted in mother having facial bruising and a sprained wrist. Oldest child was present and attempted to intervene, but was not injured. Police were called but did not arrest. There is a history of similar violence between caregivers.
Caregivers	Mother, age 38. Father, age 58. Married three years. Arranged marriage.
Children	Twenty-year-old male from mother's previous marriage. Father is in town. Two-year-old male from current marriage.
Protective capacities	Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions. At least one caregiver in the home is willing and able to take action to protect the child, including asking the offending caregiver to leave.
Education	Mother, master's degree; father, high school.
Income	Mother brought sizable savings and inheritance into relationship. She previously held good-paying job but now stays home with child. Father is in sales on commission so can have some high-income months, and others with next to nothing. Live in good-sized home she owned outright prior to marriage (inheritance). Drive one new, high-end car in both names.
Culture	Pakistani
Community	Nice suburb. Very involved extended family on both sides. Many resources in area, but they are reluctant to use non-Pakistani resources.
Roles for role play	1. Worker 2. Mother 3. Twenty-year-old son

SAFETY PLANNING EXERCISE

Group 10

Safety threats	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
Details	Altercation between caregivers last night resulted in mother having facial bruising and a sprained wrist. Oldest child was present and attempted to intervene, but was not injured. Police were called but did not arrest. There is a history of similar violence between caregivers. Fight began when father felt mother was nagging him. Mother states she was just trying to get him to finish the remodeling project he started four months ago. He is replacing the stairway to the lower level, and at this point, there is just a gaping hole in the floor with a drop of eight feet. There are power tools sitting in the area and loose nails, nuts, and bolts scattered on the floor.
Caregivers	Mother, age 27. Father, age 31. Married six years.
Children	Nine-year-old female from father's previous marriage. Mother is deceased. Seven-year-old male Eighteen-month-old female, both from current relationship (7-year-old born prior to marriage).
Protective capacities	Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions. At least one caregiver in the home is willing and able to take action to protect the child, including asking the offending caregiver to leave.
Education	Both high school graduates
Income	He brings home average wage. She does not work. Bought "fixer-upper" house right before market crashed. Planned to use equity to remodel, but now there is no equity. One pickup truck in reasonable repair.
Culture	White, very religious
Community	Edge of blighted neighborhood. Several community organizations in area, but all are struggling and have few resources themselves. She has some friends but family is out of area. He has some extended family.
Roles for role play	1. Mother 2. Worker

Slide 24

Note to trainer: Have each group briefly describe the family by reading the scenario information. Then present the plan. Ask other groups to listen for what could go wrong and see if they can come up with something that should be considered. If time is tight, don't report out from all groups.

Slide 25

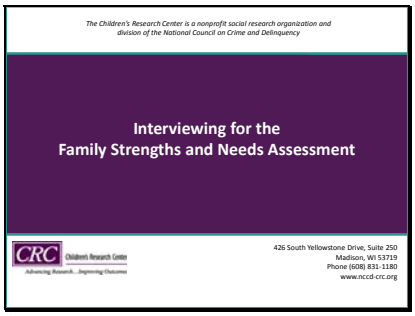
Conclude by going around and asking each person to state one thing they learned that they will take back with them and use the next day.

INTERVIEWING FOR THE FSNA

Materials needed:

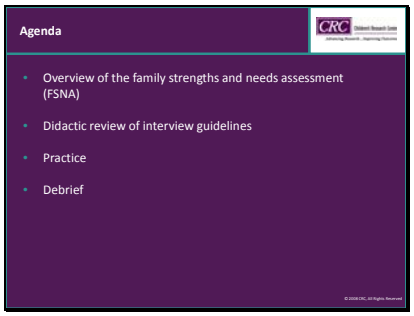
- Trainer
  - » This manual
  - » PowerPoint [FSNA Interviewing.ppt]
- Students
  - » At each seat at start of class:
    - ▪ Interviewing for the FSNA handout
    - ▪ FSNA section of P&P Manual (or entire manual)
      Note: You can have students bring their own, or have copies to hand out and collect at the end of class, or have copies they can take with them.
  - » To hand out during class:
    - ▪ Interviewing for the FSNA role play
      Print enough so that half of the students will get PERSON A and half will get PERSON B. It may be helpful to print PERSON A on one color of paper and PERSON B on a second color. Note that the Person A and B handouts are two pages each. They can be printed on front and back of the same piece of paper.
- Audio/visual
  - » Laptop/projector/screen
  - » Whiteboard or flipchart is optional

Slide 1



Trainer may start with an introductory exercise of his/her choice.

Slide 2



For the next half day, we're going to focus on four things:

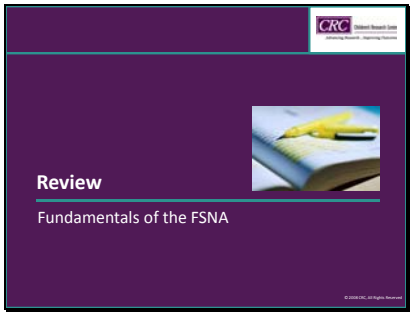
1. An overview of the family strengths and needs assessment (FSNA).

2. A review of interview guidelines. We are going to remind ourselves of good interviewing practice and how it fits with good use of the FSNA.

3. Practice. We'll break into groups to practice with what we've just learned.

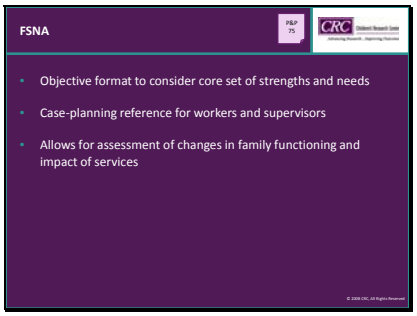
4. Debrief. We'll share what we learned from our practice with each other.

Slide 3



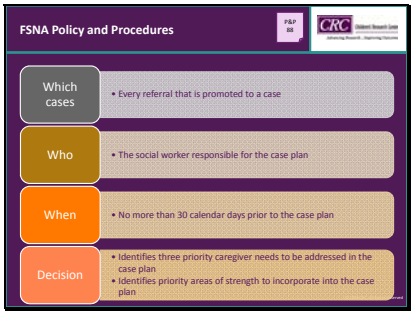
Let's go ahead and review the basics of the FSNA.

Slide 4



We will use the FSNA to assess the primary and secondary caregiver and all children in the household on a core set of domains. Each person's areas of strength and need will be used by workers and supervisors when writing and approving case plans. Over time, as we return to reassess the family at regular intervals, the FSNA will enable us to track changes and improvements in family functioning to determine if services are working.

Slide 5



The FSNA has two parts, one for the caregivers and one for the children in a household.

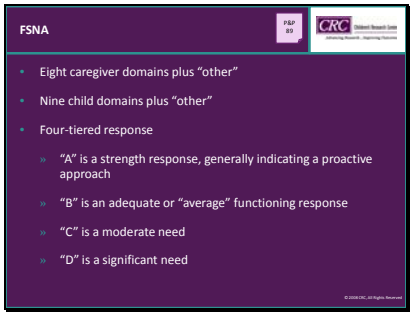
The FSNA will be completed on every open case by the social worker responsible for the case plan. Although the social worker is responsible for completing the form, the assessment itself should be completed in collaboration with the family, and we'll learn more about how to do that today.

Because we will use the FSNA to inform our case plan, the assessment should be completed within 30 days prior to developing the case plan.

Note to trainer: Workers should simply think of the FSNA as the first step in developing a case plan. When a case plan is coming due, they should start by doing an FSNA. When SafeMeasures reports on FSNA completion, it will report on the percentage of families without a case plan; then it will look at all families with a case plan and see if there is an FSNA in the 30 days prior to the case plan effective date. If so, the case is counted as having a completed FSNA. If not, it will be counted as not having a timely FSNA.

The FSNA leads to the case plan by identifying three areas of priority need to be addressed in the case plan. There may well be families who have more than three areas in which they need services, support, or assistance. However, it is important to go through the process of prioritizing these needs within the family and to use the top three needs as the guide for identifying services. Any family trying to deal with more than three domains at once is likely to feel overwhelmed.

Slide 6



On the caregiver strengths and needs assessment, both the primary and secondary caregiver will be assessed on eight domains, plus "other," where you can record an area of strength or need not covered elsewhere. Similarly, the child strengths and needs assessment will focus on nine domains plus "other" for each child in the household.

If you read each item, you can see that there are four response options in each domain. "A" and "b" responses indicate an area of strength, where "a" is a significant area of strength, generally indicating a proactive approach. For an "a" response, the caregiver or child must not only be problem-free in a particular area, but must be taking positive steps to remain strong in this area. If we think about our own lives, we may realize that it's unusual to be proactive in more than one domain. A "b" response indicates an area of average functioning. There are no significant weaknesses in that area.

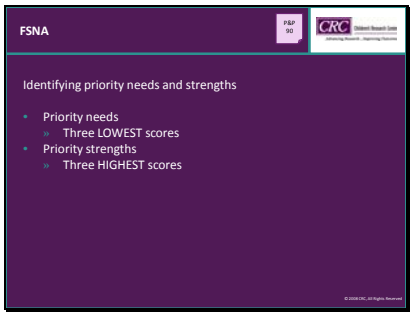
Again, if we look at our own lives, we're likely to find that in many domains, we are simply problem-free and average.

"C" and "d" responses, in contrast, indicate areas of need. "C" is a moderate need, while "d" indicates a significant need or problem that is unlikely to be resolved without significant outside supports and/or services.

The distinctions between levels of strength and need may be difficult to determine, and you MUST use your definitions.

When we answer these items, we will use all of the information we have on a family. For this session, we're going to focus on what we can learn from a family interview, but information gained from collateral contacts and the case record, including the safety and risk assessments, should also inform that process.

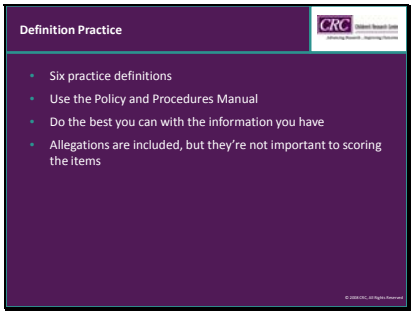
Slide 7



After each member of the family is assessed in each domain, the worker must review the assessment to identify up to three priority needs and up to three priority strengths for the caregivers. The priority needs should be the focus of the discussion with the family when the case plan is developed. The priority strengths can be used to help identify appropriate services or providers (e.g., if the parent has a strong cultural identity, it may be better to use a culturally specific provider even if that provider is farther away).

Priority needs are the three lowest scores for any household member, and priority strengths are the three highest scores.

Slide 8



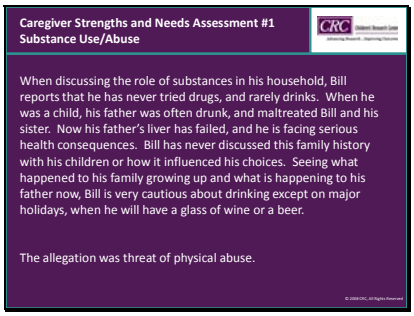
Now that we've reminded ourselves how to complete the FSNA, we're going to do a quick bit of group practice using the definitions.

The next six slides are mini-scenarios to practice scoring different domains. This means that we have to use our definitions, but it also means that we have limited information.

Today we'll be learning more about identifying the information we don't have and seeking it. In this exercise, however, we're just practicing with the definitions, so do the best you can with the information you have.

Finally, one thing we hope you'll start to realize is that although we've given you allegation types for each mini-case, the allegations don't necessarily inform how you score the items.

Slide 9

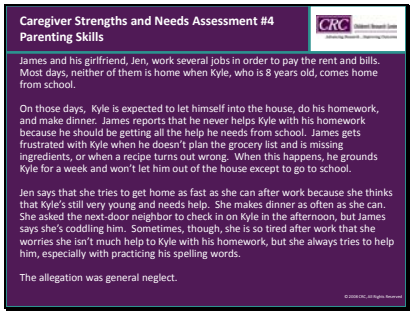


Let's practice using a few definitions. How would you rate this caregiver in the substance abuse domain?

Answer: B

Bill does not have a problem with drugs or alcohol, and is aware of the negative impact that excessive drinking can have on his ability as a caregiver. However, there is no indication that he has discussed his experiences or choices with his children to help them make healthy choices in the future. He thus fits within the "demonstrates" but not within the "teaches" requirements of the "a" definition.

Slide 10

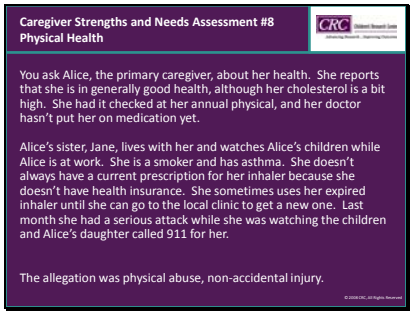


James is the primary caregiver (legal parent of child). Jen is the secondary caregiver. How would you rate them in the parenting domain?

Answer: James is rated a "c." He has unrealistic expectations of Kyle (expecting an 8-year-old to regularly cook dinner without assistance, expecting child not to need help with homework, punishing child for understandable mistakes), but he has not yet shown evidence of destructive or abusive patterns of behavior.

Jen is rated a "b." She tries to make sure that Kyle has the help and supervision that he needs. She isn't always able to give the support she wants to because of her work schedule, but she tries to use other resources (neighbor) to fill the gap.

Slide 11

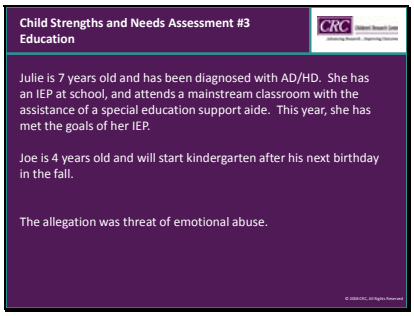


Alice is the primary caregiver. Jane is secondary. How would you rate them in the physical health domain?

Answer: Alice rates a "b." She is not proactive about her health (no evidence of exercise or dietary changes to better control her cholesterol, no evidence that she tries to teach the kids good health habits), but she does not have any major problems and she does access health care regularly.

Jane rates a "d." Her asthma is a chronic condition that she is not controlling well at this time because she does not have health insurance. Her continuing to smoke is also likely to make her condition worse. We know that her health has affected her ability to care for the children because she had an attack requiring emergency medical treatment while watching the children.

Slide 12



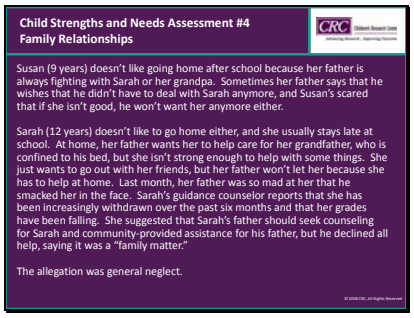
How would you rate these children in the education domain?

Answer: Both children are rated as "b."

Julie has special needs in the classroom, but the evidence indicates that her needs are being met with resources already in place. We would mark the "child has IEP" box.

Joe is not yet school-age.

Slide 13

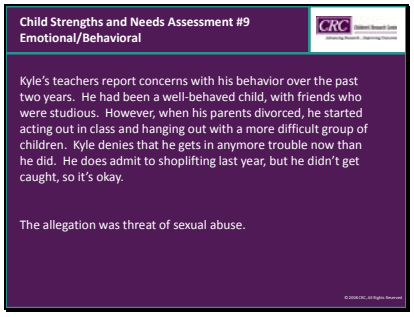


How would you rate these children in the family relationships domain?

Answer: Susan is "c." There is stress and conflict in her home that makes her feel insecure.

Sarah is "d." She has taken to avoiding her home. Her family has not been able to seek outside help to relieve some of the stress of caring for the grandfather, and it is starting to significantly impact Sarah in that her grades are slipping and she has been struck by her father.

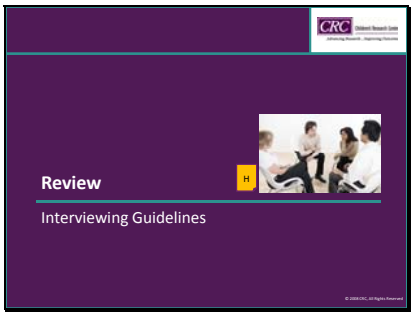
Slide 14



How would you rate Kyle in the emotional/behavioral domain?

Answer: Kyle scores a "c." We have no evidence that he has exhibited violent behaviors, but his shoplifting does indicate that this is an area of need for him.

Slide 15



Now that we've reminded ourselves of the key aspects of the FSNA and warmed up with a few items, let's review the basic principles of interviewing.

Note to trainer: Refer participants to handout.

Interviewing for the Family Strengths and Needs Assessment (FSNA)

1. General interviewing guidelines
   This guideline relates to the assessment of needs and strengths, and assumes that any safety issues and/or forensic issues have already been addressed.

   1.1. When you've joined with the family member, your interview will be more honest and open.
   1.2. Be respectful.
   1.3. Be culturally appropriate.
   1.4. Be part of a human-to-human interaction.
   1.5. Assume nothing.

2. Explain the FSNA and its purpose.

3. The best information is that provided by the family in their own words in response to **open-ended, non-directional** questions.

   3.1. How do you see your family?
   3.2. What are the most important things you want me to know about your family?

4. Ask about **strengths and successes** before asking about areas of struggle.

   4.1. What makes you proud/happy about your family?
   4.2. What has been going very well for you?

5. Ask the family to identify **areas of struggle** in non-blaming ways.

   5.1. What would you like to see different?
   5.2. What things make it hard for you and your family?

Complete Steps 3–5, gathering information as you go. Proceed to Step 6 as needed.

6. **Item-specific questions**. It is likely that one or more FSNA items could not be confidently answered based on information revealed by questions 3–5.

   6.1. Systematically inquire about any item where you could not score based on what you know. "Thank you for sharing your observations and beliefs about your family. As I mentioned, there are a few areas we always need to ask about because they are so important for families. To have a complete picture of your family in all of these areas, there are a few more questions I'd like to ask."
   6.2. Start with items you anticipate will be LEAST sensitive, based on what you have learned so far.
   6.3. Begin your inquiry in each area with a non-directional question (see Table 1).

      6.3.1. If needed, follow up with one or more positively anchored questions (see Table 1).
      6.3.2. If needed, follow up with one or more negatively anchored questions (see Table 1).

6.3.3. If needed, follow up with one or more level identification questions (see Table 2).

7. Additional **points of view**

7.1. You will be interviewing more than one person (mother, father, children, other relatives, reporters, professionals, etc.) and may be gathering information from additional sources (record reviews, police reports, medical records, etc.). When all information has been gathered, if responses to any item would differ based on the source of the information, it may be necessary to return to one or more sources for additional clarifying information.

7.1.1. Ask if the person has reconsidered any information previously provided.
7.1.2. Explain that you've spoken to another or others, reviewed records, and need to reconcile some pieces of information that don't quite fit.
7.1.3. Provide the contradictory information, being careful to guard the source if you do not have permission to reveal or if revealing the source would create safety issues.
7.1.4. Do not assume that there is a right or wrong, or if there is, who is right or wrong.
7.1.5. If needed, provide your professional assessment.

8. Complete the FSNA

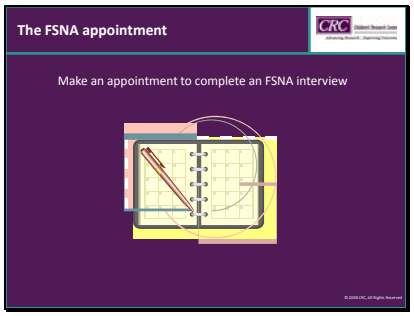
8.1. Reflect the **family's perspective** whenever possible.

8.2. If there are unresolved contradictions, proceed as follows:

8.2.1. If safety is not an issue and information is not conclusive, you may reflect the family's perspective, noting your differing point of view in the narrative.
8.2.1.1. Over time, you may be persuaded that the family is right.
8.2.1.2. Over time, you may be able to persuade the family to see themselves differently.

8.2.2. If safety is an issue, or the information is strongly pointing to a particular response, select the response that fits best, even if one or more family member disagrees. Use engagement skills to explain your choice; the narrative should reflect that there were opposing viewpoints.

Slide 16



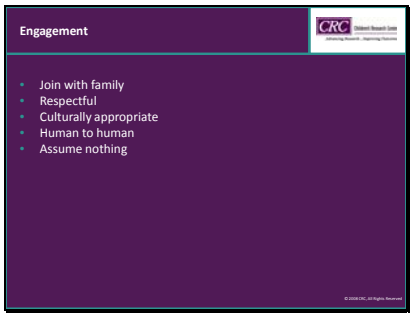
One way to do an FSNA is just to have contacts with the family and then when the case plan is due, realize your supervisor is going to ask you for an FSNA, so you sit down at the computer, think of what you know about the family, and fill in the FSNA based on what you know.

A better approach is to designate one of your first required contacts as an FSNA interview. You have to go out anyway, so why not make it a purpose-driven contact? Prepare by going over the safety assessment and risk assessment, which will have lots of valuable information. Then tell the family you would like to meet with them to get to know them better, and hear what the family thinks is going well and where they may be interested in some help.

This doesn't have to be just one meeting on one occasion. You may need to meet separately with different family members, or may meet with them all at once. You may use a family meeting approach. You will need to supplement with information such as school records, police records, existing collateral contacts, etc. But the FSNA interview is the heart of the assessment process.

Note that for case plan reviews, you should also designate one contact as a review interview. You won't be starting from scratch, but will be asking, "So in what ways has this changed?"

Slide 17



When we meet with the family to discuss and complete the FSNA, we need some useful groundrules for where we should start.

In any meeting with a family, there are certain elements that characterize a good interview, regardless of our goals.

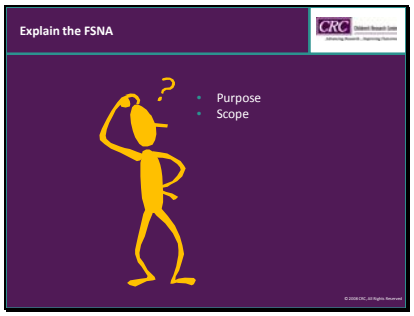
We must join with the family and try to connect with them to build trust and partnership. In order for our interview to be successful, it's important that we all feel that we're working together towards a common goal, rather than entering into a mandated conversation. If the family does not feel that they are partners in the process, it will be harder to engage them in making long-lasting changes to their family.

We can help them become more comfortable by respecting their practices, knowledge, and views. It is also important to be culturally appropriate—acknowledging that family function is influenced by culture, as are the service options that are a good fit. We can be aware of culture by being open to interpreting nonverbal cues from family members, trying to

understand their behaviors through the lens of their culture, and approaching the conversation and sensitive subjects in ways that they are likely to be more comfortable with.

When interviewing, we also try to connect to another human being, to set aside what we may think we know and assume nothing about the family situation.

Slide 18



One important step towards helping the family become partners in the process is to explain to them what the FSNA is. If they understand the purpose of the assessment and its scope, they can understand that there is a goal behind the questions you are asking that they likely agree with—trying to create a safe home environment for their children.

Don't make the FSNA a mysterious process. Parents have a right to transparency, and sharing information with them can help build the trust needed for successful interviewing.

The purpose of the FSNA is to look at eight areas of caregiver functioning and nine areas of child functioning. In each area, we want to work with the family to describe their household as it is now. For example, one area we want to understand is the quality of household and family relationships. How do the adults in the household, the caregivers, relate to each other, work together, generally get along, and how do they interact with their children? Similarly, how do the children relate to their siblings (if present) and parents? When we have a full picture of how the family members behave in each of these domains, we can use some key characteristics to determine if this is an area where the family is doing well, where they have a lot of strengths that they can draw on, or if this is an area where the family needs some assistance to be able to provide a safe and healthy home for children.

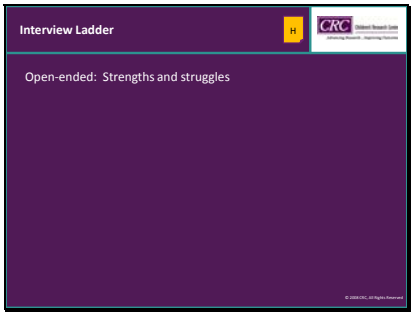
Point out that while identifying needs, we really want to focus on needs as they relate to providing a safe home for children. We cannot address every need that the family has, but we can focus on those that affect the children.

Helping the family to understand that your shared goal is to fully describe family life so that you can identify and prioritize key areas for assistance can be an important first step towards creating an atmosphere of partnership and collaboration.

Note to trainer: Should workers bring the FSNA form with them to the meeting? Should they discuss the scoring for each item?

We do not recommend bringing the FSNA form into meetings with families. The assessment form is not family-friendly, may seem confusing, and is likely to contribute to a "going down the list" approach to assessment that will not be productive. The idea that there are certain domains that we need to get a feel for can be introduced, and the basic A-D framework (proactive strength, average strength, minor need, major need) may be introduced as well to give the family a sense of the spectrum of possible responses. The definitions themselves should not be shared as they are likely to prematurely narrow the conversation.

Slide 19



When interviewing to elicit enough information to accurately complete the FSNA, the basic guidance of good social work practice applies. We describe this approach with the interview ladder. Right now, we're just looking at the top rung on the ladder, but you look at your handouts, you can follow as we step down.

We want to begin with open-ended questions about the family. We're not going to jump directly to the items, but rather will wait, listen, and allow family members to tell us what they think is most important for us to know.

After some time, we may ask family members to tell us more about what they see as their strengths or struggles, again starting with open-ended questions and allowing them to focus on whatever domain is most important to them. The goal is to ask a question that allows the family to describe their perspective on family function, and to listen.

Note to trainer: Distribute handout and discuss format briefly with group.

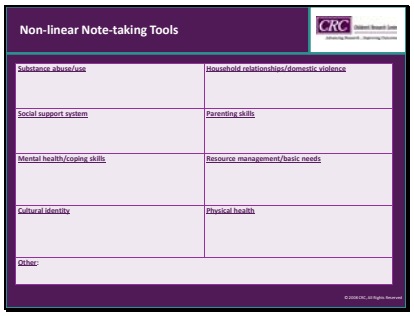
OUTLINE FOR INTERVIEWING

OPEN-ENDED
STRENGTHS
STRUGGLES

NON-DIRECTIONAL FOLLOW-UP
POSITIVE ANCHOR FOLLOW-UP
NEGATIVE ANCHOR FOLLOW-UP

LEVEL CLARIFICATON
(A vs. B, B vs. C, C vs. D)

Slide 20

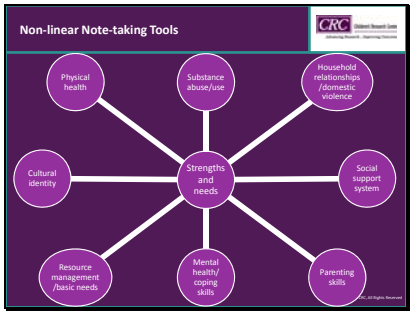


If we start high on the interview ladder with open-ended questions about the family's strengths and things they struggle with, we might gain information on several domains at once, and it may be hard to keep track of where we have enough information and where we need more if we write notes chronologically.

One suggestion for dealing with this is to divide one side of paper into eight squares, one for each caregiver item. You can lay out the child items on the other side of the page. As family members tell you about the household, you can fill in the appropriate square with the information you gather. This makes it easier to see which items need follow-up questions. If you also include a space on your notes sheet to record the score, you can see at a glance which areas are already completed, where you don't need to ask more questions.

If you're doing multiple interviews, use one sheet per interview and note who was interviewed. Then it's easy to compare across interviews.

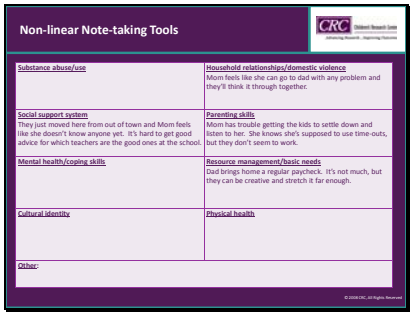
Slide 21



Of course, folding your paper into squares is not the only way that you can organize your notes to make interviewing more efficient. Some workers prefer a hub-and-spoke note-taking approach as shown here.

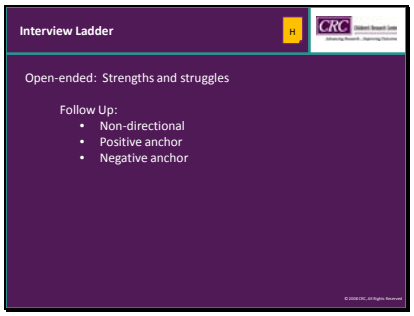
No one way is correct, but these are some suggestions to start you thinking about how you can modify them for your own needs.

Slide 22



After we ask some open-ended questions about strengths and struggles, we might have a notes page that looks something like this. We get information in a few areas, but there are still some domains where we have no information.

Slide 23

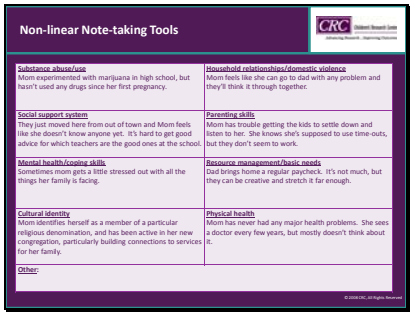


So we take a step down the interview ladder.

If at this point you don't have enough information to complete some of the items on the FSNA, ask an open-ended question about that domain. For example, "I notice you haven't spoken much about the role of alcohol or drugs in your family; could you tell me something about that?"

After the family members have described their views, you may probe further with positive or negative anchor follow-ups within the domain. For example: "Some families struggle when a family member has health concerns. Can you tell me more about the way family health influences your home?"

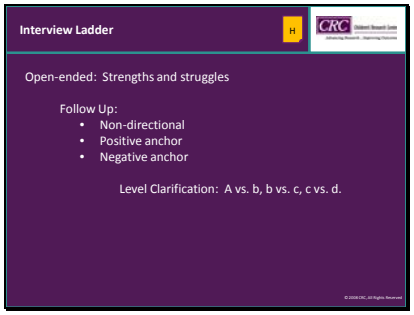
Slide 24



As we work through the domains that were empty, using follow-up questions, we can slowly fill in our notes.

Trainer might read the notes for Mental health/coping or Resource management as a set-up for the level clarification questions.

Slide 25



So, after using the first two levels of the ladder, we're closer to filling out our notes and scoring the FSNA items, but in some areas, we're still missing information. Remember mental health and resource management? We're still missing a lot of information there.
Note to trainer: The information in the other domains isn't as full and rich as we would hope to have after speaking to a family and gathering information from other sources. Focusing on these domains, however, provides a clear example of where we might want to turn to the FNSA definitions to craft some highly-specific questions to get the information we need.

If you have gathered information that does not allow you to distinguish between a moderate need and a serious need, or a strength and a moderate strength, ask a clarifying question to enable an informed decision.

Note to trainer: Review level-clarification question on the handout within a chosen domain.

INTERVIEW NOTES

Person interviewed: _____ Date: _____

CAREGIVER

Substance abuse/use	**Household relationships/domestic violence**
Social support system	**Parenting skills**
Mental health/coping skills	**Resource management/basic needs**
Cultural identity	**Physical health**

Other/notes:

INTERVIEW NOTES

Person interviewed: _____ Date: _____

CHILD (Name:_____)

Emotional/behavioral	**Physical health/disability**	**Education**
Family relationships	**Child development**	**Substance abuse**
Cultural identity	**Peer/adult social relationships**	**Delinquent behavior**

Other/notes:

Slide 26

When you're speaking with a family, the unique details of the situation will often lead you to the next appropriate question.

However, in case you need help, here are some examples of questions at each level of the ladder to get you started. You might review this sheet before meeting with a family if you anticipate a difficult conversation.

The questions are drawn directly from the definitions. When you know the definitions, it is easier to ask effective questions that move you along toward a rating for the item. Good questions will build on what you already know about the family and will be in language the family will understand. Clearly, the items on the FSNA are NOT designed as interview guides!

The first group of questions is arranged so that for each FSNA domain, there are samples of non-directional, positive anchor, and negative anchor questions. These are just examples. There are better questions and many more ways to get at the information.

Note to trainer: Review the questions in one domain as an illustration. Select a domain other than social support. You will be reviewing that domain later for the practice exercise.

The next group of questions are level clarification questions. For each FSNA domain, there are sample questions that can get at whether the better choice is A or B, B or C, or C or D. Where are you stuck? Find that item and see if that question can't help. Or at least use that question to get ideas.

Note to trainer: Review the questions in one domain as an illustration. Select a domain other than social support. You will be reviewing that domain later for the practice exercise.

There is no one best way to get at the information. The longer you do this, the better you will get at asking effective questions that are right for the family. The key is to use each question strategically to move you closer toward being able to rate the item.

Table 1

Sample Interview Questions Follow-up

Item	Non-directional	Positive Anchor	Negative Anchor
CAREGIVER			
Substance use/misuse	What role do alcohol/drugs play in your household?	What do you do to help your children avoid problems with alcohol/drugs?	In what ways do alcohol/drugs affect your family?
Household relationships/ domestic violence	How do the adults in the house get along? How do the adults handle conflict?	What are the best things about your relationship with _____? Can you describe a time the adults were very angry with each other and resolved the issue peacefully?	What conflicts are there between you and _____? Has anyone ever been hurt by another adult in the home? Do you ever feel afraid of _____?
Social support	Could you tell me about your relationships with friends and family?	Who gives you the most support? How do they support you?	In what ways do you feel alone? Like people let you down?
Parenting skills	What's being a parent like for you? How do you help your child learn right from wrong?	What advice would you give a parent based on something you do very well?	What ways would you like to become a stronger parent?
Mental health/coping skills	How do you feel about life in general?	What have you found to be successful ways to cope when things get a little rough?	How often do you feel overwhelmed?
Resource management/basic needs	How is your family doing in terms of being able to provide?	What are some of the ways you are finding to make ends meet?	What are some important needs that are currently unmet?
Cultural identity	In what ways does being [whatever culture] affect you?	How does being [whatever culture] help you?	How does being [whatever culture] make things hard for you?
Physical health	How is your health?	What ways do you take care of yourself?	How does having [condition] make it hard for you?
CHILD			
Emotional/behavioral	Most of the time, how do you think your child feels about life in general? How would you describe your child?	What makes your child happy?	How hard is it to get your child to do what you ask?
Physical health/disability	How is your child's health?	What does your child like to do for physical activity?	How does having [condition] affect your child?
Education	How is your child doing in school?	What areas is your child doing well in?	Are there any ways your child is struggling in school?
Family relationships	How does your child get along with everyone else in the house?	Who is your child closest to? What is that relationship like?	Who does your child have a hard time with? What is that like?
Child development	Compared to other children his/her age, how would you say your child is doing?	Are there some things your child can do that are advanced for his/her years?	Are there some things most children your child's age can do that he/she can't?
Substance use/misuse	Could you tell me about how your child feels about drugs/alcohol?	What would your child do to avoid drugs/alcohol?	How have drugs/alcohol affected your child?

Table 1 Sample Interview Questions Follow-up			
Item	**Non-directional**	**Positive Anchor**	**Negative Anchor**
Cultural identity	How aware is your child of his/her identity as [culture]? Could you tell me about what being [culture] means to your child?	What ways does being [culture] help your child?	What ways does being [culture] create struggles for your child?
Peer/adult social relationships	How does your child get along with other children? With adults?	Tell me about your child's friends. Are there adults your child looks up to?	Are there any children or other adults your child does not get along with very well?
Delinquent behavior	What is your child's sense of right and wrong? How successful is your child in doing what's right?	How does your child avoid situations where he/she could get in trouble?	Has your child ever been stopped by the police?

Table 2

Level Identification Questions

Item	A vs. B	B vs. C	C vs. D
CAREGIVER			
Substance use/misuse	What do you do to teach your children about alcohol/drugs? How do your children feel about alcohol/drugs? How do you suppose they came to that belief?	Has there been a time that [caregiver's] use of alcohol or drugs was the cause of problems? Has [caregiver] continued to use since that time? (When discussing struggles) Do alcohol or drugs ever play a role in that? (For someone in recovery) What is your plan for staying straight/sober? How easy or hard is that for you?	How have alcohol/drugs affected: • Work? • Finances? • Legal issues? • Relationships, etc.? How long are you able to remain straight/sober after being released from intensive treatment?
Household relationships/domestic violence	How do you feel about each other? How do you let one another know? Do you feel respected/appreciated by your partner? How do you share household responsibilities? How is that decided? How do you handle disagreements? Do your children ever physically fight or bully? If not, how do you suppose they came to choose nonviolence?	How often do you feel in conflict with one another? Is this more or less than in the past? How do the children react when they are aware of conflict? (As applicable) How do you and child's other parent work out visitation and other issues? (Ask all adults) Do you ever feel threatened or intimidated by any other adult in the household? Has someone in the household physically hurt you or attempted to do so? (Ask about throwing things, pushing, making a fist, etc.) Are there times you feel unable to do what you want because your partner won't let you? (Ask about freedom to come and go, spend money, associate, have phone calls. Sort between compromises that are appropriate vs. one-sided power.)	When you bring someone into the home, how do you know how safe they will be for your children? If a disagreement came up today, what are the chances that you and your partner could resolve it without conflict? Has there been an injury? How often? How severe? Is there a restraining order? If so, to what extent is it being followed? When is the last time you were able to just decide to [go out of the house, call someone to talk, spend a few dollars]? How fearful are you that something serious will happen? (If batterer has recently left…) What steps will you take to be sure your partner won't hurt you again? What steps will you take so your next partner won't be as dangerous?

Table 2

Level Identification Questions

Item	A vs. B	B vs. C	C vs. D
			IF ANY OF THE ABOVE IS TRUE, ask both parties if they have sought or are willing to seek help.
Social support	How often do you get together with [identified supports]? On balance, how much do they help you compared to how much you help them? How many people can you name who could help with [trusted advice, financial help, child care, transportation, etc.]?	When you need [various kinds of help] can you name at least one person who you would call to help? Can you tell about a time someone helped you? Who in your family is helpful to you?	How long has it been since you felt there was someone in your life you could turn to?
Parenting skills	What do you think your child is really good at? What do you think his/her future will be? How are you helping your child learn about and become part of his/her world? In what ways have you helped to ensure your child has what he/she needs, for example, at school?	Ask for examples of how the parent is providing the physical, cognitive, and emotional experiences children of the child's age need. Ask for examples of how the parent handles typical developmental tasks appropriate for the child's age (e.g., how are you managing potty training? Starting school? Driving?). How do you help teach your child right from wrong? What do you do if your child misbehaves?	Has your child ever been injured as a result? How seriously? How often?
Mental health/coping skills	How do you see your future? Can you tell me about a time you were faced with adversity? How did you manage?	Are you (sleeping, eating, concentrating) okay? Do you feel like you have as much energy as usual? How much do you worry about things? (If they've mentioned any symptoms) Are you getting any help with that? What are you doing for that?	Have you missed work because of [symptoms]? Is it harder to do everything the children need because of [symptom]? (Be sure to ask the children and other household members.)
Resource management/ basic needs	How long have you lived here? How long have you been working? Have you been able to start saving for a	How do you provide for bathing? Toileting? How safe is the electrical system? What does your child have to wear? To eat?	Has someone gotten hurt/sick because of the living situation? Has someone missed school or work because of the living situation?

Table 2

Level Identification Questions

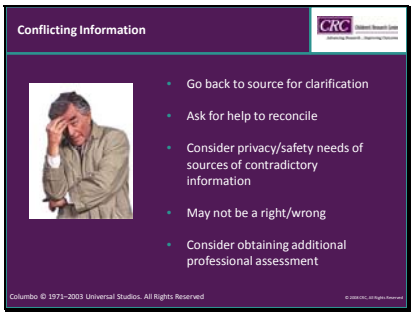
Item	A vs. B	B vs. C	C vs. D
	rainy day, college, a special treat, a house, etc.? How often do you worry about being able to provide food or shelter?	What tips have you learned for how to manage on a tight budget? Does the food run out before your next check arrives? Do you ever wish you had a little more to eat?	Has your child been sent home from school because of hygiene/clothing (not related to sensibilities)? How do you keep safe at night? Has an inspector condemned your housing?
Cultural identity	Do you feel part of a culture or community? How does being [culture] help you?	Do you ever experience conflict related to being [culture]? Do you ever experience conflict because you don't share a connection to [surrounding culture]?	How often do you experience conflict related to being/or not being [culture]?
Physical health	How are you teaching your children about staying healthy?	Are you getting routine health care for yourself? Are there any health concerns that make it hard for you to provide what your child needs?	How serious is [condition]? Who takes care of the children when you can't?
CHILD			
Emotional/behavioral	How has your child coped with [specific stressful event]? What does your child do to get help with feelings or emotions?	Has your child been more withdrawn, sad, angry, etc.? Has your child's behavior changed one way or the other? Compared to other children this age, is it any harder for your child to cope with [stressful situation]? (For infants) Can your child calm on his/her own? Compared to other infants, does he/she smile and coo as much?	Is your child getting in trouble because of his/her feelings? Has your child ever talked about/tried suicide? Has your child ever started fires, hurt animals, or hurt other children? (For infants) When your child cries, can he/she be consoled? Does he/she seem to like being held?
Physical health/ disability	What does your child say about nutrition, exercise, wellness? Does your child get routine preventive health care?	Does your child have a health condition? If so, what do you have to do to take care of it?	Did you have to get a lot of instruction to learn how to care for [condition]? Who takes care of your child's [condition]?

Table 2

Level Identification Questions

Item	A vs. B	B vs. C	C vs. D
Education	Has your child had any advanced coursework? Has a teacher reported that your child is doing work that is more consistent with an older child?	Is your child working below grade level in any subject? Has your child skipped school?	In how many subjects is your child working below grade level? How many days has your child been truant?
Family relationships	What positive things does your child say about his/her family? How loved does your child feel in his/her family?	How safe does your child feel in his/her family? How attached does your child appear with his/her family?	Is your child exposed to violence in his/her family? Does your child feel so unsafe or insecure that he/she is having trouble in school, running away, etc.?
Child development	Review expected milestones for the child's age group. Ask questions and make observations based on expected milestones.		
Substance abuse	What is your child's attitude toward alcohol/drugs? What does he/she know about the effects of alcohol/drugs?	Has your child ever tasted alcohol/drugs? How often? How long ago? Has alcohol/drug use caused any problems?	How long has your child used? How severe are the problems caused by alcohol/drug use? Could your child stop using without withdrawal?
Cultural identity	Does your child feel part of a culture or community? How does being [culture] help your child?	Does your child ever experience conflict related to being [culture]? Des your child ever experience conflict because he/she doesn't share a connection to [surrounding culture]?	How often does your child experience conflict related to being/not being [culture]?
Peer/adult social relationships	What does your child do outside of school? Does your child let others help? Does your child enjoy helping others?	Does your child have more trouble with friends than other children his/her age? How often does your child seem to have struggles with other children? How does your child resolve conflicts?	Does your child have any friends you feel good about? Do your child's friends have a positive or negative influence on your child? Does your child have any friends at all?
Delinquent behavior	Does your child volunteer to help in formal or informal ways? Does your child feel compelled to do the right thing?	Has your child ever behaved in a criminal way (caught or not)? If your child has completed probation, have at least two years gone by without re-offending?	Was any of your child's offending violent? Has your child re-offended?

Slide 27



So what do we do when the pieces don't fit?

You've interviewed all of the family members, and now you have to build a single family assessment out of these stories. When the different stories conflict or just don't fit together, involve the family in building the unified picture.

Go back to the source for clarification. Maybe it's as simple as remembering incorrectly. In such cases, an approach that begins "I'm confused…" or "There's just one thing I don't understand…" and presents the discrepancy as a legitimate difference of memory or opinion can be more successful than an approach that suggests that someone is lying. Think about Lieutenant Columbo…

Ask for their help to reconcile the stories: Involve the family in telling their story and ask them to help you understand what you've heard.

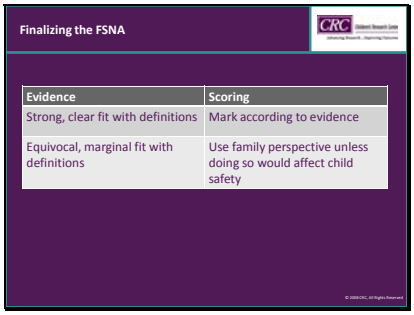
Consider privacy and safety needs: Sometimes, safety will be a concern. Use your professional judgment to know when sources and information must be kept confidential. For example, suppose the primary caregiver reports no mental health concerns, but another household member reports that the primary caregiver has a history of mental health problems and becomes violent when confronted. If we believe that the household member is credible, then we would not want to let the primary caregiver know that someone in the household had disclosed the mental health issue, but we would want to find a way to diagnose it and have it addressed.

Note to trainer: Counties may have existing policies for addressing unsafe family situations. For example, many counties use the Greenbook as a guide for approaching situations of domestic violence.

There may not be a right or wrong answer; keep in mind that it might just be different perspectives on the same facts. In this case, the important thing may be arriving at a conclusion that everyone can accept rather than the one they would want.

Consider obtaining additional assessments; if you're really stuck, call in outside help. A mental health or drug screening or special education assessment may resolve an issue.

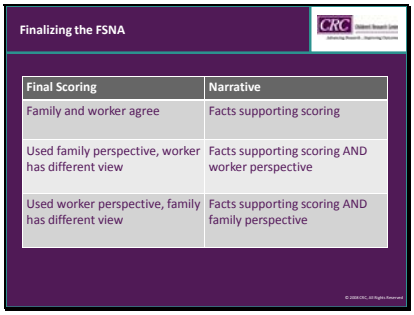
Slide 28



In the end, you have to make a decision on what to score. If the evidence is really strongly supporting one score over the others, mark that score even if one or more family members disagrees.

If the evidence is equivocal, or everyone agrees but the information is really equally suited to more than one definition, go with the family's definition UNLESS doing so would affect child safety. Since we are doing a needs assessment rather than a safety assessment, most of the time child safety won't be affected. But, for example, if the household relations/domestic violence item is between a C and D, and if it's a C it would fall off the priority need area, and you are equally drawn to C or D as a best-fitting answer, AND your judgment is that failing to address DV at this time would put child in danger, then lean to D. Keep in mind that we are only talking about a tiebreaker in the rarest of circumstances, one which can't be resolved simply by good interviewing and applying the definitions.

Slide 29



When there are differences in perspectives, even though there can be only one final score, the narrative should reflect the complexity and controversy.

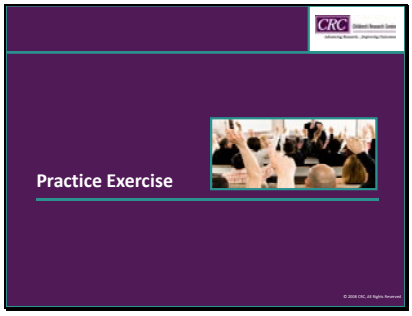
If everyone agrees, no problem; just report the facts that led to scoring decisions.

If you used the family perspective but you have some concerns, then the narrative should make your concerns explicit. For example, "Family reports no issues with substance abuse at this time. Father was treated one year ago and has been sober since that time. He is not required to be in active treatment at this time. Worker has noted that father is no longer attending AA, does not have an active relapse prevention plan, and has been spending time in bars. He states he drinks only non-alcoholic beer. Worker accepts family perspective at this time and encourages careful monitoring to maintain the impressive success father has achieved. While this will not be part of the case plan, worker will be alert for any indication of increasing need."

If you used the worker perspective but the family disagrees, the narrative should include the family voice. For example, "Father was diagnosed with alcohol dependency one year ago. He successfully completed a treatment program and reports abstinence for one year. However, father is spending time in bars and drinking NA beer, both of which are contrary to his aftercare plan. While he states he can handle it, these actions, combined with his stopping attendance at AA, suggest that he

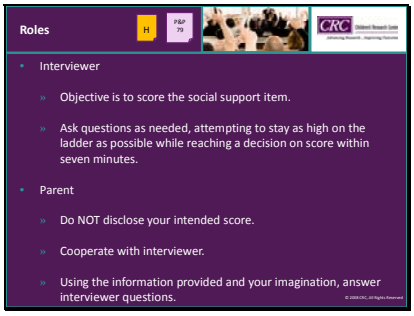
is still in danger of a complete relapse. Worker recommends immediately addressing relapse prevention so father can maintain his impressive success. Worker is willing to review assessment following a professional consultation with a relapse prevention counselor."

Slide 30



Now it's time to try some of this out with a practice exercise. Please divide yourselves into teams of two.

Slide 31



We will practice interviewing to determine the best-fitting response for social support. We selected social support because it's often overlooked and is a major factor in helping to prevent child maltreatment.

The first thing we need to do is review the definitions. Turn to page 79 of your P&P Manual.

Note to trainer: READ THE SOCIAL SUPPORT DEFINITION ALOUD AND DISCUSS IT WITH PARTICIPANTS. What is the key difference between A and B? *(The notion of MUTUAL support—not only taking help, but giving it.)* What is the key difference between B and C? *(B gets help whenever he/she needs it—he/she has enough of a network that if one person isn't available, someone else can help. A C may get a little help, but many needs are unfilled because his/her network is too small).* What is the difference between C and D? *(C gets a little help sometimes, while D is almost totally isolated, or the D person refuses help).*

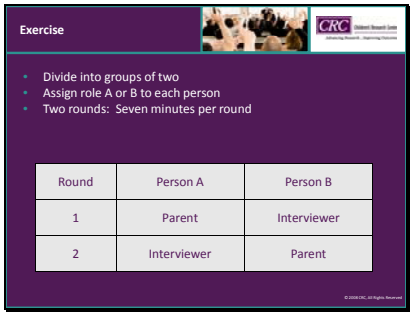
Note to trainer: Hand out one copy of PERSON A to one person from each pair and one copy of PERSON B to the other person in the pair.

Now take a moment to prepare for your role. As you prepare to be the parent, do NOT disclose your rating. Read your role and review the appropriate definition. If you need to make things up, be sure you are consistent with the definition.

As you prepare to be the interviewer, take a moment to look at the suggested interview questions. You can assume you are already mid-way through the interview, so you don't have to start by introducing yourself or the process.

We will begin with five minutes of preparation. Use this time to prepare for both rounds of practice.

Slide 32



In our groups of two, we're going to take turns being each half of the parent-social worker interview pair.

PERSON A: Page 1

Interviewing Exercise

Break into groups of two. In each group, one person is "A" and one is "B." Take a few moments and review the definitions for social support. Think about what you need to know as an interviewer. Also think about your role and how you will answer questions based on your scenario. ***Do not disclose the item score you will represent.***

There will be two rounds of the exercise, with each person taking on each role. Each round will include five minutes for preparation and seven minutes for interviewing. Assume that rapport building has already occurred and the parent is cooperative.

Scene	Person A	Person B
1	Interviewer	Parent
2	Parent	Interviewer

Scene 1

Interviewer

1. Review the item definitions and use the handout to brainstorm interview questions.

2. Objective is to score the social support item.

3. Ask questions as needed, attempting to stay as high on the ladder as possible while reaching a decision on score within seven minutes.

PERSON A: Page 2

Scene 2

Parent

1. Do NOT disclose your intended score, which is C.

2. Review the item definitions and decide who you are and how you would answer questions about yourself and your family.

3. Cooperate with the interviewer.

4. Using the information provided and your imagination, answer the interviewer's questions.

You are a single parent (mom or dad) who should score "C" on social support. Imagine yourself to have a handful of people you call friends and a small group of casual acquaintances whom you keep at arm's-length. To you, friends are people you do things with once in a while and talk about things with, like the latest thing on television, the best music group, what's in style. You have one friend you met about a year ago who you talk to about more personal things, but you don't live near one another, and neither of you can afford to visit or use long distance to talk often. You have another friend who lives nearby, and you do talk from time to time, but you feel like many sensitive topics are taboo with this person. This friend sometimes gives you a ride when you need to go to an appointment, but you don't feel like you can impose on them too often. You get along okay with your family, and your parents help you out with a little cash sometimes, but they do not have that much. You do not know your neighbors very well, just enough to say, "Hello," and "How's the weather?"

If you are asked open-ended questions or general questions about strengths and struggles, you may offer some information unrelated to the social support item, but should also include some information related to social support.

PERSON B: Page 1

Interviewing Exercise

Break into groups of two. In each group, one person is "A" and one is "B." Take a few moments and review the definitions for social support. Think about what you need to know as an interviewer. Also think about your role and how you will answer questions based on your scenario. ***Do not disclose the item score you will represent.***

There will be two rounds of the exercise, with each person taking on each role. Each round will include five minutes for preparation and seven minutes for interviewing. Assume that rapport building has already occurred and the parent is cooperative.

Scene	Person A	Person B
1	Interviewer	Parent
2	Parent	Interviewer

Scene 1

Parent

1. Do NOT disclose your intended score, which is D.

2. Review the item definitions and decide who you are and how you would answer questions about yourself and your family.

3. Cooperate with the interviewer.

4. Using the information provided and your imagination, answer the interviewer's questions.

You are a single parent (mom or dad) who should score "D" on social support. Imagine yourself to be pretty lonely. Your parents won't have anything to do with you. (They used to help, but they do not anymore, i.e., "You've stolen from us for the last time.") You are a pretty abrasive person, so people don't feel comfortable with you, but you don't have this insight—you just think people are pretty useless. You can't think of a time someone was really helpful to you, but can list dozens of examples of how people let you down. You cover up your loneliness with fierce independence, i.e., "I don't need anyone—I can manage on my own."

If you are asked open-ended questions or general questions about strengths and struggles, you may offer some information unrelated to the social support item, but should also include some information related to social support.

PERSON B: Page 2

Scene 2

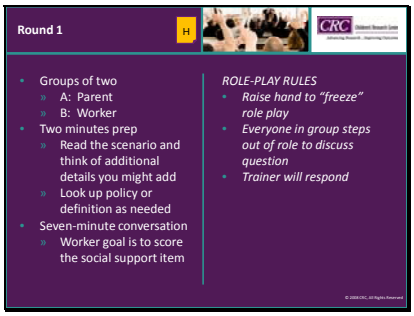
Interviewer

1. Review the item definitions and use the handout to brainstorm interview questions.

2. Ask questions as needed, attempting to stay as high on the ladder as possible while reaching a decision on score within seven minutes.

3. Objective is to score the social support item.

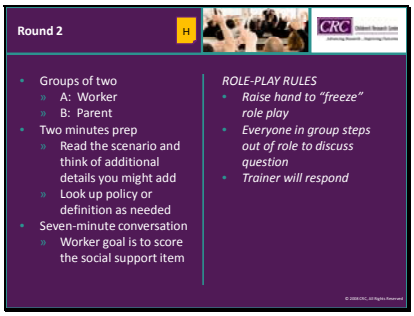
Slide 33



You will have seven minutes, after which we will ask you what score you think best fits. GO! *(Keep track of time; alert at halfway point and with two minutes remaining).*

AFTER SEVEN MINUTES, ask interviewer what they rated. If there are any responses other than expected, ask for basis. Most often, the parent made up some aspects that better fit a different score.

Slide 34



Give the pairs seven minutes for Round 2, giving alerts at halftime and two minutes remaining. AFTER SEVEN MINUTES, ask interviewer what they rated. Debrief as for Round 1.

Slide 35

Trainer invites discussion about things that were observed while completing the exercise.

First, let's acknowledge that we've done a pretty good idea of assessing one item in seven minutes. The interview ladder can get us the information we need efficiently, and allows us to work with families as allies and collaborators. In a relatively short period of time, we can gather the information that will form the basis of the case plan, which is our next FSNA advanced training topic. The domains we identify as priority need areas will be addressed through the case plan and will determine the goals the family will be assessed on at reassessment or at reunification assessment.

Slide 36

Conclude by asking every person to describe one new idea or skill that they will begin to use as soon as they return to work.

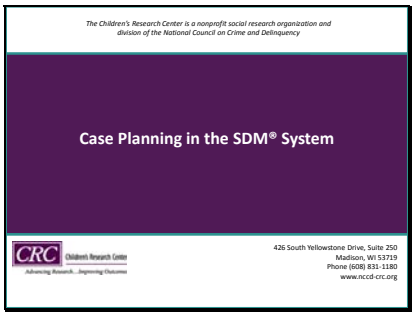
CASE PLANNING WITH THE FSNA

Materials needed:

- Trainer
  - » This manual
  - » PowerPoint [Case Planning Using the FSNA.ppt]
- Students
  - » At each seat at start of class:
    - Case planning handout
    - FSNA section of P&P Manual (or entire manual)
      NOTE: You can have students bring their own, have copies to hand out and collect at the end of class, or have copies they can take with them.
  - » To hand out during class:
    - The Conseco-Velasquez Case Summary
    - Case planning exercise 1
      Print one copy of this one-page document for each participant.
    - Case planning role play
      There are ten scenarios in this document. Print three copies of each, single-sided.
- Audio/visual
  - » Laptop/projector/screen
  - » Whiteboard or flipchart is optional

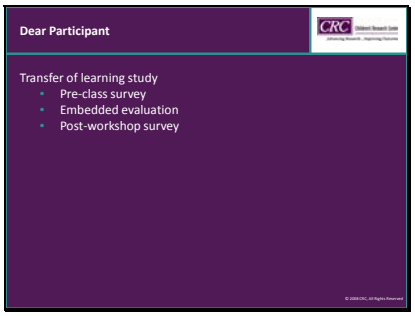
TRAINER NOTE: Discuss in advance with county management to determine their preference for how workers should enter information for the case plan into CWS/CMS. Also, encourage counties to discuss this approach to case planning with county and the courts.

Slide 1



Trainer may start with an introductory exercise of his/her choice.

Slide 2

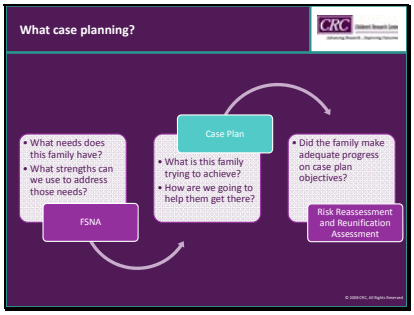


Note to trainer: If you are participating in the transfer of learning study, pass out the letter and briefly explain the components of the study. If you are not part of the study, hide this slide.

This class has been selected as part of a study on how training can better impact actual practice. You probably have a sense of what prompts a study like this. Frequently, the answer to every problem is "More training!" But it's often difficult to carry the things we learn in a classroom into the field. Researchers are attempting to figure out how training can better translate to the field. Your help in this study is greatly appreciated and will contribute importantly to better child protection practices. You already completed a web-based survey after you registered for this class. If you did not, please raise your hand, and I will pass out hard copies of that survey. Please try to complete it on break. Next, one of the exercises we do in class today will be used as an embedded evaluation. You will work individually, and we will collect your work. Please know that this is not so much testing YOU as it is testing ME (trainer) and this curriculum. Afterward, you will have one final survey to complete, and I will collect those before you leave.

Note to trainer: At press time, this is the working information. We will update as needed, which will likely include an informed consent and information about post-training study. Workers will not have to do any additional data collection after the survey, but it is hoped that they will apply what they are learning to the case plans they write. A few will be sampled and rated according to the goals of today's training. These will be compared to case plans for workers who did not attend training.

Slide 3



When you signed up for a training on case planning in the SDM system, you could reasonably have asked yourself, "What case planning?" There is no specific case-planning tool in the SDM system. It is an out-of-system process that is nonetheless important to the success of the SDM system.

Case planning starts with the family strengths and needs assessment (FSNA). When you have completed the assessment, you have identified all of the children's needs, the three priority needs of the caregivers, and the family's strengths. We're going to use this information to write a case plan. The case plan answers two basic questions: What is this family trying to achieve? And, how can we help them get there?

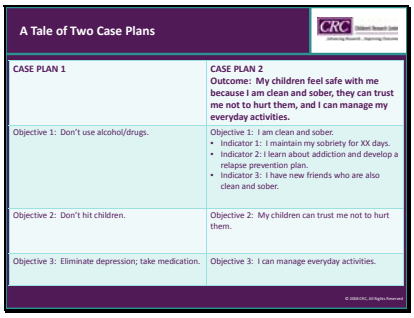
However, the case plan needs to be specific enough and thorough enough that it allows us to complete the risk reassessment or reunification review. Both of these assessments include a question about "progress on case plan objectives." We can't satisfactorily answer these questions unless the case plan does the following:

1. Describes objectives that represent significant improvements in child safety.

2. Fits the family well enough that it can feasibly help them achieve those objectives.

Today we're going to focus on writing case plans that flow out of the FSNA and back into the reassessments and that help families support their children's safety, well-being, and development.

Slide 4



Before we jump in, let's step back for a moment and consider why case plans are important.

Let's assume that we have one family and we're going to ask two workers to write a case plan for this family. The FSNA indicated priority needs in the areas of substance abuse/use, parenting skills, and mental health/coping skills. Each column shows the objectives developed by the two workers, and indicators of success in first domain are also shown. We didn't include the indicators for other domains because of space. If you were the primary caregiver in this household, which case plan would encourage you to work toward change? Which is more likely to bring about meaningful change so that the children in this home really would be safe and well-supported?

Note to trainer: Things to discuss:

How many goals in Case Plan 1 start with the word "Don't?"

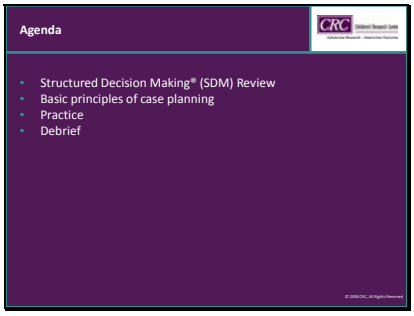
The objectives in Case Plan 1 are about compliance—producing test results, attending meetings. The objectives in Case Plan 2 are positive steps the caregiver can take to manage a problem area.

The objectives in Case Plan 2 all incorporate the impact on the children in the home.

Most individuals/families are likely to respond more positively to Case Plan 2. If a participant is of the opinion that he/she would prefer Case Plan 1, note that many in the class feel differently, and they would still need to positively engage with families to know which type of plan would be a better fit. Best practice indicates that, for most families, it will be Case Plan 2.

Either case plan can help us complete the progress toward case plan objectives item on the reassessment, but Case Plan 2 is more likely to help families make the kind of positive changes that will gain them a positive score on that item.

Slide 5



We'll start our work together with a very brief reminder of the elements of the SDM system that interact with the case plan. You've already had SDM training and the interviewing for the FSNA module, so we won't be doing any practice exercises with this.

Then we will spend some time on basic principles of how to engage families in case planning.

Our goal won't be to cover everything there is to know about case planning. What we want to do is connect what we already know about case planning to the SDM system. Much of this may feel like review to you, but we want to make sure that we all have a common understanding of process and goals before we move forward.

We'll then practice the principles we've learned in a group exercise.

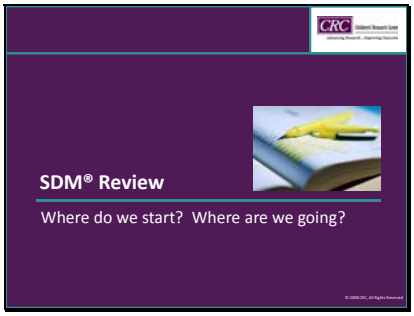
You'll have one more opportunity to write a case plan on your own.

Note to trainer: This is the embedded evaluation. You will use this exercise whether this class is part of the TOL study or

not. The only difference is that if you are part of the study, you will collect results.

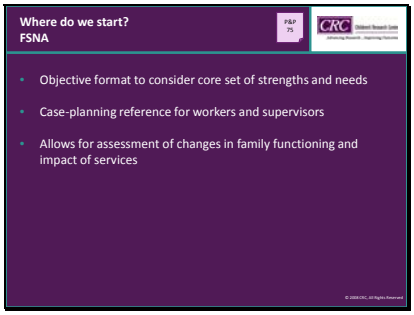
Finally, we'll come back together for a debriefing, where we'll share our observations on the exercise and lessons learned.

Slide 6



When it comes to case planning, the key SDM questions are where do we start from, and where do we need to end up?

Slide 7

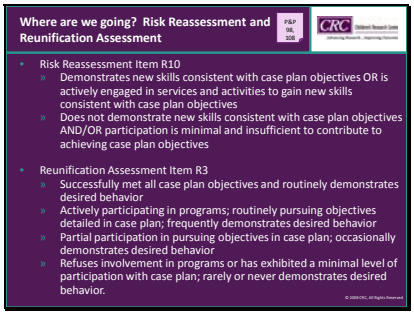


We start with the FSNA.

We use the FSNA to assess the primary and secondary caregiver and all children in the household on a core set of domains. Each person's areas of strength and need will be used by workers and supervisors when writing and approving case plans. Over time, as we return to reassess the family at regular intervals, the FSNA will enable us to track changes and improvements in family functioning to determine if services are working.

For now, the important thing to remember is that the FSNA identifies three priority areas of need for the caregivers. We will work with these need domains to write the case plan objectives.

Slide 8



After using the need domains to write our objectives, we then use these objectives to answer the items on the risk reassessment and the reunification review.

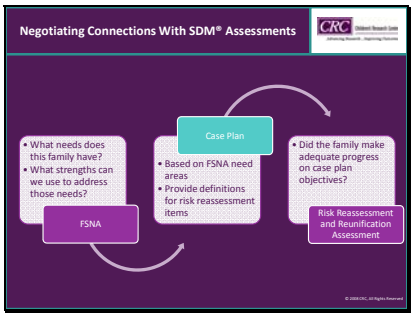
For the risk reassessment, which we use with families whose children all remain in the home, we need to be able to determine which of two categories progress towards case plan objectives falls into. Either the caregivers demonstrate new skills or are actively engaged in acquiring new skills consistent with case plan goals, or they are not demonstrating those skills and are only minimally participating.

For the reunification assessment, we have a four-tiered item we need to answer, but the basic range of success is the same. An important distinction here is that we need to write

objectives that will help us distinguish between active/routine participation (second response) and partial/occasional participation (third response).

The definitions for these items don't give specific formulas for distinguishing between active and minimal or routine and occasional. That's because the case plan for each family should be individually tailored, and is unlikely to support a simple mathematical determination. The objectives we write for the case plan **become** the definition for these items.

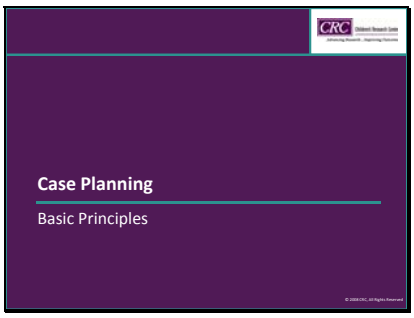
Slide 9



Today we're going to learn to write case plans that respond to the unique circumstances of families and allow us to negotiate these connections.

Coming out of the FSNA, we'll use the priority need areas to define our objectives, and we'll use those objectives to set ourselves up to complete reassessments a few months down the road.

Slide 10



As we begin to describe a structure for case planning, it's worth noting that this will not match up with the CWS/CMS case plan. We will talk about how you can integrate it with CWS/CMS, but admittedly, it's a clunky workaround. One option is to just stick with the language of CWS/CMS case plans until the new computer system is out. How helpful have you found this language for families?

Note to trainer: Discuss how the language in CWS/CMS is closer to Case Plan 1 than Case Plan 2, and may not be useful to many families.

A better option is to begin to adapt to better practice in case planning and do our best to fit it into the existing system. You'll see as we move forward that some of our steps map to CWS/CMS, albeit imperfectly, while some are completely out-of-system processes that are more about your work with the family than anything you'll record in CWS/CMS or on SDM assessments.

Slide 11

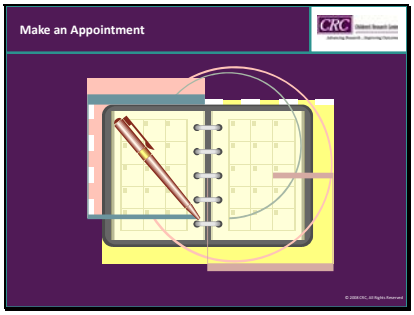
This quotation is taken from a doctor from the Mayo Clinic talking about ways that doctors and patients sometimes fail to communicate, thereby harming health. The same can be said of the families we serve. Prescribing services without gaining the family's agreement and understanding of why these services are necessary can reduce the likelihood that families will fully participate. If we want families to follow their case plans, we need to make them partners in the process of development.

Doctors are encouraged to clearly explain the patient's condition and the likely course if a patient takes no action. Doctors are responsible for knowing the best evidence-based interventions for the patient's condition. They should explain the options, including what it will be like, the side effects, and the chances for success. They should discuss possible barriers to following a plan, and ideas for overcoming those barriers.

Likewise, we should be frank with families about their risk, the impact of the various need areas on their family, and the chances of future harm. We are responsible for knowing evidence-based interventions. It's not okay to just say, "Get counseling." What kind of modalities are best suited to this family? What are the success rates of different approaches to methamphetamine addiction?

This sounds like a lot of work, and it is. It is an investment in change. Cutting corners in case planning reduces the chance the family will succeed. That means longer stays in care, fewer reunifications, more FM children becoming FR children, and more reunified children returning to care. You can save a few hours now by shortcutting case planning. But you'll spend more than a few hours later dealing with what happens when we don't effectively engage the family in the change process.

Slide 12



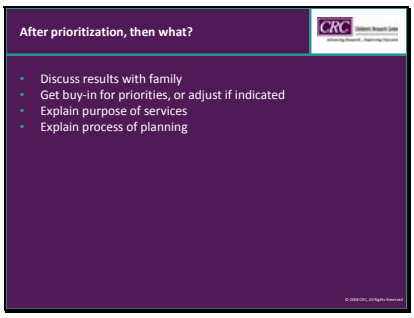
We started with a tale of two case plans, one focused on what we want families to stop doing, and one focused on what we want families to move towards.

We also have to choose between two processes for setting the case plan. We could sit in our offices, consult the FSNA, and then write the case plan we think the family should have. Then we can just hand it off to them and expect them to follow it. That's the "Here's your prescription" approach.

A better approach would be to set a time to talk to the family about the case plan, and to actively solicit their understanding and input into the process. The more we engage families, the

more likely they are to regard the case plan as something they want to do for themselves rather than a burden being imposed from the outside.

Slide 13



After completing the FSNA, you have three areas of priority need for the caregivers, and areas of child need, as well as areas of strength that you can work with to address those needs.

If you remember the previous session on interviewing for the FSNA, your next steps should flow from there. First, discuss the results with the family. If you developed the priorities list collaboratively, there shouldn't be many surprises for the family, but it can be useful to review.

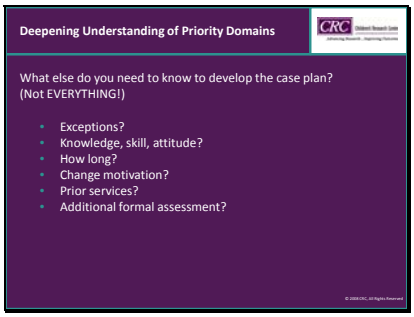
As you do this, work with the family to make sure that you have agreement that the three priority needs are the right ones to focus on at this time. Without the family's buy-in, it will be difficult to get their cooperation with and participation in services. If family members do not agree with the priorities, work together to identify three areas to focus on that they can accept.

Whenever possible, we want to respect the family's perspective and allow them to set the priorities. However, if safety is a concern, that area must become a priority. If, after explaining your concerns to the family, they are willing to agree to a priority they did not initially agree with, that would be the ideal situation. However, if the family is resistant to prioritizing an area with a legitimate safety threat, you may need to take stronger actions. For example, family violence may have been indicated as a high priority on the FSNA, but the family refuses to receive services in that area. If there is current violence in the household that presents a safety threat to the children, it makes sense to insist on including that area in the case plan, and to get a court order if necessary. If family violence was raised as a concern but there is no current violence and no likelihood of violence in the foreseeable future (e.g., the violent household member is currently incarcerated), then the safety threat isn't present, and you can focus on other priorities more important to the family.

Once you have achieved agreement on, or at least acceptance of, priorities, explain the purpose of services to the family. Your goal is to find a mix of services/activities that works for **this** family to help them improve family functioning and safety for the children. Remember, we're not trying to address all areas of need for this family; your focus is on those domains that affect child well-being and safety.

Also discuss the planning process. How will the family be matched to services, and what should they expect as they move forward? Essentially, describe the process we're about to discuss. It is also important to make clear to the family that the outcomes and objectives you agree on for the case plan are the outcomes and objectives you will use when you reassess the family after three months. If you can agree on clear, measurable outcomes and objectives that are both attainable and able to meaningfully improve family functioning, then the reassessment process will be smoother for all concerned.

Slide 14



Once you have agreement on the priorities, work to learn more about those needs. Before you begin setting outcomes and objectives and selecting strategies to address the needs, you need to come to a common and full understanding of what they are.

As you review the priority domains, you might discuss any exceptions to the overall rating given to that item. For example, if coping skills have been identified as a priority domain, there may still be examples of times when the caregiver has, in spite of mental health concerns, been able to overcome obstacles and function well for a period of time. You might ask what strategies were used, or what was different about that period of time compared to the present.

Is the need based on lack of knowledge, skills, and attitudes? *(NOTE: Attitude can sometimes have a pejorative connotation. It simply means that there may be an emotional barrier to a parent acting on knowledge and skill.)* For example, if there's a need in the parenting area, it may be a matter of knowledge: the parent may not know what good parenting practices are. Or it may be a matter of skill: the parent knows what he or she *should* do, but doesn't know how to put that into practice. Or it may be a matter of attitude: the parent may know what to do and be capable of doing it, but doesn't want to.

We should also ask about the duration of the need. How long has this area been a problem for the family? Are there longstanding habits or expectations that you'll need to overcome?

How motivated are family members to change? Did they agree with the prioritization of this domain, or do they regard it as "not a problem?" Are they equally motivated, or are some family members more invested in change than others?

Has the family received services in the past? What aspects of those services did or did not help them?

Finally, do you need additional professional assessment to create a service plan? The FSNA is designed to not require professional assessments BEFORE prioritizing. Lots of money has been spent on practices like doing psychologicals on every parent. Instead, save resources for getting professional assessments within the prioritized need areas so that they can actually influence the case plan. But if you are really stuck about how to rate an area and whether it is a priority need or need depends on this rating, OR if there is substantial disagreement about how an item should be rated, a professional assessment in that area could be helpful.

Note to trainer: Refer to the handout section on additional assessments to discuss the type of assessment that could be pursued for any of the FSNA items that may require it.

With each of these questions, you're trying to learn more about the scope of the problem for this family and narrow down the range of strategies and services most likely to be effective in the future, which includes eliminating strategies that have failed in the past.

Case Planning in the SDM System

Case planning begins after you have identified priority strengths and needs using the FSNA and creates a framework that will be used to assess the progress items on the risk reassessment or the reunification assessment.

1. Discuss results of FSNA prioritization with the family. Since you have completed the assessment with the family, there should be no surprises.

    1.1. Explain that the purpose of working together is to ensure child safety by helping adults in ways that reduce their areas of need and increase their areas of strength.

    1.2. Explain that for each need area, a plan will be developed to include one objective and strategies to reach it, with specific resources or services that will support that plan. The family's existing strengths will be used to help meet needs.

2. Increase understanding of priority need areas.

    2.1. One at a time, explore each need area with the family to get more information that will help set objectives and assist in the writing of the outcome statement. For example:

        2.1.1. Ask about exceptions (is there ever a time when it doesn't happen?).
        2.1.2. Is the need area a lack of knowledge, skill, or attitude?
        2.1.3. How long has the need existed?
        2.1.4. How eager is the family for change? Does everyone feel the same? Who wants it most?
        2.1.5. Have they tried to change before? What worked? What didn't?
        2.1.6. Consider whether more in-depth assessment would shed valuable light. For example:

Item	Additional Formal Assessment
CAREGIVER	
Substance abuse/use	Alcohol and drug assessment
Household relationships/domestic violence	Family therapy assessment Assessment of batterer
Social support	Social network assessment
Parenting skills	Parenting assessment
Mental health/coping skills	Psychological assessment
Resource management/basic needs	Financial assessment
Cultural identity	Consult with culturally specific professional
Physical health/disability	Medical assessment
CHILD	
Emotional/behavioral	Psychological assessment
Physical health/disability	Medical assessment
Education	Educational assessment
Family relationships	Family therapy assessment
Child development	Developmental assessment
Substance abuse	Alcohol and drug assessment
Cultural identity	Consult with culturally specific professional
Peer/adult social relationships	Social network assessment
Delinquent behavior	Probation consult

3. Setting the outcome. State the "issue" in terms of the outcome the family wants to achieve. This statement should express what the family will look like, how they will function, what they will be able to accomplish when things are better. Although this statement should be informed by the need areas, it is really about what the family wants to get out of the case plan.

4. Setting the objectives

    4.1. One at a time, review priority need areas. Remind the family what they said (or what others said, or what the worker observed) about this area. Ask the family what it would look like if everything in this area was better. Help the family state this as an objective. Provide guidance to make objectives concrete and measurable. You may use the a/b definitions for the domain from the FSNA for ideas.

    4.2 Provide guidance to make the objectives SMART. This can be achieved by writing additional indicators for each objective that describe in SMART details how you and the family will know when they have achieved the objective.

5. Developing the strategies. One at a time, take each objective and ask family members for ideas on how to achieve that objective. Examples:

    5.1. What is one small thing each of you can do to start?

    5.2. How can (another person, worker, etc.) help?

    5.3. Use a "scaling" question: On a scale of 1–10, where are you now? What would it take to get to (one less)?

    5.4. Use strengths: One of the things you are already doing well is *X*. How could you do something similar to help reduce this area of need? (Example: Your physical health is very good. How do you suppose you have been able to stay in good health? Are there some ways doing similar things could help as you try to stay sober?)

    5.5 Use additional information you gathered about the areas of need. Focus on exceptions.

6. Selecting services

    6.1. Formal vs. informal

        6.1.1. Some services are informal. They take advantage of resources available in the community at little or no cost. Remote areas may need to rely heavily on informal services because few formal resources exist. Informal services may seem less confrontational. Informal services are often overlooked, but can be very effective. However, serious problems may be insufficiently addressed through informal services.

6.2. Cultural considerations

6.2.1. Will a potential service provider be culturally competent for the family?
6.2.2. If the best service provider does not have experience working with a family's culture, are they open to learning? How can the provider be supported in achieving cultural competence? Can the family help?

6.3. Logistics

6.3.1. Transportation. Can the family get there?
6.3.2. Scheduling. Can appointments be made without compromising work and school, and without overloading the family? What is the balance between helping the family recognize the importance of working on their needs while not creating needless additional stress?

7. Working the case plan—How we can make this manageable for families?

7.1 The refrigerator case plan. Break down the case plan into week- or two-week-long sections and list the activities the family (and the worker!) must accomplish in that time to stay on track towards the objectives.

7.2 Use face-to-face contacts and/or weekly telephone calls to discuss which tasks have been accomplished and which have not. Can you move on to set new tasks for the next week? Were there unanticipated obstacles you need to address first?

7.3 Organize your contact notes around these tasks to measure progress towards case plan objectives. At each contact, ask if the family is on track to achieve their objectives before the next reassessment. If not, what can be done?

8. Using the case plan at reassessment

8.1 Review objectives and indicators—has the family achieved the objectives? If not, how much progress has been made?

8.2 If the family has not achieved the objectives, use your contact notes to determine the frequency of improved behavior. Has participation been active or partial? Is desired behavior demonstrated frequently or occasionally?

Slide 15

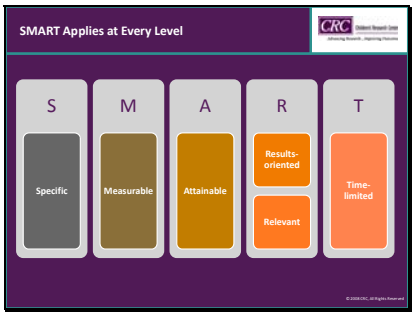
Outcomes, objectives, strategies, activities. It's a useful framework, but there's no quiz. While we're using specific terminology to describe the process here in training, you can use whatever language makes the most sense for you and for the family while writing the case plan. The point is that you need to know where you're starting, where you're going, and have a useful way to think of breaking down the trip into manageable steps. Then you need the support to take those steps.

In this diagram, the pieces that have equivalents in CWS/CMS are shown in black boxes. You have a space to record objectives and services. What we're trying to suggest with these purple, out-of-system boxes is that there's more to case planning than picking objectives and plugging in some services.

There is no such word as "outcome" in CWS/CMS. There is a section for "objectives," but you will see that the language we will learn today won't show up on drop-down lists. There is a place in CWS/CMS to put services or activities, but again, we'll be reframing the way we think about what to include in that space.

And don't get too hung up on whether something is more of an objective or strategy. Just be sure your ideas are nested: activities are parts of strategies, which help you achieve your objectives, which support your desired outcome.

Slide 16



As we step through the process of writing a case plan with the family, keep in mind that SMART will apply at every level of our process. Many of these will be most applicable to objectives, but we're going to keep them in mind throughout.

Specific—In that it describes in rich and positive detail what the family will look like after they have improved. How will family members behave differently? How will they relate differently to each other?

Measurable—Measurable outcomes can be the easiest to measure progress towards, and the easiest to determine success for. In many ways, "measurable" is easier to apply to objectives, which we'll be discussing next. Essentially, measurable objectives can be the most motivating because improvement can be tracked more easily. Try asking questions such as "How much?" or "How many?" If you can't fit something measurable in the objective itself, try adding a few indicators to the objective statement. For

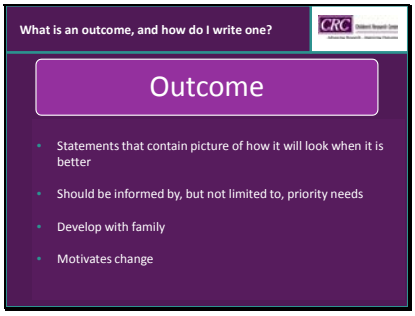
example, the objective statement is, "My children feel safe with me because I am clean and sober." Ask for possible indicators. (1. Children get better grades in school now that they are less worried. They are getting B averages. 2. Family is doing at least one family hour each week and children report enjoying this time. 3. Mom has at least 90 days of sobriety. 4. Mom participates in random drug screens that are 100% negative.)

Attainable—As we move through the planning process, we'll learn more about making outcomes attainable. Although we're trying to describe an ideal state, it should be one that can reasonably be attained following steps that are available to the family.

Results-oriented, relevant—Describe in terms of outcomes, not process. For example, "Learns what 7- to 9-year-old children can reasonably do" vs. "Attends parenting class."

Time-limited—We should have a reasonable timeframe for when we expect to attain our motivator state. This will help us decide what interim benchmarks might be, and motivate our efforts because there is a kind of deadline on our activities.

Slide 17



The outcome is a statement of where the family wants to go.

Click to show text box.

It describes in rich detail what the family will look like when their needs have been addressed—who will act differently and in what ways.

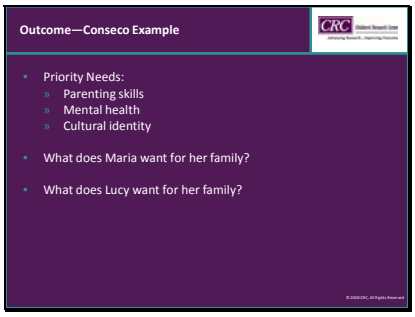
You can use the priority needs as a starting point. Certainly your outcome should describe how things will be better when these needs have become strengths, but you do not need to limit yourself to rectifying these three needs.

It is important to help the family write this statement themselves. Although the outcome should always reflect improved child safety and well-being, it is important that this be a legitimate statement of how the family wants to be in the future. It should be a statement that they can turn back to when discouraged to remind themselves of why the services are important.

Help to set the outcome high enough so that when they reach it, you are willing to walk away (assuming there are no safety threats). Help to set the outcome low enough so that it can

be attained.

Slide 18



Remember Maria and Madelyn Conseco from SDM training?

Note to trainer: Participants may not remember Maria and Madelyn. Some workers may not have completed the SDM training or may have completed it so long ago that the details of the Conseco case have been forgotten. Distribute the advanced training Conseco case summary and ask workers to read it.

At the first FSNA, we identified three priority needs:
Parenting skills: Although Maria loved Madelyn very much, she wasn't always able to care for her properly, with particular problems with regular and adequate feeding, and safe sleeping conditions.

Mental health needs: Maria was still having nightmares and suffering from PTSD from her father's abuse when she was a child.

Cultural identity: There is some conflict between Maria and her mother around intergenerational issues, which is causing stress in the household.

So we have our priority needs. Now we need to understand what Maria wants for herself and Madelyn. What is an outcome that would be motivating for Maria?

Generate some ideas on a white board. For example, Maria might want Madelyn to grow up to be strong, healthy, to know that she is loved, to feel safe in her home and free from violence, to grow up knowing that Maria will respect her independence, to finish high school on time.

Next, because Lucy is also a member of this family and a member of this household, we need to know what she wants as well. She's Maria's main support in the home, so if she doesn't have an outcome that she agrees with to work towards, we're going to have trouble getting her to help Maria achieve the outcomes.

Generate some ideas on a white board. For example, Lucy might want Maria to stop running around with boys and complete school. If this comes up, point out that we would want to work with Lucy to get to something positive that she would want Maria to achieve related to this idea. For example, instead of NOT running around with boys, maybe Lucy would want Maria to feel confident and secure in herself so that she doesn't need someone else to make her

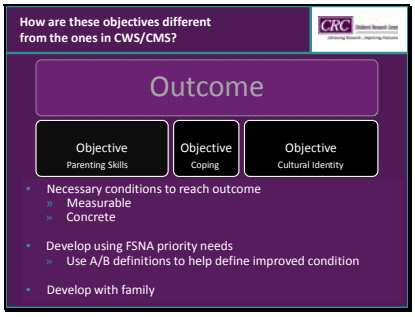
safe.

Next, to write our outcome, we want to integrate these things—the needs, Maria's wants, and Lucy's wants—into a unified statement that they can all believe in of how they want their family to be. We've generated a lot of ideas. We don't need to fit everything into this statement, but we're going to try to include the things that are most important to the family members.

Take a few minutes with the group to write an outcome statement using the need areas and Maria and Lucy's desires. For example:

Maria is a loving and supportive mother to Madelyn, meeting her daily needs and helping her grow up to be a confident and healthy girl. Maria and Lucy are able to work together to nurture Madelyn's feelings of safety because Maria feels safe and secure herself ,and Lucy is able to accept that Maria and Madelyn both need the tools to make their own choices.

Slide 19



Now that we've written our outcome—our main, motivating statement—we can move down and start working on our objectives.

Click to make the description of an objective text box appear.

In general, the case plan should have three objectives, which are based on the priority need areas. These objectives describe the conditions that would need to exist in the family for them, in time, to achieve their outcome, and, since we're looking forward, we want these to be positive, behavior-based statements.

If we think back to the Conseco family, we had three priority needs related to parenting skills, mental health/coping, and cultural identity.

Click to make the domains appear.

Now let's practice writing some objectives for the Conseco family.

Trainer should work with class to translate each need domain into an objective that fits under the overall outcome we've selected. If necessary, let the group know that they can revise the outcome if they write an objective that would require it.

Some possible objectives might be as follows:

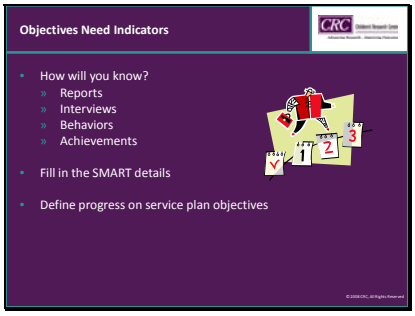
Parenting skills: Maria understands and meets Madelyn's basic needs for adequate nutrition, safe sleeping conditions, clothing, and appropriate playthings. She is aware that these needs will change with time and is prepared for these changes.

Coping: Maria manages her symptoms, including her nightmares, so that she can get adequate sleep, form healthy and supportive relationships, and help Madelyn feel secure in her family.

Cultural identity: Lucy and Maria agree that Maria must be responsible for her own choices regarding relationships and Madelyn's care. They also agree that "being responsible" includes both understanding likely consequences before choices are made and accepting those consequences afterwards.

Write these objectives on a whiteboard or flip chart. Leave a lot of room for each objective. If possible, give each objective one page on the flip chart or large section on the whiteboard.

Slide 20



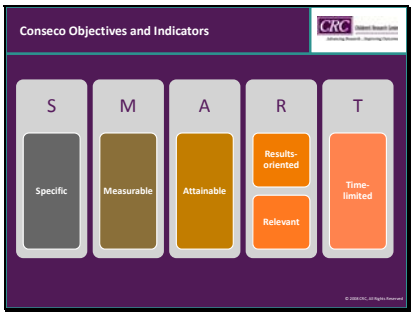
We said before that the objectives would be our "definitions" for the case plan progress items at reassessment time. This means that we need to add indicators to these objectives to provide details of what success means.

We can start by thinking about the kind of evidence that we would want to see if the objective had been achieved, what some interim steps might be, and what specific behavioral changes we would want to observe.

We can also go back to our SMART objectives and try to fill in the aspects of SMART that are missing from our main objective with these indicators.

This step doesn't show up on our main diagram, but it is very important. Six months from now when it is time to review, this is the yardstick you will be using. You need to know it now, and the family has an absolute need to know it now.

Slide 21



Let's go back and look at our objectives for the Conseco family and see how we can make them SMARTer.

Trainer returns to whiteboard or flip chart and helps group add indicators to the objectives that will add the SMART details.

For example:

Parenting skills: Maria understands and meets Madelyn's basic needs for adequate nutrition, safe sleeping conditions, clothing, and appropriate playthings. She is aware that these needs will change with time and is prepared for these changes.

Specific: Maria will improve her knowledge of infant nutrition, safe sleep, and play, and will learn about child development. She will improve her skills in feeding Madelyn and ensuring that her sleep conditions are appropriate. She will improve her behaviors in setting consistent mealtimes for Madelyn with correct food at each meal, changing the mealtimes and food types as appropriate as Madelyn gets older. She will create a timeline of child development for the first three years and a plan for how she will feed/clothe/play with Madelyn differently at each stage.

Measurable: Maria will pass a child development knowledge assessment designed by her visiting nurse. Madelyn will achieve and maintain a healthy weight. Lucy will report on Maria's feeding habits, providing the number of meals, their spacing, and content.

Attainable: Maria, Lucy, and her visiting nurse will agree that these things can be accomplished within six months.

Results-oriented: This objective will be achieved if Maria's parenting behavior improves and Madelyn's pediatrician agrees that she is within the normal bounds of healthy.

Time-limited: Maria will complete the "learning" portion of this objective after three months, and the "practical" portion by the end of six months.

Coping: Maria manages her symptoms, including her nightmares, so that she can get adequate sleep, form healthy

and supportive relationships, and help Madelyn feel secure in her family.

Specific: Maria will be free from nightmares/anxiety symptoms, if possible. If Maria's counselor/therapist suggests that this is not possible, Maria will have sufficient symptom management skills to be able to care for Madelyn, maintain non-exploitative relationships, and complete a full day of school or work on a consistent basis.

Measurable: Work with Maria's counselor to determine if quantitative goals are feasible or appropriate.

Attainable: Work with Maria's counselor to determine if the objective is realistic or if it will need to be modified to include obtaining some type of ongoing permanent support such that Madelyn will be safe if the specific indicators are not met.

Results-oriented: Maria and Madelyn feel secure and safe in their home.

Time-limited: Work with Maria's counselor to create a feasible timeline of indicators for success.

As you are working through the coping item, you might use it as a time to emphasize the importance of including outside assessments in the completion of the FSNA and the possible benefits of including service providers (or potential providers if they have already been identified) in the case-planning process.

Cultural identity: Lucy and Maria agree that Maria must be responsible for her own choices regarding relationships and Madelyn's care. They also agree that "being responsible" includes both understanding likely consequences before choices are made and accepting those consequences afterwards.

Specific: Lucy expresses acceptance of Maria's choices to Maria herself and to other members of the family. Maria acknowledges that Lucy wants what's best for Maria even if they don't always agree on what "best" is. Maria can explain her decision-making process, including an understanding of likely consequences.

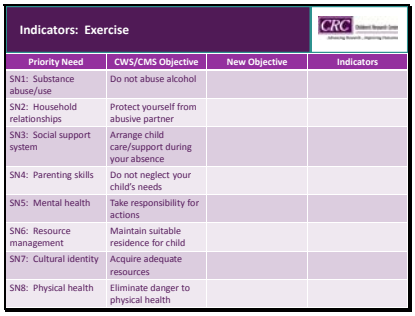
Measurable: Family members report that Lucy has made no disparaging remarks about Maria, her choices, or Jorge. If Lucy makes non-positive remarks about Maria, family members report that they are always constructive. Family members report that Maria has not made remarks dismissing Lucy's views, even if she does not agree with them.

Attainable: Maria, Lucy, and other family members agree that this objective is feasible.

Results-oriented: Maria, Lucy, and Madelyn experience less household conflict and stress.

Time-limited: Conflict is reduced after three months, and largely controlled within six.

Slide 22



I know that these objectives, with their indicators, are a big change from the way we're used to writing case plans. So let's do a little more general practice in groups of three or four before we move on.

Note to trainer: Distribute Exercise 1 to the class.

On your handout, you can see each of the FSNA domains, and one CWS/CMS objective for each domain. You can see that they're not a very good fit for the kind of approach we've been talking about so far. Your task is, in your groups, to rewrite each of these objectives as a positive-change objective answering the question, what will this family look like when there is no need in this area? Then write some indicators for each objective to make it SMART.

The way we're doing this now is a bit artificial. When we really develop objectives, it will be in the context of a unique family, so do the best you can.

Note to trainer: Allow at least 20 minutes for this activity. If the class has been having difficulty writing objectives for the Conseco family, assign two domains to each group.

When the 20 minutes are finished, bring the group together to share their objectives and indicators. Discuss what they found difficult about this exercise, and encourage groups to share brainstorming strategies that they used.

SAMPLE OBJECTIVES, STRATEGIES, AND SERVICES FOR FSNA PRIORITY NEED AREAS			
Priority Need	**Sample Objectives**	**Sample Strategies**	**Sample Services**
CAREGIVER			
Substance use/ abuse	Be clean and sober for at least 90 days.	• Detoxify from drugs or alcohol. • Stop hanging out with friends who use. • Understand how to avoid triggers for use. • Develop alternative interests. • Learn about addiction. • Develop insight into reasons you use.	• Detox. • AODA counseling (inpatient or outpatient). • Support groups. • Join a football league.
Household relationships/ domestic violence	• Adults love and respect one another. • Adults work out disagreements. • No one hits, throws, or hurts. • Have a safe place to live. • Have an emergency plan. • No adult has power over another adult. • Choose a partner who will not hurt you.	• Learn healthy ways to argue. • Decide who will live in the house. • Make and follow a plan for sharing responsibilities. • Restraining order. • Learn how to stop an argument before someone hits. • Learn how to trust one another. • Understand victimization. • Learn and use nonviolent ways to express anger.	• Home visiting. • Family counseling. • Elders/spiritual advisor. • Read a book about relationships and discuss. • Talk to a healthy couple. • Shelter. • Court. • Law enforcement. • Counseling. • Elders/spiritual advisor. • Child care.
Social support	Develop and maintain positive, mutually supportive relationships with at least three people.	• Participate in activities where you can meet people. • Do one thing every week to help another person. • Ask for help for one thing every week. • Do an activity with another person every week. • Ask advice from a trusted person every week. • Call [person] every week just to talk.	• Home visiting. • Support groups. • Psychotherapy (if needed to address underlying barriers). • Activity groups. • Churches or spiritual centers. • Email, chat rooms (as first step, or if very remote).
Parenting skills	• Know what my child can do at his/her age. • Help my child learn right from wrong. • Teach my child without hitting.	• Learn about child development. • Learn and practice three ways to discipline without hitting.	• Home visiting. • Parent training. • Parent aid. • Elder/spiritual advisor. • Read books. • Talk to a role model.

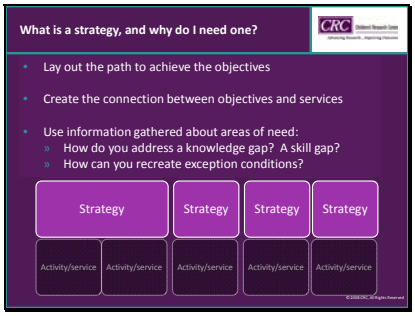
SAMPLE OBJECTIVES, STRATEGIES, AND SERVICES FOR FSNA PRIORITY NEED AREAS			
Priority Need	**Sample Objectives**	**Sample Strategies**	**Sample Services**
Mental health/ coping skills	• Caregiver has hope for the future. • Caregiver has positive feelings about self. • Caregiver is able to cope with stress and demonstrates by [making good choices, getting good sleep, etc.].	• Learn and practice meditation to reduce stress. • Learn ways to change self-talk. • Take prescribed medication. • Use exercise to feel better. • Develop a plan for the morning routine to reduce stress. • Identify patterns that lead to depression and develop alternative patterns.	• Home visiting. • Psychotherapy. • Reading books. • Spiritual advisor/elder. • Support groups. • Internet sites.
Resource management/ basic needs	• Maintain a safe home. • Provide adequate food. • Provide adequate clothing.	• Get a job. • Develop a budget and follow it. • Learn to make low-cost meals instead of eating out. • Learn ways to find bargains. • Spend money on necessary expenses instead of gambling (or other competing expenses). • Develop a plan to clean up the house, and follow it. • Understand and overcome emotional reasons for out-of-control spending.	• Supplemental income supports. • Housing supports. • Employment services. • Financial advisors. • Spiritual advisor/elder. • Books on budgets, cost-saving ideas. • Education, learning a trade. • Job seeking on the Internet. • Child care.
Cultural identity	• Identify positively as [culture]. • Peacefully coexist as [client culture] within a family and/or community of [other culture].	• Gain knowledge of [culture] (could be client's own cultural background if issue was lack of identification, or culture of family or community if issue was conflict with another cultural group). • Gain insight into potential conflicts between self and surrounding culture. • Learn ways to avoid or resolve conflicts with family and/or community who are members of [culture].	• Home visiting. • Books, Internet sources for information on cultural groups. • Participate in events of cultural groups. • Spiritual leader/elder. • Culturally specific support groups. • One-on-one dialogue with member of conflicting group.
Physical health	• Recover from [illness/injury]. • Achieve the best level of functioning possible given [illness/injury that will not resolve]. • Someone else assists with necessary responsibilities that can no longer be done because of [illness/injury].	• Get medical care, including physical therapy, medication, etc. • Follow doctor's orders. • Get necessary devices (e.g., wheelchair, walker, hearing aid). • Develop plan for other family members to help with (e.g., cooking, cleaning, getting children ready for school). • Family members gain knowledge of [illness/injury] and plan ways to help.	• Case manager to assist with arranging medical appointments, transportation, etc. • Home health nurse. • Extended family/community members. • Support groups. • Child care.

SAMPLE OBJECTIVES, STRATEGIES, AND SERVICES FOR FSNA PRIORITY NEED AREAS			
Priority Need	**Sample Objectives**	**Sample Strategies**	**Sample Services**
CHILD			
Emotional/ behavioral	• Child is well-adjusted. • Child has a range of emotions that fit the situation and can express them in healthy ways. • Infant smiles and coos, can be alert, and enjoys being held by caregiver. • Child learns age-appropriate behaviors (be specific).	• Caregiver helps child learn things to do when (angry, sad, bored, frustrated). • Child has a chance to talk about how he/she feels about [loss, trauma, etc.] with [someone he/she trusts]. • Caregiver consistently responds to child (be specific; e.g., notices when infant is hungry and responds). • Caregiver sets consistent limits for child.	• Child therapy. • Family therapy. • Books. • Parent mentor. • In-home support services. • Child care.
Physical health/ disability	• Child recovers from [illness/injury]. • Child obtains the best health possible given [illness/injury].	• Caregivers provide medical care needed (be specific). • Caregivers follow medical advice at home (be specific). • Caregivers help child learn about [illness/injury]. • Caregivers provide needed supplies (be specific).	• Medical providers. • Home health. • Support groups. • Books, Internet sites. • Child care.
Education	• Work at or above grade level (or at expected level if in special education). • Attend school regularly.	• Develop good study habits. • Plan for how to get ready for school on time, every day. • Create a special place to study (could be under a shade tree!).	• Special education. • Tutor/mentor. • Educational games. • Online resources.
Family relationships	• Child feels loved and accepted within family. • Child feels safe and secure in family.	• Family does things together (be specific; include fun and work). • Caregivers learn ways to help child know he/she is loved and accepted. • Caregivers discuss differences outside of child's awareness (or caregivers model peaceful ways to discuss differences, depending on child's developmental and emotional level). (All items included above for caregiver relationships, domestic violence, as applicable.)	• Family therapy. • Spiritual advisor/elder. • Mentor family. • In-home support services. • Books. • Internet sites for ideas on family activities. (All items included above for caregiver relationships, domestic violence, as applicable.)

SAMPLE OBJECTIVES, STRATEGIES, AND SERVICES FOR FSNA PRIORITY NEED AREAS			
Priority Need	**Sample Objectives**	**Sample Strategies**	**Sample Services**
Child development	• Child is functioning at developmental level. • Child is functioning as close to developmental level as possible.	• Caregiver provides opportunities for child to learn and grow (be specific). • Caregiver learns about [child's developmental limitations] and ways to provide opportunities for child to learn and grow.	• Child development specialist. • Preschool. • Special educational settings. • Books on child development. • Support groups for parents. • Play groups for child. • Child care.
Substance abuse	Be clean and sober for at least 90 days.	• Detoxify from drugs or alcohol. • Stop hanging out with friends who use. • Understand how to avoid triggers for use. • Develop alternative interests. • Caregivers know all child's friends. • Caregivers set curfew and know child's whereabouts at all times. • Caregivers conduct periodic checks of child's room and belongings. • Caregivers learn about substance use and how to help child remain clean and sober.	• Detox. • AODA counseling (inpatient or outpatient). • Support groups. • Join a football league. • Support group for parents.
Cultural identity	• Child develops positive identity as [culture]. • Child lives peacefully as [culture] within family/community.	• Gain knowledge of [culture] (could be client's own cultural background if issue was lack of identification or culture of family, or community if issue was conflict with another cultural group). • Gain insight into potential conflicts between self and surrounding culture. • Learn ways to avoid or resolve conflicts with family and/or community who are members of [culture].	• Books, Internet sources for information on cultural groups. • Participate in events of cultural groups. • Spiritual leader/elder. • Culturally specific support groups. • One-on-one dialogue with member of conflicting group.
Peer/adult social relationships	• Gets along well with friends. • Gets along well with adults.	• Have a play date with at least one other child once a month. • Learns how to share. • Learns how to have conversations.	• Home visiting. • Mentor. • Team sport or activity. • Books, videos, and discussion with parent.

SAMPLE OBJECTIVES, STRATEGIES, AND SERVICES FOR FSNA PRIORITY NEED AREAS			
Priority Need	**Sample Objectives**	**Sample Strategies**	**Sample Services**
Delinquent behavior	Avoid offending behavior.	• Learn about effect of behavior on others. • Learn about consequences for behavior. • Choose friends who are not involved in offending behavior. • Develop alternative activities. • Earn money legitimately. • Make plans for trade school or college. • Caregiver sets boundaries.	• Probation/parole. • Spiritual advisor/elder. • Mentor. • Learn to play a musical instrument.

Slide 23



Now you know where you're starting from (priority needs from the FSNA) and where you're going (the outcome and objectives), but you still need a strategy to get from here to there. Strategies are the methods that will help a family move from their current situation to the ideal that they developed in their outcome and objectives.

For example, if this family has a need related to resource management with an ideal of maintaining stable housing and paying all bills on time, the objective might be "I am proud to consistently provide my children with a roof over their heads, food to eat, and clothes to wear." Of course we would want to fill that out with some indicators, but for the moment, we can see where an objective like that could require several strategies.

One strategy might be to find and keep a job. There will be activities and services to support that objective. Another objective might be to move into and stay in an apartment.

You can develop strategies with the family by using the information you gathered at the beginning of the conversation about their needs.

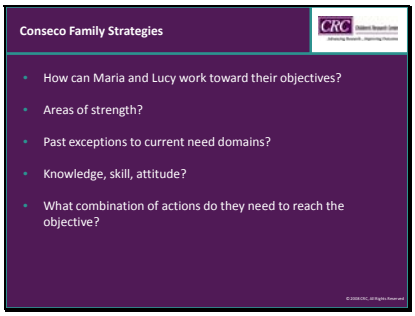
For example, if you identified that a need was due to a lack of knowledge, you could ask the family how they usually learn new things, or what learning strategies have worked for them in the past. In our current case, Maria Conseco has needs in the parenting skills area related to knowledge of child care and child development. We know that she was a good student in high school. We might ask her what strategies she used to learn material for her classes—did she read books and take notes? Sit in a lecture? Practice new skills in a science lab?

If you identified that a need was due to an obstructive attitude, you could focus on an area of strength where someone had to overcome an attitude obstacle and then use that strategy to address the current need. In our current case, Maria has a need related to mental health. She used to have a relationship with a counselor who helped her, but she stopped seeing Rose when her mother objected. How did she deal with her mother's disapproval when she initially started therapy? Quitting marijuana must have taken a lot of courage to admit that she needed to change—how did she persuade herself to start and then to stick to it?

These strategies are the steps the family members will take to address their needs. Put another way, it is how they will go

about changing their lives. Some of these steps the family members will be able to do on their own. Other steps they will need additional assistance for, and that's where the services come in.

Slide 24



Before we move on to activities and services, let's try to brainstorm some strategies for the Conseco family to achieve their objectives.

As we go through this exercise, we might find that we're rushing ahead to get to the services we want to provide to the family. Please resist that impulse. The strategy step may feel like an impediment, and in some ways we can think of it as a speed bump. The usual process of case planning is to move directly from an objective to a service that matches **the objective**. What we're doing here by discussing strategies is ensuring that we are able to select a service that matches **the family**.

Note to trainer: Because this is a new step for most workers, try to work with the group to develop two or three strategies for each objective you identified in the last exercise. If the group struggles with this, bring them back to brainstorm based on areas of strength for Maria and Lucy, and which habits in those areas might transfer, to what might have been different when these need areas were stronger, and to diagnosing the nature of the need (knowledge, skill, attitude).

For example:

Parenting skills:
If Maria lacks knowledge, she could get that through reading, having a teacher, having a mentor, meeting other parents with children of a similar age.

If Maria lacks skills, information resources won't be enough. She'll need a more experiential strategy. So a parenting mentor, a parenting coach, or behavior modeling from her mother or another family member.

Possible strategies:

- *Learn about what an infant needs to be healthy.*
- *Create supervised opportunities to practice feeding and get constructive feedback.*
- *Observe children at different developmental levels with their parents to understand appropriate care.*

- *Create opportunities to go shopping with parents of similarly aged infants to learn how to meet Madelyn's needs on a budget.*

Mental health:
How can Maria overcome the social/cultural taboo about talking about her problems outside the family? Does she need a strategy that includes her mother, since this is where the resistance comes from? Can her cousin, who helped her with marijuana earlier, help her assert herself to get help here as well? If she's afraid her father will find her, does she need to know where her father is (e.g., if he is dead, in prison, or in another country, it might reduce her anxiety)?

Possible strategies:

- *Address Lucy's resistance to "thinking of the past."*
- *Find encouragement to stick with services if resistance at home continues.*
- *Determine an appropriate and acceptable therapy approach.*

Household relationships:
Did Maria and Lucy always fight? What was different when they weren't fighting? Does Lucy remember having similar fights with her family? Would Lucy trust someone outside the family to help them? Does mediation need to come from another family member?

Possible strategies:

- *Learn about conflict resolution.*
- *Practice stepping away from conflict and returning when calmer.*

Learn how to give constructive, non-judgmental opinions, and practice skills.

Slide 25

Now we're ready to talk about activities and resources. These are the specific supports the family needs to put their strategy into action. We usually think of these as "services," but too often that terminology locks us into thinking about a place a parent will go and a thing that he or she will receive. We want to focus on what the parent will do to learn to function differently and how we're going to support him/her in that activity.

We're looking for specific actions, selected in collaboration with the family, that fit the strategy we've developed. This may mean choosing between a structured program and coaching by the social worker, a family member, or a neighbor. This choice should be informed by the family's experience, learning styles, needs, and availability.

So, since we've already introduced them, let's talk about parenting classes and how we'd decide if they're an appropriate activity for our strategy.

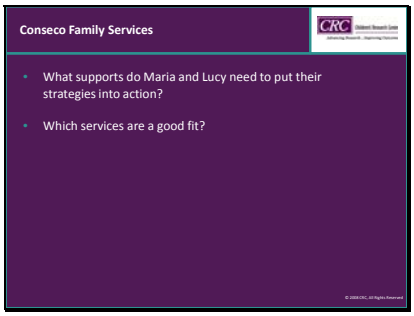
Can anyone tell me what research shows about the effectiveness of parenting classes? Does effectiveness vary depending on the type of class or the needs of the parent? How do we usually respond if all the parenting classes in the area have waiting lists? Does anyone want to share a creative approach they've tried with families? Can anyone think of a need that could not be met through informal services?

Cultural considerations are also highly important. Some cultures and belief systems will not support some types of interventions. Families are more likely to participate in services if the approach fits their cultural norms.

Finally, logistical barriers should not be ignored. Work with families to address supporting issues of time, work schedules, child care, and transportation.

Keep in mind that we want to make these choices with the family. Our overall goal is to help this family get to a point where they don't need us anymore. A good approach to making this happen is to help them focus on things they are going to do to help themselves—activities. We think of this as different from services, which may feel to families like something that is done to them, rather than something they take on themselves.

Slide 26



Now, at long last, let's get some services for our Conseco family!

Move back to the whiteboard where objectives and strategies are written and fill in services to help Maria and Lucy achieve their objectives. For each service, ask the participant proposing to explain its fit into the strategy and its fit with the family.

For example:

Parenting skills:
Possible strategies:

- *Learn about what an infant needs to be healthy.*
- *Create supervised opportunities to practice feeding and get constructive feedback.*
- *Observe children at different developmental levels with their parents to understand appropriate care.*
- *Create opportunities to go shopping with parents of similarly-aged infants to learn how to meet Madelyn's needs on a budget.*

Possible services:

- *Join a new parents' group at the local community center to learn from other parents' experiences.*
- *Volunteer in a community babysitting service to learn to care for children under the supervision of more experienced professionals.*
- *Ask a family member with children (older than Madelyn) to be her parenting mentor.*
- *Take a parenting class ONLY if Maria learns well from a lecture setting.*

Mental health:
Possible strategies:

- *Address Lucy's resistance to "thinking of the past."*
- *Find encouragement to stick with services if resistance at home continues.*

- *Determine an appropriate and acceptable therapy approach.*

Possible services:

- *Start meeting with Rose at the community center again.*
- *Ask Maria's cousin Anna to help her have a conversation with her mother about how talking to a professional can help her.*
- *Ask Lucy to attend some sessions with Maria and Lucy to understand why "forgetting" may (or may not be) a strategy that works for her but not Maria.*
- *Join a support group of other survivors of child abuse to share experiences discussing the experience with family members.*

Household relationships:
Possible strategies:

- *Learn about conflict resolution.*
- *Practice stepping away from conflict and returning when calmer.*
- *Learn how to give constructive, non-judgmental opinions, and practice skills.*

Possible services:

- *Take a conflict resolution class (note: most conflict resolution classes focus on skills practice and group problem solving, rather than lecture/reading).*
- *Ask a family member or outside authority recognized by both Lucy and Maria to mediate disputes.*

End each day by discussing three areas in which Maria has improved her care for Madelyn or herself.

Slide 27

Let's try a second exercise to get us thinking of how strategies help us select services that are a good fit. Assume we must address a need in the area of parenting. What strategies might we use if the family had a strength in the area of cultural identity, etc? How would this inform our selection of services?

Examples:

Cultural identity (strength): The caregiver is very connected to the Latino community and has a strong support system in the local neighborhood.

Strategy: I have a community of people I can call who will help me if I need respite.

Service: I will attend a parent support group at the community center.

Physical health (strength): The caregiver is in good health and practices prevention by jogging daily.

Strategy: I learn more about my children's strengths and personalities by participating in sports with them.

Service: I will join a family running group with my 12-year-old.

Service: I will get involved with my daughter's soccer team and learn from the coach's techniques for managing conflict and motivating the players.

Basic needs (strength): The caregiver has successfully sought out available community resources, such as food pantries, food stamp assistance through the county, and volunteering at the community center garden to meet her family's needs for food.

Strategy: I use my resourcefulness to find different ways of handling my stress instead of being frustrated when my kids have tantrums.

Service: Participation in in-home parenting support sessions offered through the county.

Social support (strength): The caregiver is part of an extended family that includes siblings, cousins, the caregiver's parents, and several aunts and uncles within an hour's travel of each other.

Strategy: I will learn from my relatives' successful strategies for raising children.

Service: A relative with older or grown children agrees to be a parenting mentor to the caregiver.

Substance use (strength): The caregiver is an alcoholic with eight years' sobriety who attends AA once a week.

Strategy: I have a network of friends through AA who have also struggled with the impact of alcohol on their children. I will use this network to help me develop strategies to guide my children through the dangers of drug and alcohol use.

Service: I will attend Alateen meetings with my children.

Household relationships (strength): The caregiver's partner has supported caregiver's other efforts at change and self-improvement (e.g., has prepared healthier meals to help caregiver lose weight, supported caregiver through school, helped caregiver start a business).

Strategy: I will use my partner as a "reality check" to help me be aware of when I'm improving and when I'm falling into old habits.

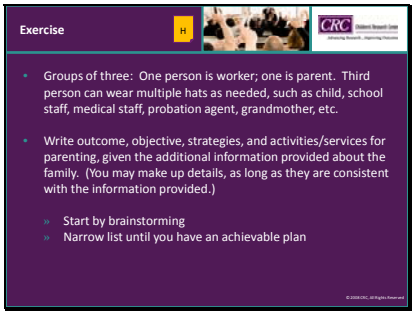
Service: At the end of each day, my partner and I will spend ten minutes listing at least three improved behaviors I showed that day and, at most, three behaviors that still need improvement.

Slide 28

So far, we've been practicing this in pieces; now, we're going to do an exercise that's about bringing it all together.

Please divide up into groups of three. We can have one group of two or four if we must, but three is best.

Slide 29



You will have 20 minutes for this exercise.

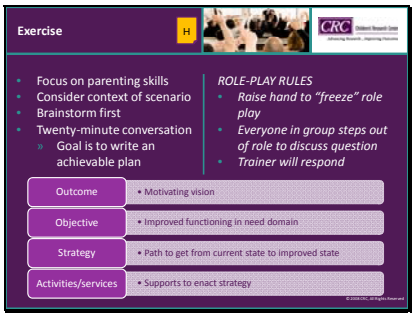
In your groups, decide who will be the worker; who will be the parent; and who will be the other household member, ally, or resource.

Working together in a mock planning session, write an outcome that addresses all the priority family needs. Then write an objective for a need in the area of parenting skills, and the strategies and services you will use to achieve that objective. I will pass around scenarios, so use this information and your imagination and experience to go through the process we've outlined to create a feasible plan. Each scenario is a little different:

- Different priority needs besides parenting skills—remember that you're going to need to address these priority needs when you're writing your outcome!
- Different reasons for a score of "need" on parenting skills
- Different family structures
- Different areas of strength

Each of these differences should change the parenting skills objective that is most meaningful for these families, and the strategies and services that will get you to that objective.

Slide 30



Case Planning Exercise: Group 1

This exercise will take 20 minutes.

In your group, decide who will be the worker; who will be the parent; and who will be the other household member, ally, or resource.

Working together in a mock planning session, write one outcome statement and the objective, strategies, and activities that will be used to **address a need in the parenting skills domain**, given the additional information provided about the family. (You may make up details as long as they are consistent with the information provided.)

- Assume that you have already completed the FSNA at a family meeting and a level of trust and cooperation has been established.
- Start by brainstorming.
- Narrow the list until you have an achievable plan.

Priority need area is parenting skills. Keep in mind that you will consider the other needs (in the chart below) when writing your outcome statement. Then you will write an objective for parenting skills, and select strategies and activities to help you achieve the objective.

Area	Additional Information
Priority strengths	Substance use, domestic violence, household relationships
Other needs	Coping skills, physical health
Reasons for parenting skills score	Had expectations of child that were developmentally inappropriate
Parent ages	Single parent, age 19
Child ages	1 year
Culture	African American
Parent education level	High school
Family structure	Single parent, has a steady boyfriend; father is unknown
Economic status	Never worked, government assistance; has no car

Case Planning Exercise: Group 2

This exercise will take 20 minutes.

In your group, decide who will be the worker; who will be the parent; and who will be the other household member, ally, or resource.

Working together in a mock planning session, write one outcome statement and the objective, strategies, and activities that will be used to **address a need in the parenting skills domain**, given the additional information provided about the family. (You may make up details as long as they are consistent with the information provided.)

- Assume that you have already completed the FSNA at a family meeting and a level of trust and cooperation has been established.
- Start by brainstorming.
- Narrow the list until you have an achievable plan.

Priority need area is parenting skills. Keep in mind that you will consider the other needs (in the chart below) when writing your outcome statement. Then you will write an objective for parenting skills, and select strategies and activities to help you achieve the objective.

Area	Additional Information
Priority strengths	Substance use, social support, basic needs
Other needs	Coping skills, domestic violence
Reasons for parenting skills score	Uses excessive physical discipline
Parent ages	Both age 19
Child ages	1 year and 6 months
Culture	Native American
Parent education level	High school
Family structure	Living together
Economic status	Living wage job for dad, no work for mom; no car

Case Planning Exercise: Group 3

This exercise will take 20 minutes.

In your group, decide who will be the worker; who will be the parent; and who will be the other household member, ally, or resource.

Working together in a mock planning session, write one outcome statement and the objective, strategies, and activities that will be used to **address a need in the parenting skills domain**, given the additional information provided about the family. (You may make up details as long as they are consistent with the information provided.)

- Assume that you have already completed the FSNA at a family meeting and a level of trust and cooperation has been established.
- Start by brainstorming.
- Narrow the list until you have an achievable plan.

Priority need area is parenting skills. Keep in mind that you will consider the other needs (in the chart below) when writing your outcome statement. Then you will write an objective for parenting skills, and select strategies and activities to help you achieve the objective.

Area	Additional Information
Priority strengths	Substance use, physical health, coping skills
Other needs	Basic needs, domestic violence
Reasons for parenting skills score	Pays no attention to needs of children for supervision or care
Parent ages	Ages 19 and 20
Child ages	2 years
Culture	White American
Parent education level	Did not finish high school
Family structure	Married
Economic status	Low-wage job for dad; part-time, low-wage job for mom; no car

Case Planning Exercise: Group 4

This exercise will take 20 minutes.

In your group, decide who will be the worker; who will be the parent; and who will be the other household member, ally, or resource.

Working together in a mock planning session, write one outcome statement and the objective, strategies, and activities that will be used to **address a need in the parenting skills domain**, given the additional information provided about the family. (You may make up details as long as they are consistent with the information provided.)

- Assume that you have already completed the FSNA at a family meeting and a level of trust and cooperation has been established.
- Start by brainstorming.
- Narrow the list until you have an achievable plan.

Priority need area is parenting skills. Keep in mind that you will consider the other needs (in the chart below) when writing your outcome statement. Then you will write an objective for parenting skills, and select strategies and activities to help you achieve the objective.

Area	Additional Information
Priority strengths	Domestic violence, household relationships, social support
Other needs	Substance use, physical health
Reasons for parenting skills score	Had expectations of child that were developmentally inappropriate; uses excessive physical discipline
Parent ages	Single parent, age 25
Child ages	4 years and 2 years
Culture	Eastern European immigrant
Parent education level	Some university courses
Family structure	Divorced; joint custody with father of both children
Economic status	Living wage; has a car

Case Planning Exercise: Group 5

This exercise will take 20 minutes.

In your group, decide who will be the worker; who will be the parent; and who will be the other household member, ally, or resource.

Working together in a mock planning session, write one outcome statement and the objective, strategies, and activities that will be used to **address a need in the parenting skills domain**, given the additional information provided about the family. (You may make up details as long as they are consistent with the information provided.)

- Assume that you have already completed the FSNA at a family meeting and a level of trust and cooperation has been established.
- Start by brainstorming.
- Narrow the list until you have an achievable plan.

Priority need area is parenting skills. Keep in mind that you will consider the other needs (in the chart below) when writing your outcome statement. Then you will write an objective for parenting skills, and select strategies and activities to help you achieve the objective.

Area	Additional Information
Priority strengths	Domestic violence, household relationships, basic needs
Other needs	Substance use, coping skills
Reasons for parenting skills score	Uses excessive physical discipline
Parent ages	Ages 25 and 30
Child ages	Ages 4, 2, and 6 months
Culture	First-generation Mexican American immigrant
Parent education level	Some university courses
Family structure	Married
Economic status	Living wage job for dad, mom not working; no car

Case Planning Exercise: Group 6

This exercise will take 20 minutes.

In your group, decide who will be the worker; who will be the parent; and who will be the other household member, ally, or resource.

Working together in a mock planning session, write one outcome statement and the objective, strategies, and activities that will be used to **address a need in the parenting skills domain**, given the additional information provided about the family. (You may make up details as long as they are consistent with the information provided.)

- Assume that you have already completed the FSNA at a family meeting and a level of trust and cooperation has been established.
- Start by brainstorming.
- Narrow the list until you have an achievable plan.

Priority need area is parenting skills. Keep in mind that you will consider the other needs (in the chart below) when writing your outcome statement. Then you will write an objective for parenting skills, and select strategies and activities to help you achieve the objective.

Area	Additional Information
Priority strengths	Basic needs, cultural identity, physical health
Other needs	Social support, coping skills
Reasons for parenting skills score	Pays no attention to needs of children for supervision or care
Parent ages	Single parent, age 28
Child ages	7 years
Culture	Undocumented Mexican immigrant
Parent education level	College graduate
Family structure	Single parent; father known but uninvolved
Economic status	Living wage

Case Planning Exercise: Group 7

This exercise will take 20 minutes.

In your group, decide who will be the worker; who will be the parent; and who will be the other household member, ally, or resource.

Working together in a mock planning session, write one outcome statement and the objective, strategies, and activities that will be used to **address a need in the parenting skills domain**, given the additional information provided about the family. (You may make up details as long as they are consistent with the information provided.)

- Assume that you have already completed the FSNA at a family meeting and a level of trust and cooperation has been established.
- Start by brainstorming.
- Narrow the list until you have an achievable plan.

Priority need area is parenting skills. Keep in mind that you will consider the other needs (in the chart below) when writing your outcome statement. Then you will write an objective for parenting skills, and select strategies and activities to help you achieve the objective.

Area	Additional Information
Priority strengths	Coping skills, basic needs, household relationships
Other needs	Social support, cultural identity
Reasons for parenting skills score	Pays no attention to needs of children for supervision or care; uses excessive physical discipline
Parent ages	Ages 28 and 34
Child ages	Ages 7, 6, 4, and 2
Culture	Gay
Parent education level	College graduates
Family structure	Married; oldest two children are biological children of older mother, younger two children were adopted
Economic status	Living wage for one, good wage for other; have a car

Case Planning Exercise: Group 8

This exercise will take 20 minutes.

In your group, decide who will be the worker; who will be the parent; and who will be the other household member, ally, or resource.

Working together in a mock planning session, write one outcome statement and the objective, strategies, and activities that will be used to **address a need in the parenting skills domain**, given the additional information provided about the family. (You may make up details as long as they are consistent with the information provided.)

- Assume that you have already completed the FSNA at a family meeting and a level of trust and cooperation has been established.
- Start by brainstorming.
- Narrow the list until you have an achievable plan.

Priority need area is parenting skills. Keep in mind that you will consider the other needs (in the chart below) when writing your outcome statement. Then you will write an objective for parenting skills, and select strategies and activities to help you achieve the objective.

Area	Additional Information
Priority strengths	Physical health, basic needs, domestic violence
Other needs	Coping skills, social support
Reasons for parenting skills score	Pays no attention to needs of children for supervision or care
Parent ages	Single parent, age 32
Child ages	Ages 10 and 2
Culture	Deeply religious
Parent education level	Did not finish high school
Family structure	Divorced; father visits regularly
Economic status	Good wage; has a car

Case Planning Exercise: Group 9

This exercise will take 20 minutes.

In your group, decide who will be the worker; who will be the parent; and who will be the other household member, ally, or resource.

Working together in a mock planning session, write one outcome statement and the objective, strategies, and activities that will be used to **address a need in the parenting skills domain**, given the additional information provided about the family. (You may make up details as long as they are consistent with the information provided.)

- Assume that you have already completed the FSNA at a family meeting and a level of trust and cooperation has been established.
- Start by brainstorming.
- Narrow the list until you have an achievable plan.

Priority need area is parenting skills. Keep in mind that you will consider the other needs (in the chart below) when writing your outcome statement. Then you will write an objective for parenting skills, and select strategies and activities to help you achieve the objective.

Area	Additional Information
Priority strengths	Cultural identity, coping skills, social support
Other needs	Basic needs, domestic violence
Reasons for parenting skills score	Had expectations of child that were developmentally inappropriate; uses excessive physical discipline
Parent ages	Ages 32 and 33
Child ages	Ages 10, 5, and 1
Culture	Chinese
Parent education level	College graduate
Family structure	Married
Economic status	Living wage for dad, no work for mom; has a car

Case Planning Exercise: Group 10

This exercise will take 20 minutes.

In your group, decide who will be the worker; who will be the parent; and who will be the other household member, ally, or resource.

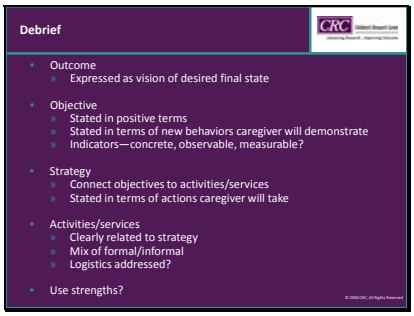
Working together in a mock planning session, write one outcome statement and the objective, strategies, and activities that will be used to **address a need in the parenting skills domain**, given the additional information provided about the family. (You may make up details as long as they are consistent with the information provided.)

- Assume that you have already completed the FSNA at a family meeting and a level of trust and cooperation has been established.
- Start by brainstorming.
- Narrow the list until you have an achievable plan.

Priority need area is parenting skills. Keep in mind that you will consider the other needs (in the chart below) when writing your outcome statement. Then you will write an objective for parenting skills, and select strategies and activities to help you achieve the objective.

Area	Additional Information
Priority strengths	Coping skills, physical health (only two)
Other needs	Substance use, cultural identity
Reasons for parenting skills score	Uses excessive physical discipline; pays no attention to needs of children for supervision or care
Parent ages	Single parent, age 38
Child ages	Ages 7, 3, and 1
Culture	Deaf
Parent education level	High school
Family structure	Single; father of 7-year-old is unknown; father of 3-year-old and 1-year-old lives in at times; he is hearing
Economic status	Living wage; has a car

Slide 31

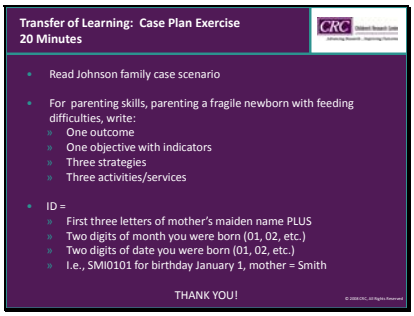


Note to trainer: Have each group report out their motivator, at least one objective, and at least one resource/activity.

Ask the other groups to comment on the extent to which the plan meets these criteria.

(Note: These are the scoring rubrics for the embedded evaluation.)

Slide 32



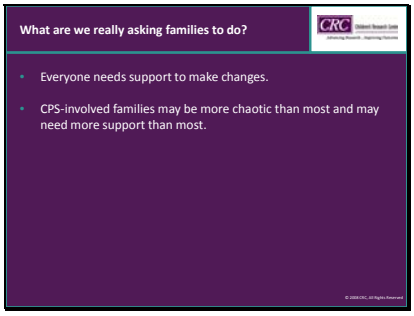
Now it's time to do some individual work. I am going to hand out a new case scenario about the Johnson family. Take a moment to read it, and then write one outcome, one objective with indicators, three strategies, and three activities/services.

Note to trainer: If this class is part of the TOL study, be sure worker uses his/her ID as described. Collect the case plans. If the class is not part of the study, you can omit the ID.

If it is not a TOL study class and time is tight, you can skip this individual case plan.

When completed, ask for a few examples. Point out that there is not a single "correct" case plan. What is important is that you address the priority needs, and have a good logic model connecting services/activities through objectives to a motivator the family wants to achieve.

Slide 33



As we practice developing a case plan, it may be good to develop a little empathy! When was the last time you tried to change your life, even in some small way?

If we wander down the self-help aisle of a bookstore or flip through the pages of a lifestyle magazine, it's pretty clear that we're all trying to change ourselves. Think of a personal goal you're working towards right now. Are you trying to do any of the following?

- Spend more time with your family?
- Eat more fruits and vegetables?
- Give up smoking?
- Lose five pounds?
- Run a marathon?
- Reduce your carbon footprint?
- Save money for a special vacation?
- Finish all of your paperwork each week?

Are you always on track for your goal? Do you sometimes

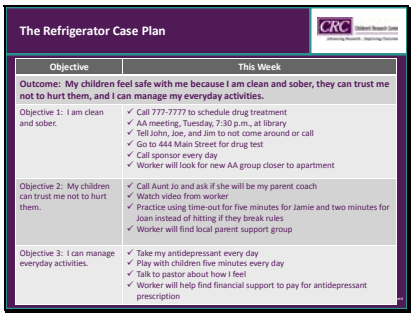
slip up? Miss a deadline? Spend your vacation money on a new shirt? Leave the paperwork on Friday?

When working with families, it can be useful to acknowledge that change is hard and that we all slip up. We're still going to hold ourselves and families accountable, but when we slip, maybe that's when we need more encouragement and more resources.

Slide 34

Now that we have an initial case plan, we print off this document (which is unfortunately many complicated pages), and what happens to it? Too often, the family puts it away and the worker doesn't think of it again until it's time for review. What happens in between depends on what happens to be going on in family life, and that is often a chaotic lurching from one crisis to another.

Slide 35



After we've pulled the outcomes, objectives, strategies, and services together into a case plan, we can still be stuck on the question of "Okay, what now?" Although we need this plan and this process to achieve the ideal state that we described in the outcome, the incremental week-by-week reality can still be daunting.

One strategy to make this easier is to work on a "refrigerator" case plan. Families should have a copy of the complete case plan, but each visit with the family can involve breaking the case plan down into the steps that should be accomplished before worker's next visit. The idea is to have a list of tasks short and simple enough to be stuck to the front of the refrigerator and consulted frequently so that the family always has an idea of how they're doing. The refrigerator case plan can include both activities to be completed by the family and by the worker so that you have a sense of partnership and shared responsibility in this mission.

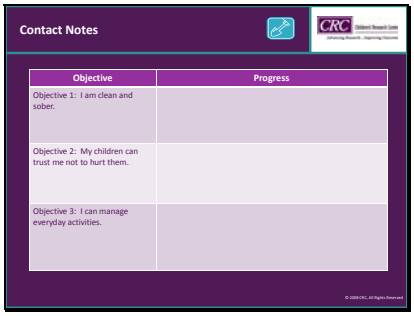
At each visit, or during a weekly check-in phone call with the family, review the last refrigerator plan with the family. Did they accomplish all the tasks? If not, why not? Can these tasks be moved forward to the new refrigerator plan, or is there a significant barrier in place that means we should modify that task to something else that will help us obtain our objective but through a different path? If all the tasks have been accomplished, what are our next steps?

Keep in mind that this can also help you with your progress notes. The idea of the refrigerator case plan is that after six

months of these short interim case plans, you'll be closer to achieving your overall outcome and objectives, or maybe even have achieved them. The refrigerator case plan can be a tool for you not just to organize the family's activities, but also to organize the way you describe and evaluate their overall case plan progress.

TIP: Make up a bunch of these with the outcome and objectives filled in and the "this week/month" blank. But be clear—this is not a new form. They can just write it on a piece of notebook paper.

Slide 36



Almost home… let's tie this all together.

Every visit you make with the family needs to include some review of the family's progress towards case plan objectives. You may even focus on this to the exclusion of all else EXCEPT FOR changes in safety.

Too often, between writing the case plan and the FSNA review, contact notes tell interesting stories about families, but don't even mention the case plan or what the family is or is not doing.

One easy thing to do to avoid this situation is to organize your visit AND your contact notes around the case plan. Just drop in the objectives statements (and if applicable, indicators) and write about how the family is doing. You might not hit every objective every visit, but you should be sure to be checking in on each one periodically. If progress is slow, you want to know that in month two, when there is still time to make adjustments. This will help keep the family on track. It will help identify barriers early. You might discover that the assessment needs to change because the family now trusts you enough to disclose a need they previously hid. That's a lot of work, but it's a good thing!

You might discover that the need is right but the family isn't really motivated. Change the outcome! The objective may be right, but the family is stuck. Maybe we have the wrong strategy. Or there is a barrier to the service or activity we didn't anticipate. Fix it. Stay on the case plan.

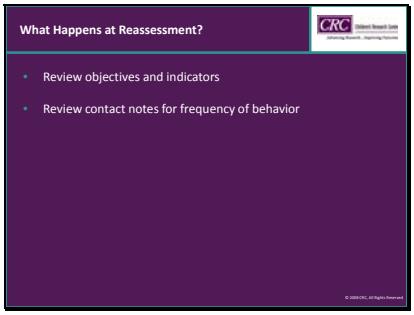
If a family brings up an issue that is unrelated to the case plan, it's fine to listen a little, maybe provide some information. But don't let it derail the case plan UNLESS it really is a safety threat or suggests the FSNA needs to be revised.

This is NOT a new form. It's just a way to organize your

contact notes. It may also help to make your notes more concise because it will focus on critical information. Unless you have a legal reason to include something else in the notes, it does not belong there if it is not directly related to case management activities.

Note to trainer: The digging deeper hyperlink goes to the NASW code of ethics about documentation.

Slide 37



If you've been organizing your contacts with the family around the case plan objectives, you'll have a lot of information to work with by the time you get to the risk reassessment or the reunification review.

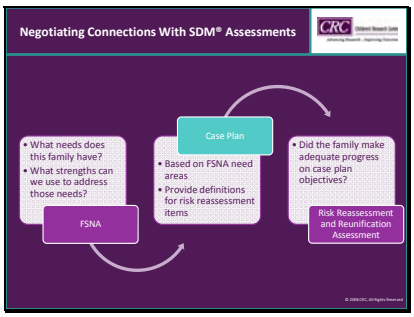
Start with a simple review of the objectives and indicators. Has the family achieved the objective and met all of the indicators? If not, have they met some of the indicators? Which ones?

If the family has achieved their objectives, then your evaluation task is simple. You can answer the progress item with the most positive response.

If the family has not achieved their objectives, you must decide if they have made significant progress. Are they actively pursuing their objectives? Frequently? Occasionally? If you have been organizing your contact notes around the objectives, it should be relatively easy to get a sense of how consistent the family's efforts and progress have been.

Remember, the objectives and indicators are your definitions for these items, and your contact notes can help you assess the frequency of positive progress and behavior if the objectives have not been achieved.

Slide 38



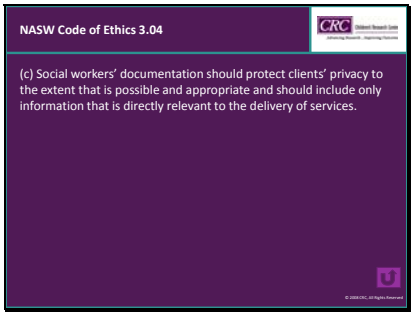
If we've written a detailed case plan, in collaboration with the family, and adequately supported its implementation through frequent progress monitoring, we're setting ourselves up to have a smooth transition back into the reassessments, and we've given the family a clear understanding of how much progress they've made and what they can expect at the next reassessment.

Slide 39

Close by having everyone state one new thing they learned that they will use when they return to work.

If this is a TOL study session, have workers complete the final survey and submit before leaving (try to end ten minutes early to give them time to do this in class).

Slide 40



If participants express concern about limiting the focus of case notes to case plan progress and safety, read this statement from the NASW Code of Ethics. This focus is consistent with the professional standards of the field.