A Model of Practice

for the

Illinois Department of Children and Family Services

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Director

Prepared by

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PRELIMINARY REPORT
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Preface

In December 1994, Illinois Department of Children and Family Services (DCFS) Director Jess McDonald commissioned a work group to define a practice model for DCFS. He appointed Richard H. Calica, Executive Director of the Juvenile Protective Association, as Chair and contracted with the Child Welfare Institute to provide consultation and support.

The accompanying paper represents the culmination of work by the members of the practice work group and its consultants. Members of the group include:

Denise Kane, Inspector General
Diane Scruggs, Chicago Child Care Society
Bernadette McCarthy, DCFS
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Jeanine Smith, Jewish Children's Bureau
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In addition, Thomas D. Morton, Executive Director of the Child Welfare Institute, served as a member of the group and primary consultant. Other consultants to the group included:

Wayne Holder, Action for Child Protection
Dr. Vera Fahlberg
Ronald Davis
Michael Budlong, Child Welfare Institute
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The following paper reflects the range of practice issues considered by the group and consultants. It is not represented as a consensual document. Primary authorship rests with Richard Calica and Thomas Morton. The opinions and recommendations expressed by them are an attempt to represent the best thinking by group members, with the acknowledgement that there were many points of individual disagreement, some of which may be included here as recommendations for practice.

Executive Summary

The Department of Children and Family Services, in its attempts to remain responsive to categorical streams of funding, various lawsuits, and an ever-shifting political context, has lost its focus on its core business as well as its social contract as a government agency. Put simply, DCFS has lost its core focus on the safety and emotional security of abused and neglected children and its position as a leader in the area of services to abused/neglected children and their families.

This document is intended as a much needed road map for DCFS. It is based upon the assumptions that society has a right and responsibility to intervene in families where parents (or caregivers) have so violated prevailing standards as to put the safety and well being of children in danger. This road map has implications for job descriptions, training, assessment, organization of work units, models of service delivery and parental involvement and responsibility, standards for intervening to change behavior, and standards for critical decisions regarding removal of children on a temporary or permanent basis.

The outstanding features of this Model of Practice for DCFS include:

- A clear explication of the variables associated with child safety and developmental opportunity;
- A practice model that distinguishes between persons who should be prosecuted for criminal activity and persons who should be evaluated for service;
- A set of principles which will serve as a foundation for DCFS' organizational structure, training, and seeking accreditation from the Council on Accreditation;
- A rationale for limiting the number of children removed from their birth parents and the limiting of time to decide on permanent plans for those children who are removed;
- A practice model that makes clear the positive incentives, both from the child and system viewpoint, to leave children in their own homes unless they are at imminent risk of severe physical injury;
- A rationale for simplifying the case management structure and reducing the number of helping professionals who are involved with any particular family;
- A practice model that allows for maximum participation of clients in determining what problems are being worked on, how those problems are being worked on, and what results are expected. Clients are treated with respect, are given options, and accept the consequences of their choices and behaviors;
- A practice model that clarifies what DCFS has a right to expect from its employees and its contract agencies on behalf of the children and families they serve;

Introduction

This paper is designed to offer the Illinois Department of Children and Family Services (DCFS) a road map for practice with children and families. It seeks to answer the question, "What is the problem to which DCFS is the solution?" and it attempts to describe how DCFS can be a solution to this problem.

DCFS is confronted with the charge of responding to a serious social problem: child maltreatment. Its response is expected to be simultaneously quick, compassionate, reasoned, resolute, and unerring. The public expects that DCFS will not intrude upon families where no maltreatment occurs and leave no child unsafe where maltreatment has occurred or is likely to occur. The public also expects that parents who will do significant harm to their children will be prohibited from doing so, and that children who are not in danger will be left with their families. Finally, this public expects that these results will be achieved with efficiency and at a minimum of cost.

Meeting these expectations requires finessing a lengthy walk down a tightrope where each successful journey is likely to be forgotten or go unnoticed, each slip magnified, and each fall memorialized. While it is unlikely that DCFS can succeed with every family and child in the political realm, it is possible for DCFS to experience success in practical terms. This requires a framework to describe the decisions DCFS must make and the actions it must take to implement these decisions. DCFS must have a model of practice which clearly lays out its theoretical assumptions about what causes child maltreatment, what variables must be influenced to stop it, and what is the best way to exercise this influence.

This report is an attempt to lay out the details of these assumptions. Any endeavor to describe an approach to a social problem as complex and varied as child maltreatment inevitably will suffer two faults. The diversity of the problem requires too much differentiation to be concise. At the same time, readers looking for answers to specific issues in practice will complain that the level of analysis is too shallow.

Hopefully the trail has been laid clearly enough so that there will be a path to follow. For those who seek a condensed meaning of what follows, the authors have attempted to find some simple truths. The three most important of these are:

1. Most parents are capable of and motivated to protect and nurture their children;

2. Most caseworkers can be developed and are motivated to help families in which children are at risk of maltreatment;

3. All change for the better takes place in the context of a helping, supportive relationship.

To these statements we may add some corollaries:

4. The role of the caseworker is to offer the helping, supportive relationship that enables change;

Foundations and Assumptions

What Is Practice?

All organizations employ technologies to convert inputs into outputs. In human service organizations, these technologies are generally referred to as practice. **Practice** is the means by which human beings (inputs) are helped to change their behavior, live in better conditions, or become eligible for benefits (outputs). Practice varies among human service organizations. In mental health services, practice includes verbal therapies, medication, and environmental control. In health care, practice includes surgery, medication, and verbal efforts to influence changes in lifestyle that cause or contribute to health problems. In child welfare, practice includes interpersonal efforts to influence understanding of a problem and action to resolve it (e.g. verbal therapies), making available necessary resources, and safety interventions to control behaviors of caregivers that present the possibility of harm to a child.

Better results are believed to be achieved with best practices. There are different ways of viewing best practices. One is like ingredients in cooking, better inputs make better results. In child welfare, this means that better techniques and services get better results. A second view is like the chef's skill in combining ingredients. There is both a best order in which to combine ingredients and a best technique for incorporating them. In child welfare, the work of helping is enhanced when attention to relationship precedes or accompanies a focus on instrumental acts to achieve goals. A third view is similar to the kitchen in which the chef works. Properly organized, it supports efficient work. Poorly organized, it hinders even the most skilled chef using the best ingredients. In child welfare, this pertains to the organization of supervision, continuity of contact by the intervenor, DCFS organizational culture, workload, and other organizational variables.

Unfortunately, discussions of practice tend to wander among these three views. All are relevant to good outcomes. For purposes of the discussion that follows, a distinction is made among the concepts of *practice*, which incorporates aspects of the first two views, and *service design* which pertains to the third view. In fact, the discussion here is based strongly on the belief that service design flows from a clear concept of practice, rather than the reverse. As Frank Lloyd Wright once said, "Form follows function." Therefore, primary emphasis here is on the questions of: 1) what results are intended, 2) what variables must be influenced in order to achieve these results and 3) what sequence of activities employing what techniques is likely to have the desired influence?

What Results and for Whom?

DCFS has stated a commitment to five outcomes. They are:

1. Family care of a child is at or above a threshold level of safety and developmental opportunity;

2. When the family's care of the child falls short of that threshold, the level of care will be raised to that threshold;

3. When the above is not possible and children are placed outside the family, the child's physical, emotional, and cognitive developmental needs are met;

4. When the family will meet the child's needs for safety and development, the child will be returned to the family;

5. When the family will not meet the child's needs for safety and development, the child will live in an appropriate permanent living arrangement.

Achieving these outcomes requires serving several consumer groups. Foremost among these are children and their families. They are clearly linked to these results. However, DCFS also serves two other important groups. Identification of children who might be unsafe requires that professionals and other citizens who have reason to believe a child might be maltreated inform DCFS of what they have observed. By accepting their reports, DCFS provides a way for these citizens to respond to the public problem of child abuse and neglect, and to ease the personal anxiety created by what they may have witnessed. Each reporter of maltreatment is a consumer of the DCFS investigative and family assessment capabilities.

A second group are the creators of the public policy that requires each accepted report of maltreatment to have a determination. This group is made up of the legislative representatives of the people and advocates for specific policies. Did maltreatment occur or not? Who is the maltreator? DCFS is mandated to answer these questions and to found or unfound the report. One might simply view this as a means to determine who is safe or not and who will receive a protective intervention. Even where no protective intervention may be needed, DCFS is required to make a determination of the report. Indeed, a significant amount of resources and staff time are consumed in the pursuit of a determination.

A determination is a result, in the same way that a judicial decision is an outcome of a court process. Presumably, the quality of determinations is important to both protecting children and public acceptance of DCFS' legitimacy. Further, each reported family is impacted by the inquiry that follows, even if the report is eventually unfounded and no intervention is necessary. The act of engaging a family in an inquiry or subjecting a family to an investigation can have positive or negative effects on the family regardless of the outcome. The focus of this effort has been on the means of helping children and families. Defining practice relative to each of the other two groups and functions is important and should follow as a subsequent effort. Each is important to the success of DCFS.

Current practice reflects central themes of protection, permanence, family preservation, adoption, and independent living. These concepts remain viable. The problem with current practice is the variable meaning and use that surrounds these terms. How one defines a problem often dictates how one will attempt to solve it. In selecting a practice model, it is important for DCFS to choose definitions that guide practice toward the right variables, strategies, and decisions. At the beginning of subsequent sections are definitions that guide the suggested practices. In some instances these definitions may vary from current practice. Therefore, each should be considered in light of its implications for changing current practice.

The above outcomes do not represent the entirety of DCFS' responsibility. Rather, they reflect those aspects of its work that directly affect children and families at risk due to maltreatment. A complete examination of practice would also include such functions as licensing of foster homes and day care facilities, approval of relative caregivers and adoptive families, regulatory services, and so on. For purposes of the following discussion, practice has been limited to those interactions directly designed to make decisions about and changes on behalf of families in which children are unsafe or may soon be.

Basic Assumptions

Model building is a component of theory building. Models rest on assumptions about relationships between variables and about cause and effect. In describing a model of practice, several assumptions have been used as a basis for construction. These are:

- A child's safety takes precedence over all other concerns;
- A child's emotional security powerfully influences development;
- Where maltreatment does not make a child unsafe, the child's emotional security takes precedence over agency safety;
- A child's emotional security is strongly linked to family membership, and particularly to continuity in the relationship with the birth parent(s), followed by continuity of caregiver relationships;
- Family members' emotional security powerfully influences their focus on the child's needs versus their own;
- Interventions to assure safety invariably affect the emotional security of the child and other family members;
- A child's need for emotional security takes precedence over certain parental rights and, therefore, limits the time that can or will be afforded a parent to demonstrate the ability to meet a child's need for safety and development;
- Success in meeting the child's needs requires attention to both safety and emotional security;

Elements of a Model of Practice

As stated in the previous section, practice is the means by which people are helped to change behavior or environmental conditions. In DCFS, there are three types or categories of results. They are changes in behavior, in environmental conditions, and in decisions. Changes in behavior may relate to the pattern or frequency of a behavior. For instance, a parent who was previously unresponsive to a child's initiation of contact may now demonstrate awareness of the child's behavior as an invitation and respond by giving the child affection or engaging in play. Another behavioral change is acquiring a skill or ability. For example, a parent may be able to demonstrate the ability to employ forms of discipline other than physical punishment as the result of coaching. Having the skill is a necessary condition for its use, but it is not the same as employing the skill regularly. These are separate behavioral results and often require different practice interventions.

Since DCFS services are not universal, it is necessary to determine *who* receives *what* help. Decisions tend to categorize clients and make them eligible for services or interventions. This is part of DCFS' people processing function and supports its people changing function. The most obvious form of this initial decision-making includes determining which calls to accept as reports of maltreatment, which reports require immediate response, which children are safe or unsafe, which cases to open and which safety plan to employ.

In some instances, it is the environment that requires change. Families may require housing, access to income, clothing, or food. Families may need access to services. Children may need a safe environment or an adoptive family. Such changes alter the environment around a client but do not necessarily require a change in client behavior.

Subsequent decisions include which interventions are needed to address which underlying conditions, which providers will guide the intervention, when the intervention has succeeded or is not succeeding, when to close a case or recommend termination of parental rights, and which children will be adopted. These are only a few of the many decisions that support other elements of practice.

Although decision-making and change in environmental conditions do not require behavioral change, these interventions will inevitably lead to changes in behavior patterns. Assessment is often the first intervention and does begin a change process. The mere act of being asked questions begins to alter people's perception of themselves, others, and their view of the world. This may be the family's first experience with what may later be an offer of ongoing help. Being in a different environment requires adaptation, leading to new or different behavior. The behavior of a child in a foster home will not mirror exactly the child's behavior in his own home. Change, whether planned or unplanned, is a companion of all interventions.

Variables Influencing Human Change

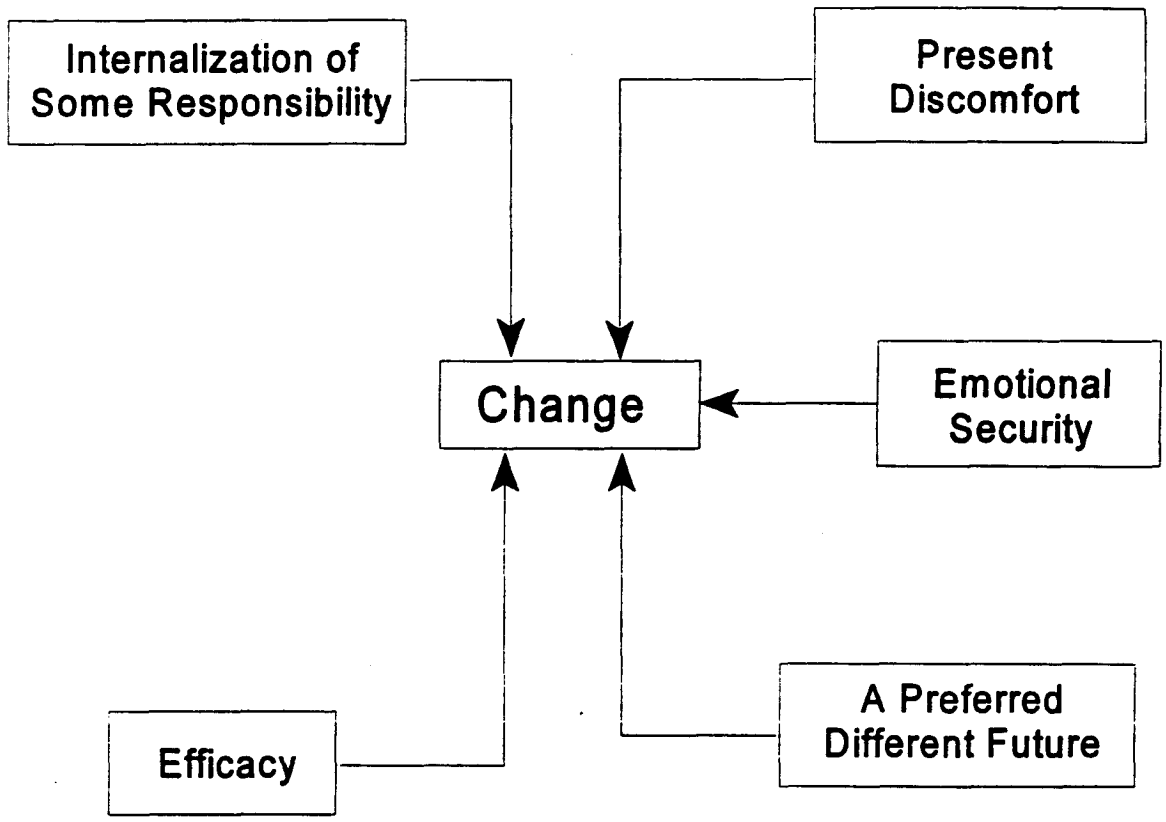

Diagram 1

One of the most significant environmental modifications made by DCFS and caseworkers is the change in the caregiver relationship and residence of children. Placement as a safety intervention is an environmental change. Changes in environmental condition can have powerful effects on the pattern of behavior. However, the change may be only temporary and occur as long as the new environmental conditions holds. Parents may not be able to maltreat the child if no access is possible. However, absence of maltreatment in these circumstances does not mean that the parent will not maltreat the child again.

Sometimes resources are available, but the client may be unwilling or unable to access them. Practice should address ability, opportunity, and motivation of the client and not focus singularly on access or availability. Changes in environmental conditions are often necessary elements of both nurture and control. However, they should not be confused with actual behavioral change.

Strategies for Human Change

At the point of entry into families, there are several sources of discomfort that can serve as sources of energy for change. First, there is the loss of privacy and autonomy accompanying the report and investigation. Second, for families in which maltreatment has occurred, there is the pain associated with the tension and conflict between the caregiver's positive intentions for the child and the real consequences for the child of the caregiver's current behavior. Focusing on the caregiver's concern for the child, the pain within the family, and discrepancy between positive intent and reality is more powerful in creating change than the will of the family to rid itself of the agency's intrusion. The latter offers a convenient source of focus and identifies with the family's anger about the intrusion. But its use will more often lead to compliance than change. Further, it implies that the best the agency has to offer is the hope of being left alone. Never the less, this may be the best way to reach the client psychologically, and therefore could be the place to start. If the client is left at this place it may be as far as the intervention proceeds.

The emotional security necessary to risk change comes through the formation of a trusting relationship. This relationship begins with empathy for the family's present experience and validation of their strengths. The intervenor must demonstrate that the family will be supported as well as confronted. This requires balancing nurture and positive feedback with clinical use of confrontation and environmental control. The former communicates understanding. The latter communicates that the intervenor has limits that will be maintained. Other core conditions such as warmth, positive regard, respect, genuineness, and concreteness are also used to support empathy.

Empathy permits the internalization of responsibility. Influencing the internalization of responsibility requires reconciliation of the differences between family's espoused goals and present actions. Families who perceive themselves as victims who have contributed nothing to their present discomfort will continue to blame others and focus their attention on avoidance of or conflict with externally perceived sources of family problems, one of which is the caseworker.

Families who come to see their own contributions find power in their own ability to grow and change. The principle strategy for internalization involves helping the family develop a picture

Strategies for Practice

The preceding discussion provides a framework for selecting strategies for practice. Strategies will be discussed at two levels. The first level involves principles that apply in almost all elements of practice. The second are more tactical elements of strategy, applying to the specific variables that must be influenced in order to achieve DCFS' stated outcomes.

General Practice Strategies and Principles

1. **Different forms of maltreatment have different etiologies and require different treatment in assessment and intervention.** Physical abuse, physical neglect, sexual abuse, and emotional abuse may derive from different underlying family conditions. These differences may require distinctions in the way the family is served.

2. **There should be a distinction in the use of legal authority between families in which there are criminal forms of maltreatment versus social forms of maltreatment.** Where legal intervention is required for reasons of possible violation of criminal statutes, both an investigation and assessment are indicated. Where the nature of maltreatment does not suggest criminal behavior and the family does not contest the need for or legal basis for intervention, an assessment approach should be used.

3. **Child safety should be the primary focus of assessment when initially entering a family and should remain a focus throughout the life of the case.** While concerns about safety are always evident at initial contact, there should be a systematic way of applying safety criteria at regular decision points throughout the service life of DCFS' relationship with a family.

4. **The distinction between child safety and risk of maltreatment should be reflected in differential practice with families.** Safety refers to the imminent danger of significant harm to a child without immediate or ongoing interventions. Risk concerns the presence of conditions within the family known to be associated with maltreatment. Its presence makes intervention desirable or necessary to assure that a child can and will be safe in the care of a family in which maltreatment exists. Safety decisions lead to changes in environmental conditions that make the child unsafe. Risk assessment guides changes in caregiver behavior. As with safety, periodic and systematic reassessment of risk should be a component of practice.

5. **Interventions in families should be based on need**. What caseworkers often identify as problems are actually symptoms of underlying conditions in families. These underlying conditions are needs for which the problem behavior is perceived as a solution by the family members exhibiting these behaviors. Services often include interventions, but are not the same thing. DCFS practice should be based on interventions to meet needs rather than services to address problems.

11. **The emotional security of family members can best be supported when interventions occur within and are supported by the family's social network and within the family's home community.** The family's social network contributes to the family's current functioning and is the most valuable resource in sustained change. Sustained change generally requires restructuring of the contributions of network members as individuals and altering the interactions among network members. Attachments, identity, and family efficacy can best be maintained when families are served within the area they define as their home community and from which they will use ongoing resources.

12. **The emotional security of family members requires continuity of relationships.** Multiple caseworkers, even with the benefit of specialized expertise, cannot compensate for the lost emotional security due to fragmented attachments. Continuity of care requires minimal changes in caregiver relationships for children and in helping relationships for the child and family.

13. **The primary intervenor must be responsible for assessing and treating the maltreatment dynamic in families.** Families who are subdivided into contributing symptoms and sent to symptom targeted services do not receive sufficient help in resolving the interaction of these variables. It is most often the interaction of these dynamics within families that lead to maltreatment, rather than simply the cumulative presence of separate factors.

14. **Practice must differentiate between ends and means.** Family preservation, reunification, adoption, and independent living are all means to ends. The ends are safety and emotional security. An intact family with a child who, because of DCFS intervention, no longer feels emotionally secure in the parent-child relationship is not a preserved family. Similarly, a child is only prepared for adoption to the extent the child feels emotionally secure enough to risk a new attachment to an adoptive parent.

15. **The child and birth parent(s) attachment represents the most powerful resource for change in child and parent interactions.** While the threatened loss of this attachment creates discomfort in both parent and child, the purposeful use of this discomfort by the agency creates emotional insecurity in both parent and child, which undermines real change and often extracts only compliant behavior. Therefore, all acts of intervention should be based on principles of maintaining and strengthening the attachment between child and parent.

These general strategies and principles imply several things for the formulation of a service response and a practice strategy. First, except in extreme cases of child maltreatment where there is criminal behavior or strong caregiver denial of the maltreatment, the family should be approached with an offer of concern and help for the child's safety rather than through a quasi-criminal investigative procedure. This expression of concern must recognize and validate the positive contributions of the parents to the child's present development as well as supportively confront the parents' contributions to the child's maltreatment.

Dynamics of a Model of Practice

Defining a model of practice involves several steps. The first is a statement of believed causal relationships. DCFS' responsibility for child safety is related to circumstances in which the threat to safety arises from child maltreatment. This social problem drives practice at the front end of service delivery and continues to do so throughout the life of services to families

General definitions:

- **FAMILY**
  The definition of family varies with the context in which it is defined. For a child, there are three families, which may be different or the same. First there is the genetic family, defined by those persons who share the same genetic heritage. Second there is family of circumstance, which is a network of related and non-related persons, who serve as a source of identity, safety, and developmental opportunity for a child. Third there is an ideological family, created in the child's mind and woven from fabric of the child's perception of family experience and the child's wishes.

- **CAREGIVER**
  A caregiver is a person who accepts responsibility for and acts to meet a child's needs for safety and development. A child may have multiple caregivers, both within and external to the family.

- **SERVICE PLAN**
  The service plan defines the goals and interventions that will address the family's needs (including the child). A service plan may contain one or more component plans to address specific needs such as safety, risk, visitation between children in out-of-home care and birth family members, and permanency.

Safety and Child Maltreatment

Key Definitions:

- **CHILD MALTREATMENT**
  Child maltreatment is a symptom of underlying family conditions. It is expressed through caregiver-child interaction in which the child is physically, emotionally, and/or sexually treated in such a manner that the child's emotional, cognitive, and/or physical development is or will be impaired and the caregivers are unwilling or unable to behave differently.

Diagram 2 identifies the primary intervention variables associated with child safety and child maltreatment. Safety is a condition, whereas maltreatment is an action or behavior. Assuring safety requires decisions and environmental interventions. Ensuring the family's capability for providing safety additionally requires behavior change. Behavior change requires influencing the variables associated with maltreatment.

Because the proposed definition of child maltreatment focuses on caregiver-child interactions, the key variables have been separated into child influences and caregiver influences. The primary caregiver influences are the caregiver(s)' individual functioning and the family's functioning. The primary child influences are the child's capability for self-protection and the child's response to the caregiver. *The child variables in no way imply that children cause their maltreatment.* However, it does say that certain child responses together with certain caregiver attributes increase the likelihood that a child will experience maltreatment.

The caregiver influences derive from both the caregiver's family and self. Variables influencing family functioning include environment and resources, family members' ways of expressing their needs, the size and nature of the family's social network, family members' interaction management skills, the family's awareness and perception of present functioning, and culture.

Variables influencing individual caregiver functioning include parenting capability, caregiver's acceptance of responsibility for child's needs, caregiver's attachment to the child, availability and access to environmental resources, presence and impact of disabling conditions (e.g. substance abuse, mental illness, developmental disability, physical health), the individual's availability for the caregiver role, the caregiver's behavioral means of expressing needs, and the maturity level and developmental task accomplishment of the caregiver.

Intervention may require influencing any or all of these variables. Some variables may be directly and sufficiently influenced through the casework relationship. However, other variables may require dependence on relationships with other persons or agencies.

Successful management of this interdependence is a critical component of effective service delivery. To the extent that caseworkers are uncomfortable with mutual dependence and are forced to rely on others, there are incentives to employ placement as a safety plan. Placement reduces the risk associated with the provider's failure to follow through or the family's unresponsiveness to the treatment intervention.

The child variables tend to receive inconsistent treatment in practice. At one level, they appear to be blaming the victim and making the victim responsible for his or her own maltreatment. Yet a child's response to a caregiver taken in the context of the caregiver's ability to meet the child's needs represent an important combination of variables.

Variables Influencing Family Functioning

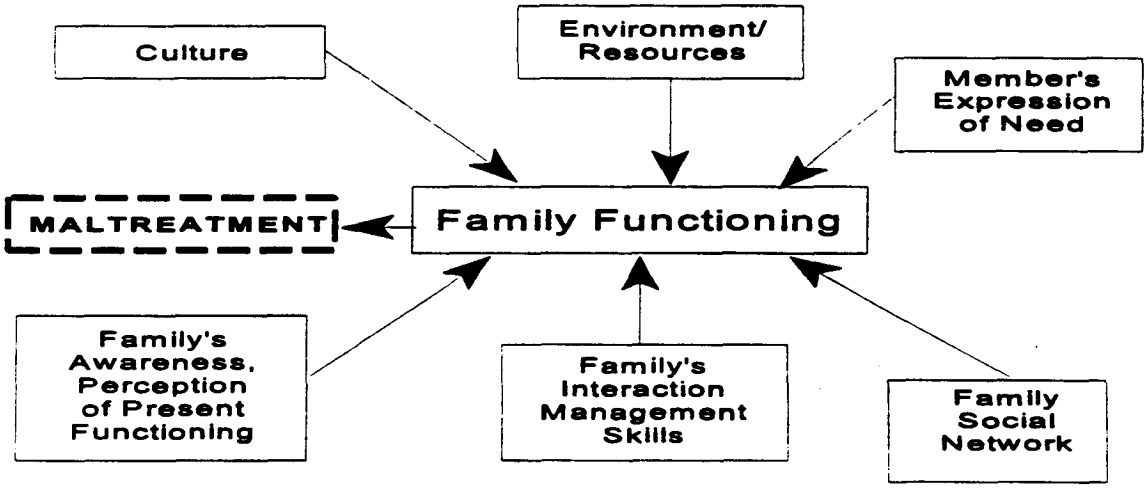

Diagram 3

Variables Influencing Child's Response to Caregiver

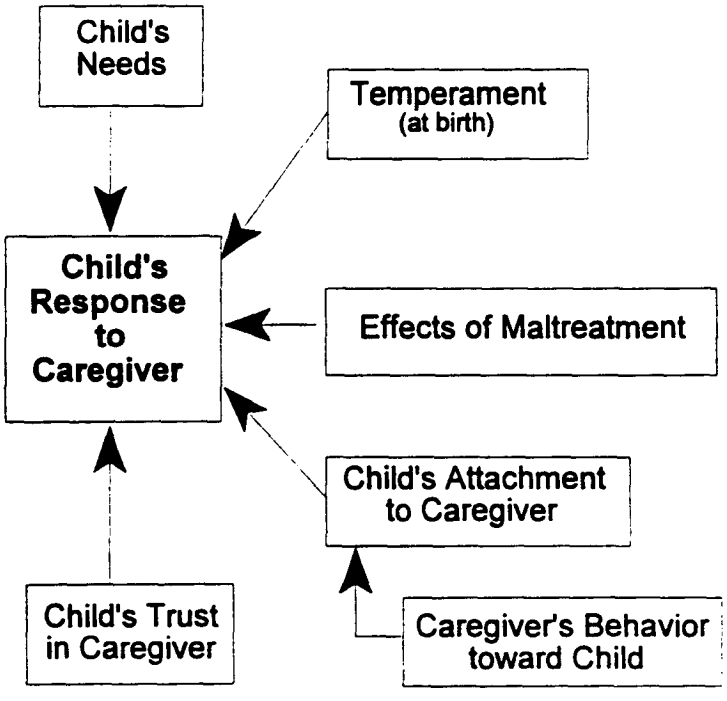

Diagram 5

Strategies for Child Safety

The components of practice in child safety are:

1. Determine mutually (with the family) the specific safety factors that are present;

2. Mutually determine whether or not the child is safe;

3. Mutually develop a safety plan;

4. Implement the safety responses contained in the safety plan;

5. Mutually determine the underlying conditions in the family (risk influences) that influence the safety factors;

6. Mutually select and develop a plan of interventions to meet underlying needs and conditions;

7. Implement the interventions;

8. Mutually reassess the safety factors and risk influences;

9. Modify the safety and service plan in response to changes in the safety factor and risk influences.

For DCFS, practice begins with a call to the hotline. This initial phase of practice involves a decision. The decision is whether the reporter is conveying a concern about child safety." Presently, DCFS focuses on the question of "Does what the reporter is conveying fit the statutory and policy definitions of child abuse and neglect?" These are related, but are not necessarily the same concepts.

The question of the definition of child abuse and neglect is very relevant to an allegation-based system and remains relevant for those cases in which an investigation is required. However, in a safety-based model of practice, the initial question is more focused on: "What have you seen or do you know that would cause you to believe the child might be in imminent danger of significant harm?" rather than "What have you seen the parent do to the child?"

The question of safety arises quickly at initial intake as another decision requirement, i.e., "Is an immediate response indicated?" Therefore, there is no attempt to convey that current practice lacks a safety focus. A consistent application of criteria to the evaluation of the safety concerns is needed.

DCFS has moved recently to adopt a modification of New York state's approach to safety assessment. The Illinois version of the preliminary assessment of safety focuses on thirteen identified factors, with an option to include others based on professional judgement. The 14 factors are listed below:

Missouri has passed legislation creating a differential response to families at initial contact, distinguishing between families in which an investigation or assessment will occur. The latter has been designated as a Family Intervention Determination (FID). The caseworker determines any risk to the child's safety, whether the family needs assistance from the department, and what service needs exist. While Missouri appears to offer preventive services to greater proportions of its caseload than does Illinois, it still stands to reason that cases not indicating criminal violations of statutes and emergency placement could initially be approached similarly.

When the Missouri department chooses a FID response, the family is approached as follows:

> The Division of Family Services has received a report of concern regarding your child(ren). Missouri law, Chapter 210 RSMO, requires the Division to conduct either a family intervention determination or an investigation when a report is received. Because the report does not seem to be criminal in nature, a family intervention determination will be completed with your family. The purpose is to discuss:
>
> - Your family's strengths,
> - Your family's needs, and
> - Your family's need for services.
>
> If the family intervention determination indicates that your family could benefit from services, a plan will be developed with you. This will be done by discussing with you and your family the reported concerns, as well as other areas that may worry you. We will then make plans with you on how to address your concerns, what services will be arranged, and what changes may need to be made.
>
> If a family chooses not to cooperate with the family intervention determination process, we may proceed with a child abuse/neglect investigation to confirm the safety of the child. If the result of an investigation is that abuse or neglect occurred, the individual who committed abuse or neglect will have his/her name placed in the Child Abuse Central Registry.

While the above language is not being suggested literally, it does offer a framework for approaching families. Even in those families where an investigation will be conducted it could be approached from the standpoint that DCFS has received a report of concern about the family's child and is required by Illinois law to determine the safety of the child. This deviates from a pure investigative approach that might begin with a statement that DCFS has received a report of child abuse and neglect and is required by law to determine if it occurred and who may have maltreated the child.

There are different formulations of risk influences. DCFS is examining use of the safety factors used by New York, so it may be useful to examine the risk influences used in their model. New York separates risk influences into five categories. These are caretaker (caregiver), child, family, intervention, and abuse/maltreatment influences. Under each there are specific influences. These include:

Caretaker Influences

Abuse/maltreatment of caretaker
Alcohol or drug use
Expectations of child
Acceptance of child
Physical capacity to care for child
Mental capacity to care for child

Child Influences

Child's vulnerability
Child's response to caretaker
Child's behavior
Child's mental health and development
Child's physical health and development

Family Influence

Domestic violence
Ability to cope with stress
Availability of social supports
Living conditions
Family identity and interaction

Intervention Influence

Caretaker's motivation
Caretaker's cooperation with intervention

Abuse/maltreatment Influences

Access to child by perpetrator
Intent and acknowledgement of responsibility
Severity of abuse/maltreatment
History of abuse/maltreatment committed by present caretaker(s)

These are not proposed as the specific set of risk influences DCFS should accept. However, DCFS needs to adopt a practice perspective on risk assessment and its relevance to family intervention.

Resolution of Underlying Family Conditions

Underlying conditions are those conditions in a family that specifically drive risk and safety influences. They may relate to capabilities, motivation opportunity, or dynamics of relationships affecting all three. The diagrams illustrating dynamics of safety and maltreatment identify clusters of underlying conditions. There may be others as well.

This goal begins to link a model of causation with a model of change. Presumably, intervention to achieve change will need to address both safety (and maltreatment) variables and emotional security variables. It requires influencing individuals, family systems, family and community networks, and community service systems. The purposes are to enable families to use available resources, develop their capabilities, and to *alter patterns of behavior within families.*

Influencing Caregiver Parental Role Functioning

The key components of practice include:

1. Engaging the caregiver based on identification of positive intent toward the child and strengths in the parental role;

2. Joining with the caregiver through sharing in concerns about emotional security and mutual (family and agency) goals for the child;

3. Engaging the caregivers' social support network to achieve an understanding of the caregivers' family's needs and the child's specific needs;

4. Determining with the caregiver the nature of the underlying conditions that influence the child's safety;

5. Exploring earlier successful interventions with the caregiver;

6. Supporting the caregiver's identification of interventions to meet these needs;

7. Determining the threats to emotional security and experiences of loss of security for the caregiver and implementing supportive interventions to restore this condition.

8. Supporting and enabling the caregiver's use of these interventions;

9. Providing feedback and coaching the caregiver toward successful use of the interventions or reassessment and selection of new interventions if desired results are not being obtained;

10. Coaching and developing network members' (including foster parents) development and demonstration of a positive helping alliance with the parental caregivers;

11. Periodically redetermining the current level of safety factors and risk influences;

- Providing for the emotional needs of the child, including love, security, affection, and the emotional support necessary for healthy development;
- Providing necessary stimulation for normal intellectual, social and spiritual development (if the family believes spiritual development to be important);
- Helping socialize the child;
- Disciplining the child and keeping him from developing patterns of behavior and attitudes disapproved of by society;
- Protecting the child form physical, emotional, or social harm;
- Presenting a model for the identification of sex-linked behavior;
- Maintaining family interaction on a stable, satisfying basis so that effort is made to meet the needs of all members of the family;
- Providing a fixed place of abode for the child and providing a clearly defined place for him in the community; and
- Acting as an intermediary between the child and the outer world, defending the child's rights in the community, and protecting the child from unjust demands of the community.

Different cultures and changing social norms may suggest some modification of how these elements are expressed. However, most cultures have relevant equivalent applications for the intent of each element.

Caregivers need several capabilities in the parenting role. First among these is the ability to recognize and interpret the child's behavior and the underlying needs for which the behavior is an expression. Without this, the parent cannot competently respond and the child cannot experience efficacy.

The parent must be capable of several basic responses. These include protection, assurance of safety, emotional reassurance, feeding, holding, responding to a child's initiation, initiation with the child, development of social skills, development of conscience and a set of values, cognitive stimulation to aid mental development, and learning and physical stimulation to aid physical development. As children develop, the caregiver needs to be able to balance structure with the child's growing need for autonomy and self-control.

Neglect occurs through failure to recognize a child's expression of needs and/or to respond with need-meeting behavior. Assessing parenting capability requires examination of parent-child interactions. Simply noting developmental deficiencies in a child, even if deprivation is obvious, is not sufficient to determine what needs exist in the child's caregiver. Similarly, generic parenting skills training may not respond to the caregiver's unique conditions and requirements.

- Intervention to moderate the contribution of environmental stressors.

Availability/Access to Environmental Resources

A child may be endangered when caregivers are unable to provide food, shelter, clothing, or utilities. An immediate intervention strategy is to alter this condition through linking the family to resources. There may be underlying conditions within the family that raise the probability that these conditions will return. *Assessment should focus both on the presence of resources and the caregiver's contributions to the absence of these resources in the family.*

Key practice strategies include:

- Determination of caregiver's resource needs relative to the child's needs;
- Engagement of social network members as resources;
- Information and advocacy regarding access to resources;
- Follow-up with caregiver and provider;
- Reassessment.

Caregiver's Attachment to the Child

A caregiver who is not attached to the child may fail to initiate or complete the cycle of need. The caregiver may fail to respond to the child's expressed needs. The child's response to the caregiver may consequently be a failure to attach. A caregiver with low frustration tolerance may either punish the child for failing to engage or choose to ignore needs. Intervening to address this variable requires examining the cycle of child-caregiver interactions and increasing the accuracy of caregiver perception, timeliness of response, and accuracy of response to the child's needs.

Key practice strategies include:

- Determination of caregiver's attachment to child;
- Support caregiver's decisions about future commitment to child's needs;
- Provide caregiver-child interventions to resolve attachment disorders.

Presence and Impact of Disabling Conditions

Caregiver disabling conditions represent a series of challenges for DCFS, generally requiring specialized services to address the contribution of the disabling condition. This dependency creates ambiguity about who is responsible for treating the maltreatment dynamic, DCFS or the specialized service. While there is presumed to be a relationship, treatment does not necessarily assure elimination of the problem. The services may have different success criteria. For example, a drug treatment program may consider itself successful if a client demonstrates an adequate period of non-use of the substance, whereas DCFS considers the caregiver's functioning in relationship to the child as a criteria for success. The substance abuse program may be able to

- For children in relative or foster care, determine the impact of the disabling condition on visitation and structure visitation, in response to the child's needs and the caregiver's ability;

- For treatment, evaluate change in risk and safety status, along with progress of treatment.

AVAILABILITY FOR THE CAREGIVER ROLE

This variable is relevant in two contexts. First, absent caregivers cannot meet a child's needs. Parents who are incarcerated or whose whereabouts are unknown cannot meet a child's ongoing needs. Decisions about continuation in the role need to be based on the length of time the caregiver will be absent relative to the child's developmental stage and needs.

The second context concerns parents of children in out-of-home care. These parents or caregivers cannot develop in the role nor work on improvement of child-caregiver interactions without access to the child. Further, absence from the role on an active basis leads to deterioration in the parent-child attachment. Attachment is a learned behavior and, therefore, can be unlearned. Visitation that includes only social contact without opportunities for a range of caregiver role performances does not develop a caregiver's ability and undermines the child's and caregiver's attached relationship.

Key practice strategies include:

- Determine the duration of the caregiver's expected absence relative to the child's developmental needs;

- Determine and implement a plan of visitation that will respond to the child's needs;

- Where no visitation is possible within a timeframe appropriate to the child's needs, terminate parental rights and seek adoption.

CAREGIVER'S EXPRESSION OF NEEDS

How a caregiver expresses needs to the child partially determines the child's response to the caregiver. Continued failed responses with a caregiver who has a low frustration tolerance may lead to physical abuse or to neglect if the caregiver gives up. Assessment of this variable must focus on the caregiver's verbal, para-verbal and non-verbal expressions of needs and the match of these expressions with the child's cognitive ability, prior life experiences, and developmental stage.

Key practice strategies include:

- Observe caregiver-child interactions and determine nature of caregiver initiation with the child and caregiver's response to the child's initiation;

- Determine caregiver preferences in communication of needs to the child and in responding to the child's communication of need with the caregiver;

- Determine caregiver communications and responses likely to result in an abusive interaction or neglect of the child's needs;

4. Exploring earlier successful interventions with the family members;

5. Supporting the family members' identification of interventions to meet these needs;

6. Determining threats to emotional security and experiences of loss of security for the caregiver and family members, and implementing supportive interventions to restore this condition;

7. Supporting and enabling the family's use of these interventions;

8. Providing feedback and coaching the family members toward successful use of the interventions or reassessment and selection of new interventions if desired results are not being obtained;

9. Periodically redetermining the current level of safety factors and risk influences;

10. Determining the maximum time feasible for the child's need for permanence during which evidence of the family's ability to assure safety must be demonstrated;

11. Where safety cannot be achieved within the family in the timeframe of the child's developmental needs, assuring the safety and emotional security of the child through relative guardianship or adoption.

When safety influences require placement in foster or relative care, the following additional component of practice applies:

12. Developing a positive alliance between the alternate caregiver and the family members on behalf of the child.

The following six variables were identified as influencing family functioning. They are: culture, environment and resources, family member's expression of needs, the family's social network, family member's interaction management skills, and the family's awareness and perception of present functioning. In addition, the individual functioning of members other than the caregiver will affect family functioning.

CULTURE

Culture is "a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems." (Schein, 1992). Culture is expressed at several levels, these being artifacts (visible behaviors, symbols, and customs), espoused values (statements about preferred choices and solutions) and basic assumptions (beliefs that are taken for granted and exhibit very little variation within a cultural unit).

Key practice strategies include:

- Observe family member interactions and determine nature of members' initiation with each other and the response to this initiation;
- Determine member preferences in communicating needs and in responding;
- Determine member communications and responses likely to enable an abusive interaction or neglect of the child's needs;
- Determine with the family previously successful interactions and alternatives that might lead to success;
- Coach and support the family members in new interactions.

Family Social Network

The family's immediate support system is defined by its existing social network. Families in which neglect occurs have been characterized as lacking sizeable networks or as having networks that do not support problem solutions. In fact, some network members may enable current problems (e.g. a friend who engages in substance abuse or denies a family member's problem). The network is both a source and resource, and can contribute to the present problem. Attaining sustained change without involving formal helping systems may require reconstruction of the family network.

Key practice strategies include:

- Engage the caregiver and family members in an identification and assessment of the current social network;
- Identify the positive and negative contributions of current network members and needs not met within the network;
- Engage and involve network members by emphasizing concern for the welfare of the child or concern for the welfare of the caregiver;
- Support and enable network members in the roles they have agreed to perform in support of the family.

Family Members' Interaction Management Skills

A family's management of interactions will depend on the family's rules, boundaries, role organization, power distribution, and communication process. In addition, it depends on the individual contributions of members. Most adult skills are a combination of skills learned from parental modeling during childhood and adaptations made to adult family life. Because the family is a social unit, the ability of its members to successfully interact is as important as the individual capabilities of its members. Unfortunately, individual capability doesn't always mean system capability.

Influencing Child's Response to Caregiver

The key components of practice include:

1. Determining the child's expected behavioral capabilities based on age;

2. Determining present functioning through evaluation of patterns of initiation, expression of need to the caregiver, and response to caregiver;

3. Determining prior experiences with maltreatment and the adaptive patterns exhibited by the child in response to these experiences;

4. Determining caregiver capabilities indicated by the child's needs and adaptive responses;

5. Determining caregiver patterns of initiation and response to child's initiation;

6. Altering the caregiver's patterns of initiation and response to match with the child's needs through direct coaching and feedback;

7. Depending on the age and verbal ability of the child, engaging the child in clinical services designed to ameliorate the effects of maltreatment with the explicit permission and cooperation of the caregiver;

8. Engaging the child and caregiver in clinical services designed to support improved interaction;

9. Developing the capability of relative caregivers and foster parents to recognize and respond to children who have experienced maltreatment and who demonstrate adaptive responses that are a risk to the child.

There are three contexts to consider with this variable cluster. The first is the child-caregiver interaction where the caregiver is the birth parent. The second is where the caregiver is a relative or foster parent. The third is adoptive parents.

It bears repeating that this variable is not an indication that children cause their abuse. However, there are child characteristics that, when taken in relationship to caregiver characteristics, raise the risk of a child's maltreatment. To the extent that the child's characteristics can be modified, the probability of abuse may be lowered.

Child's Needs, Temperament

These variables are generally given and practice should take into context the demands these variables place on the caregiver.

Key practice strategies include:

- Determine needs and temperament tendencies;

CHILD'S TRUST IN CAREGIVER

Trust is an easy quality to destroy and a difficult one to build, especially after it has been violated. The cycle of maltreatment represents repeated violations of the child's trust in the caregiver. As trust deteriorates, the child may withdraw from the caregiver, inviting caregiver rage or abandonment. Restoring this trust is particularly important for children who have had continuity of their relationship disrupted by placement. Restoration of trust generally requires repeated success over time, a difficult condition when the child is with the birth parent for only briefs periods during visitation. Current caregiver and caseworker misgivings about the trustworthiness of the birth parents may be communicated unintentionally in much the same way that a birth parent non-verbally communicates anxiety to a child.

Key practice strategies include:

- Identify, through observation and verbally eliciting the child's perceptions, the child's trust concerns about the caregiver;
- Identify what actions on the part of the caregiver would provide reassurance;
- Coach the caregiver in trust-building interactions.

Influencing Child's Ability to Protect Self

The key components of practice include:

1. Providing the child with information to develop the child's differentiation of maltreatment from acceptable parental behavior;
2. Coaching the child in responses to caregiver initiation of maltreatment and in reporting maltreatment if it occurs.

Physical size differences and adult-child authority relationships render resistance to maltreatment difficult if not impossible. Yet a child who is able to recognize maltreatment may be able to report incidents and avoid subsequent repetition of episodes. Four variables appear to be related to the child's capacity for self protection. Two of these, age and disabling conditions, are not directly open to influence. The others, awareness of acceptable caregiver-child interaction and a trusting relationship with a protector, are open to influence.

AWARENESS OF ACCEPTABLE CAREGIVER-CHILD INTERACTION

Influencing this variable may require a trusting relationship, for the child may be fearful of even discussing maltreatment. Given this relationship, there are strategies for influence.

Key practice strategies include:

- Give the child information about acceptable adult and caregiver interactions with children;

As a result of this type of caregiving, a child develops a sense of basic trust, the capacity to give up immediate gratification for later reward, a sense of self, a sense of efficacy, the capacities to cooperate, compete and to love, and ultimately functional autonomy. Without emotional security, a child has little capacity to devote any energy or attention to the tasks of either cognitive or emotional development.

Basic trust comes from a primary attachment to a caregiver. It derives from having biological needs met consistently and in a manner that does not allow an infant to become overwhelmed. Basic trust is the feeling that one will survive and is not at the hands of a violent caregiver or in danger of annihilation through neglect.

Frustration tolerance presupposes the capacity for basic trust. It develops within an attachment relationship, encouraging the child to give up his immediate gratification for the love of the primary attachment object. This is possible because the love of the other is valued by the child and because the delay in gratification is kept to a tolerable level. Admiration and love is consistently supplied as the promised substitute. It is the ability which allows developmental progress in areas such as toilet training and learning to read.

Identity is a state of being which is experienced as continuous over time. It comes from being treated as a valuable individual with wishes, needs, and motives of one's own. It develops within the primary attachment relationship with a consistent caregiver who treats the child as real, i.e. a person who is able to reflect to the child that he is being experienced by another as important and that the child's accurate perceptions are validated rather than ignored, defended against, or denied.

A sense of efficacy comes from the context of the primary attachment relationship, and later through successful interactions with others. It evolves from both the experience of having an effect on the environment and from being loved and admired for one's development. Thousands of day-to-day experiences contribute to one's sense of efficacy. Events such as a child finding his own thumb and being able to consistently put it in his mouth, moving a toy, attaching a sound to a word with meaning, making his caregiver respond positively, and being able to throw a ball all contribute to a sense of efficacy. Likewise, the lack of appropriate admiration and mirroring can lead to a sense of failure and doubt about efficacy. A caregiver's admiration, sense of hope, and confident expectation, or the lack thereof, all contribute to a child's sense of efficacy.

Cooperation and competition are developed within the family and with peers and other adults. These capacities develop as a result of having shared goals and rules about how to proceed. Cooperation and competition are interpersonal skills acquired in a social context and nurtured by the giving and receiving of positive regard and support for goal achievement.

Love is the capacity to put another's needs, wishes, and gratification before one's own. It allows one to share ones self and belongings with another. The capacity to love is a necessary condition to be able to provide for a child.

For birth parents, it is difficult to trust those who have taken away the family's children. Similarly, it is difficult for the parents to trust the motives of the alternate caregiver. Typical birth parents' reactions to this loss of emotional security may include efforts to undermine the child-caregiver relationship, or to forego the attachment to the child as a way of easing the pain and shame of the loss.

Similar issues exist for alternate caregivers and caseworkers. Foster parents who experience emotional insecurity may undermine the child birth parent relationship. Caseworkers experiencing emotional insecurity may seek to employ controlling strategies with birth families and alternate caregivers.

Resistance, common in efforts toward human change, comes from underlying feelings associated with vulnerability and loss of control. While it is a natural component of change, it can be significantly increased when the impact of interventions on emotional security is not recognized. Intervenors can be both proactive and reactive. Proactive efforts minimize threats to emotional security in the basic design of the intervention. Reactive approaches seek to ameliorate the effects of loss and to demonstrate empathy for the loss.

What is commonly labeled as non-cooperation on the part of parents is most often a reflection of their reaction to the emotional insecurity created in their lives as a result of the intervention. The impact of this on efforts to help can range from simple resistance to a refocus of the entire intervention on control issues.

Strategies for Emotional Security

The components of practice in emotional security include:

1. Assuring the physical safety of family members;

2. Maintaining attachments that are essential to the long-term plan for safety;

3. Retaining elements of identity essential to a sense of self and well-being;

4. Developing trust with and between family members;

5. Promoting and restoring autonomy.

A child experiences loss of emotional security due to maltreatment and to interventions by DCFS to address maltreatment. In the former instance, threats to physical safety and survival represent a major source of insecurity. However, placement of a child in foster care, while it may provide for practical safety, does not alleviate this insecurity. In fact, it raises new areas of concern for the child who may now depend on persons previously unknown to the child or his family for survival.

Where children are separated from their family of origin, the cumulative effect of time raises new issues of emotional security. Because it appears less likely that permanence will be experienced in a relationship with the birth parent, the child inevitably wonders if it will exist all. In other words, will there be attachments that offer continuity and trust over time? This forms a basis for permanency planning and the desire to resolve the issue of permanence quickly. Replacement from home to home tends to destroy the basic capability for trust (Littner, 1977).

For parents, the primary threat to emotional security stems from the loss of family autonomy inherent in state intervention. With loss of control comes loss of trust. Similarly, the removal of the child leads to loss of family identity and attachments. Whether or not placement actually occurs, these threats are present in parents' minds.

Five primary variable clusters support emotional security. These are physical safety, attachment, identity, trust, and autonomy. Intervenors must consider their impact on each of these variables. While the ultimate goal is emotional security, emotional insecurity is one form of present discomfort that supplies energy for change.

One of the dilemmas of long-term foster care is that the discomfort of the separation of child and family dissipates, thus removing the tension necessary to resolve the parent and child's ambivalence and create permanence for the child. This implies an element of practice using existing feelings of insecurity as an element of the change process. However, utilizing discomfort arising as a logical consequence of a family's behavior is distinct from the creation of discomfort as an arbitrary or punitive act of the intervenor.

For purposes of discussion Fahlberg's distinction between attachment and bonding is used here. Attachment refers to the child's connection to the parent and others. Bonding refers to the parent's link to the child. Interference in the parent-child bond and attachment presents the possibility of harm to the child, a harm that may be just as consequential for the child's development as maltreatment by the parent.

For this reason, separation of child and parent must be considered carefully. The attachment between child and parent must be considered even when the child remains in the care of parents.

When children move into foster care, they are faced with forming new attachments to their caregivers. It is not sufficient that the child remain attached to the birth parent. Attachment to the caregiver is necessary for continued growth and development. Similarly, attachment to birth parents is essential to maintaining the motivation and commitment to remain in the original parent-child relationship.

The requirements for bonding and attachment vary with the child's stage of development. For infants, the nervous system becomes progressively more organized over the first year of life. Children gain muscle control from their head downward; therefore, attachment begins with the control the infant gains in his face. An infant first learns to focus on objects eight or nine inches away, often the distance between the infant and a mother's face. Face-to-face contact is important to the formation of attachments in early life. Infants who are separated from their mothers at birth may require significant visual contact with the mother in order for attachment to develop.

Significant aspects of bonding and attachment occur during the first three years. This does not mean that attachment cannot develop later. Otherwise, adoption of older children would not be possible. However, it does imply that visitation between parent and child for very young children needs to be frequent if the plan is to reunite the parent and child. Without frequent visitation, the child may exhibit characteristics of the insecurely attached child. These children have less self-esteem, express more negative affect, are less resilient, independent, compliant, empathetic, and socially competent than others (Stroufe, 1983).

Key practice strategies include:

- While loss of attached relationships may be a consequence of a caregiver's failure to protect or nurture a child, the threatened loss of the child should not be used as an inducement to change;

- Intervenors should create an alliance in support of the parental bond with the child and the child's attachment to the parent;

- Alternate caregivers should form an alliance with the birth parent in support of the parental bond and the child's attachment to the parent;

- Interventions should demonstrate a concern for strengthening the parent-child connection;

TRUST

According to Rutter (1981), children between six months and four years of age experience the most emotional distress over parental separation. Younger children have not yet developed the capacity for selective attachments, and older children are more likely to have the skills necessary to know that attachments can be maintained. The risk associated with separation during the toddler years is the interference with the balance of autonomy and dependency (Fahlberg 1991). This leads to the fear in children that adults will not be there when needed.

Maltreating parents have likely experienced their own broken trust relationship early in life. Removal of a child from the family may be seen as yet another confirmation that one can't count on relationships. When this occurs, the parent may conclude that reliance on the child is not possible, leading to emotional abandonment.

Key practice strategies include:

- Assure consistency and immediacy in responses to child and parent;
- Assure continuity in relationships between caseworker and family and between child and caregivers;
- Enable the grieving process by supporting the expression of feelings by both child and parent;
- Explore the child's perception of the separation from the parent and the reasons for it, resolving instances of magical or egocentric thinking;
- Resolve the separation to enable new attachments;
- Minimize the trauma of moves through pre-placement preparation and post-placement contacts;
- Enable the birth parents to help the child move;
- Minimize loyalty conflicts for the child and parent;
- Prepare the child and family members (birth, foster, relative and adoptive) for moves and expected changes.

AUTONOMY

The resolution of dependence versus autonomy is a basic developmental task. Both children who have been maltreated and parents who maltreat may have histories indicating difficulty with resolution of these issues. Even where resolution occurred successfully, one might expect resistance to the loss of autonomy. In involuntary child welfare interventions, the loss of control can be even more significant.

attachments to birth family members (family preservation). Because safety, both present and future, represents the greatest threat to permanence within the birth family, safety criteria take precedence in decisions. These competing variables should be reflected in the model for permanence.

Among the key variables DCFS must influence are the birth family's ability to provide for safety, the agency's ability to demonstrate reasonable efforts, the child's emotional security (including resolution of the loss of the birth family and resolution of the effects of maltreatment) and the agency's ability to influence and support a commitment to the child by another family (including relatives, an adoptive family, or a foster family).

The dynamics of permanence depend partially on whether permanence is experienced within the birth family or in an alternate permanent living arrangement such as adoption or relative guardianship. Separate discussions follow about each situation. For purposes of the practice model, family preservation, by preventing the threats to the birth family inherent in placement of the child, and family preservation through the restoration of the autonomy and efficacy of family functioning through reunification, operate on similar variables. Practice and service strategies will differ in each context.

While the child receives care within the family, the greatest threats to family preservation are the treatment dynamics and environmental conditions that raise issues of child safety. Once the child is removed from the family, significant agency and system variables come into play.

Family Preservation

Key Definition:

- **FAMILY PRESERVATION**
  Family preservation is a strategy for assuring emotional security for a child through the development and maintenance of attachments, identity, autonomy, and efficacy in family member's relationships.

  - When children are safe in their family of origin, family preservation first means providing permanence by having the child remain in the care of the family of origin caregiver(s), and second by the child returning to their care in the shortest time possible.

  - When children cannot be considered safe in the care of their birth parent(s), the child's attachments and identity are preserved through extended family or relative caregivers. Though identity and attachments are preserved, this arrangement means the loss -- temporary or permanent -- of the full autonomy and efficacy of the birth parent and child relationship.

  - When children are not safe within their extended family network, children are assured that attachments and elements of identity with their family of origin which present no threat to safety should be maintained according to the child's

containing the structural elements listed previously. Yet no other term fits the expanded practice concept as well as family preservation.

The principle variables influencing family preservation are shown in *Diagram 8*. There are four principal variable clusters. These are agency, parent/family, caregiver (in circumstances where the child is in out-of-home care), and child.

Examination of the agency cluster appearing in *Diagram 8* quickly reveals why entry into care makes the achievement of permanence more complicated. The addition of significant additional parties expands the alliance network and multiplies the number of people who must reach agreement to proceed.

The caregiver cluster also reveals new dynamics of practice. The birth parent and child clusters also have new relationship dynamics. Where the focus of practice could once be placed primarily on the birth parent-child interaction, multiple interactions now require management with a corresponding increase in time, personnel, and resources.

When the birth parent's physical caregiving responsibility has been interrupted by a safety plan that includes placement, family preservation interventions exist at two levels. The first level includes efforts to restore the autonomy of the birth family as the primary caregiver. The second involves efforts to assure continuity of identity and the efficacy of the birth parent in that do not represent threats to child safety. The maintenance of these roles is essential to the emotional security of the child and birth family, and to maintenance of attachment. The exchange of needs and responses between parent and child represents the principle means of maintaining and building attachment. Placement disrupts this cycle of need, leading to lost attachment over time.

When the permanency goal is attained through relative guardianship, elements of family preservation remain possible. Siblings can remain together, and birth parents may still be able to have some connection to the child, even at the level of a legacy of information about origins. Self worth is closely tied to identity. Acceptance of these origins by adoptive families provides a basis for the child's emotional security.

Even when permanency cannot be attained and the child exits care to independent living, elements of family preservation are essential. As many as 50 percent of youth exiting care return to their families within one year. This suggests that a component of work with these youth should involve family restructuring, or preserving the elements of the birth family that can become a source of support for the young adult.

For another population of children, efforts toward permanency are even more confusing. These are children who remain in care while other siblings are returned home. Such circumstances increase the likelihood of self-blame and loss of self-esteem. *While the decision may pragmatically make sense, the effects on children remaining in care should become an additional focus of work with the child and family.*

Agency Cluster

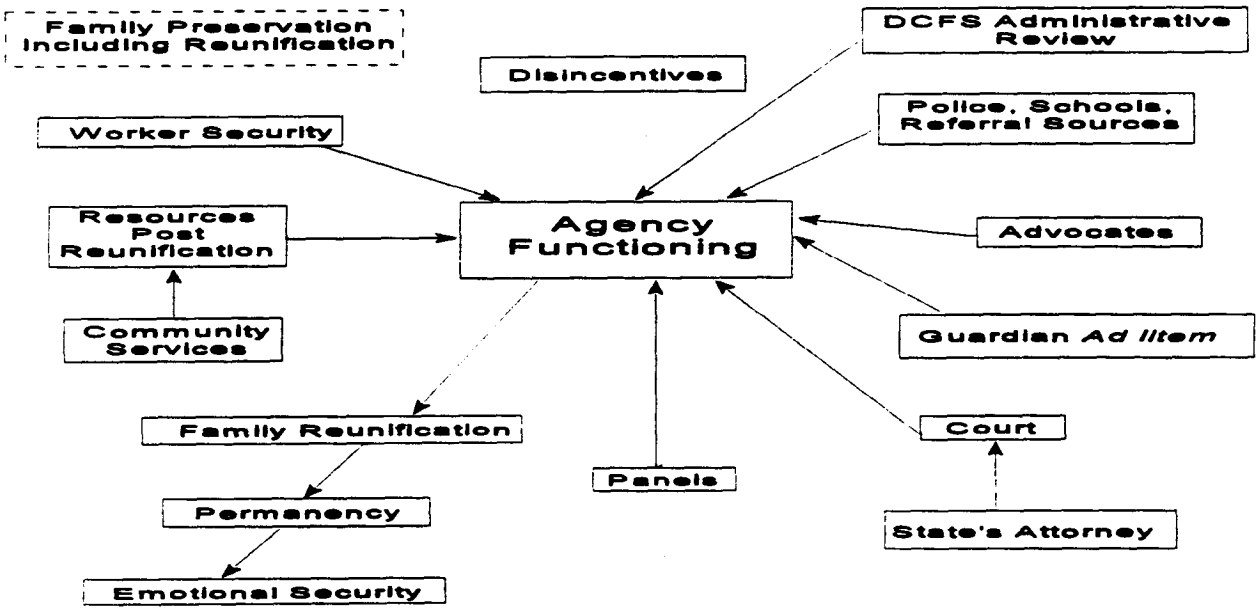

Diagram 9

Birth Family Cluster

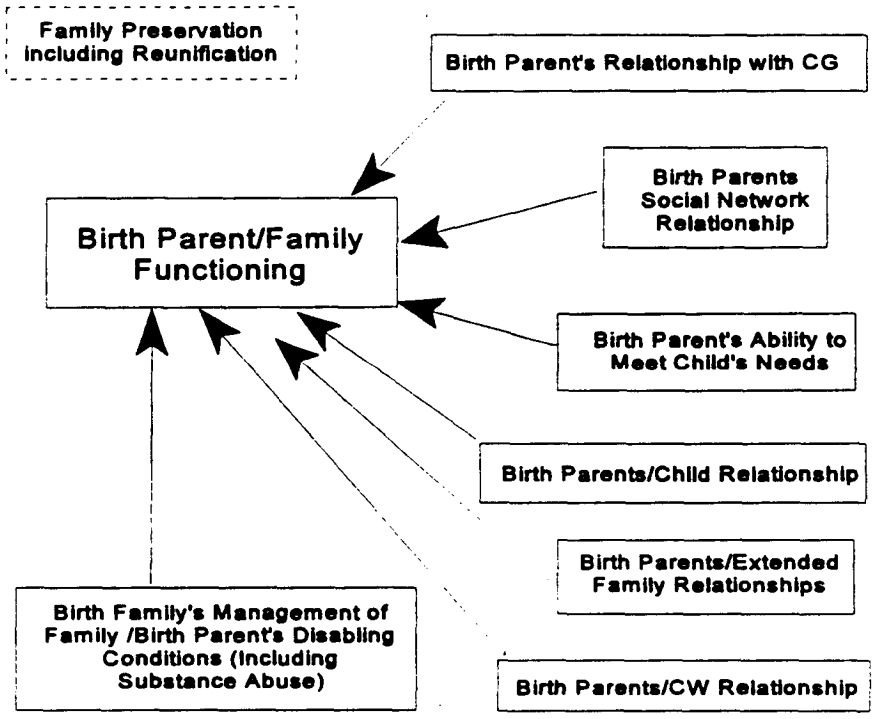

Diagram 11

Strategies for Family Preservation

Four variable clusters have been identified for family preservation. These clusters relate to the birth parent and family, the child, the agency, and the caregiver who is not the birth parent. The integrity of the birth family is threatened when the safety of the child cannot be assured. Certain circumstances may preclude safety interventions that permit the child to remain in the birth family. These include a caregiver who is violent and out of control, a child who has suffered significant harm, a child who has been sexually abused (and the child cannot be protected from the abusing person in the home) or a caregiver whose substance abuse seriously affects their ability to assure the child's safety.

Family preservation services are most commonly used where crises within the family have reduced caregiver and family functioning to a level where the child may become unsafe. The nature of the crises will determine the intensity of the intervention. Traditional models have focused on short-term (90-180 days) intensive interventions to stabilize the crises, address concrete service needs, and restore the family to baseline functioning, such that the child may still be at risk but is no longer unsafe.

It is recommended that a continuum of family preservation strategies be employed, all in the same practice model but with different levels of intensity (a dimension of the service model). All caseworkers would work with families based on the same causal model and intervention strategy, but the service model might vary with intensity of effort and availability of resources.

Of the elements identified by Whittaker and Tracy (see page 62), four contain elements of practice strategy. These are: focusing on the family as a unit, a crisis orientation, teaching skills to family members, and basing services on family need rather than strict service categories.

Consistent with the definition offered earlier, family preservation services would be defined by the following categories:

1. **Intensive interventions to prevent separation of a child from the current caregiver.** These services would be short-term and intensive family-centered interventions where crises in the family, including maltreatment, suggest that a child may become separated from the family. These services would be used primarily in instances where the child's continuation in the birth family is threatened by issues of safety. The second use of these services would be in adoptive families where adoption disruption or dissolution is threatened. The third use of these services would be in reunited families where new crises threaten re-entry into care. These services also would be in foster and relative care placements, where continuation of the placement is in the best interests of the child.

2. **Placement of a child outside of the birth family but within the family kinship system.** As noted previously, this allows the child to retain elements of identity and attachments to members of the child's kinship network.

Influencing Alternative Caregivers

The key components of practice include:

1. Preparing and selecting caregivers capable of and willing to develop a positive alliance with birth parents on behalf of the child;

2. Placing children with caregivers whose strengths match child and birth family needs;

3. Developing a team relationship between the caregiver and agency;

4. Including the caregivers as part of the family's social network;

5. Including the caregiver in the development of the helping strategy with the birth family;

6. Establishing regular contact between the caregiver and birth parents based on the caregiver's reinforcement of the birth parents' positive actions toward the child.

AGENCY/CAREGIVER RELATIONSHIP

The influence of this relationship begins with the recruitment, preparation, and selection of the caregiver and is reinforced through the ongoing qualities of the relationship. *Caregivers must be recruited for a role that includes supporting birth families and that is not based on rescuing children from undesirable families.* Preparation and mutual selection is preferable to strategies of training and assessment. Preparation includes role competency development, but also addresses one's own readiness to accept the role. Mutual selection requires open disclosure of mutual expectations, mutual examination of each party's capacity and interest in responding to these expectations, and explicit offers of support and exchange when expectations are met.

Current practice tends to emphasize assessment and training. Often an agency's approach to assessment is experienced by parents as an investigatory means test in which the "means" are kept secret. Caregivers feel the experience is very one-sided. At worst, this dynamic begins a process of keeping information closely guarded rather than openly sharing it. Once children are placed with the caregiver, the dynamic erodes trust, cooperation, and teamwork.

Key practice strategies include:

- Base decisions and actions on joint agreements;

- Negotiate clearly defined role agreements between the caseworker and caregivers;

- Support direct expression of feelings and needs, and model through the agency/caregiver relationship the type of relationship, the agency wants the caregiver to have with the birth family and child.

Key practice strategies include:

- Identify strengths the child has gained from network members;
- Facilitate continuity of relationships that have been a source of support for the child and offer continued strength in the future, including family and peer relationships.

CASEWORKER/BIRTH FAMILY RELATIONSHIP

A positive working relationship between the caseworker and the birth family enables a positive relationship between the caregiver and child and the caregiver and birth family. The caseworker is a source of reassurance to both families in regard to their uncertainties about each other and about the child.

Key practice strategies include:

- Focus on providing positive feedback to the birth family about the caregiver's respect for the birth family and child relationship;
- Avoid, at all costs, triangulating birth parents and caregivers;
- Help the birth family include the caregivers as part of their support network.

CAREGIVER/CHILD RELATIONSHIP

The caregiver/child relationship offers the child a sense of emotional security and a source of nurture. The child's emotional security depends on a sense of physical safety and on the continuity of the child's relationship with attachments and sources of identity. These are necessary ingredients for reunification and preservation of the birth family in the long term. Historically, practice has focused on the daily care and nurture of the child, with the assumption that a positive environment would ameliorate past damage and continue normal development.

Unfortunately, this thinking overlooked the impact of lost emotional security on the child's development. Although many caregivers implicitly recognized needs stemming from the loss experience, response to these needs has been neither consistent nor systematic.

The child's attachment to the alternative caregiver is necessary for continued development. The continuity of the child's attachment to the birth family is necessary for reunification with the birth family and for the resolution of the birth parent/child relationship. Caseworkers appear most comfortable with the caregiver's parenting role and least comfortable with the caregiver's role in permanency planning. Permanency is most likely to occur when the caregivers identify with the permanency planning role and view getting children safely back home as their responsibility as well.

Whatever the choice, the standard of care for out-of-home care must be well above the minimal standard it uses to justify the decision to remove children from their families. Where there is not a sufficient difference, the lost emotional security means a net loss for both child and birth family.

Is foster care a practice or a tool for practice? Historically it has been seen as a field of practice, a subset of the larger field of endeavor called out-of-home care. It has been financed and administered. It contains it own unique requirements owing to the recruitment, preparation, and selection of foster families.

Yet the most relevant question may be how foster care fits in the DCFS model of practice rather than what should the model of foster care practice be. Foster care is primarily used as a safety intervention. With the intent to reunify the child and birth parents. Foster care can offer a short-term safe circumstance where the child can continue development and be assisted with physical, cognitive, and developmental needs arising from the experience of maltreatment. The separation of parent and child provides tension and discomfort needed to resolve the parent's ambivalence about their role in the child's permanency and safety.

There are several implications for the design and practice of foster care. First, it must be considered as a specialized service in the child protection intervention rather than a separate "holding" system where the child remains while work continues with the birth family. It must be viewed as an extension of the birth family system. The child and birth family must be treated as a unit even though its members are separated. The fact that other caregivers have a principle responsibility for the child's care requires special efforts to keep the child connected to the birth family system.

Second, because this is not the traditional role of foster families, careful consideration should be given to preparing and selecting foster families. This role is important to the success of the child-birth parent relationship. Foster families who cannot perform this role should not foster children in the child welfare system.

Third, the caseworker must be an active bridge to support and enable the success of the relationship among the child, birth family, and foster family. There are significant trust barriers to the success of this relationship. Active direct work is required to facilitate the development of this trust.

Fourth, maltreated children often have special needs. These unique needs can create significant stresses for foster families. Families should be prepared for these specific stresses and children matched with caregivers who exhibit strengths matched to the child's needs.

Since 1977, there has been a concerted national focus on permanency planning for children in foster care. This movement has stressed timely decision-making, by applying pressure to parents, agency, courts, and other systems to resolve the child's emotional limbo. If there is a downside to this movement it is that there has been more emphasis on decision-making than on the work with families necessary to permit reunification. Foster care caseloads nationally have risen more from absence of exit than increased entry (Toshio Tatara, APWA). Without effective practices enabling families to be reunited, increased decision-making may push more children into the

Following the Oregon Project, much attention was focused on decision-making for children in care. While PL 96-272 contained provisions requiring periodic case review, pre-placement preventive services, and reunification services, little substance was required to meet the terms of the legislation in the last two areas. Though case review became institutionalized, practice in many states evolved into an effort to assure certification for Title IV-E funding rather than developing a true utilization review mechanism.

Practice seemed to be separated, with the foster family caring for the child and the agency focusing on permanency decision-making. Two studies by the Child Welfare Institute during the 1980s examined the role of foster parents in permanency planning. One found that caseworkers were strongly resistant to foster parent's participation in the permanency planning role. Another, demonstrated that the foster parents' ownership of the permanency planning responsibility and role was a significant predictor of a child leaving care to a permanent placement rather than another placement.

These and other studies suggest that foster care must be an active resource in the permanency solution. Though foster parents seem willing, agencies have been resistant to developing foster parents in these roles. Practice suggests that foster parents are more willing to have direct contract with birth families, participate in case review, and advocate for permanence than agency staff are willing to acknowledge. It also suggests that outcomes improve when these roles are played by foster parents.

This suggests a model of foster care practice based on the concept of supplemental care and shared parenting rather than substitute care. The foster family supplements the capabilities of birth families in areas of safety and development, while not trying to replace the birth family as the psychological parent. Further, there is an active effort to develop a positive parenting alliance between the foster parents and the birth parents.

Unfortunately, this is not the social contract offered to most foster families. Agencies are frequently reluctant to forward these conditions for fostering for fear of having no resources. Ironically, the quality of care may decrease more because agencies fear demanding quality than because they demanded it and frightened prospective families away.

This suggests an approach to practice similar to that posed for adoption. In this context, the key components of practice include:

1. Basing recruitment messages on the child *and* birth family's needs rather than on the child's past experiences;

2. Combining preparation and selection processes;

3. Basing preparation and selection on criteria related to accepted child needs in foster care and implications for family strengths;

4. Basing approval decisions on a process of mutual selection between the family and agency;

These factors suggest a different strategy for relative care practice. Though an emphasis on permanence remains, the preservation of the family in an extended context offers less tension to resolve the ambivalence in the birth parent and child relationship than does foster care. Further, there is some evidence to suggest that relative placements are more stable and that children fare better in these placements.

The key components of relative care practice include:

1. Selecting relative caregivers for a child with the broadest possible participation of the extended family network;

2. Since placement in relative homes often occurs in close proximity to the birth family crisis and without time for preparation of caregivers, an educational support group format should be used in lieu of traditional training or preparation methods with foster and adoptive families;

3. The unit of intervention should be the extended family network responsible for caregiving and should include the birth parents and the relative caregivers;

4. Case plans should be developed jointly with the birth parents and the relative caregivers and the relative caregivers, should be defined as part of the support system for implementing the plan;

5. The relative caregiver's goals for the children should be clarified at the beginning, and their commitment to these goals made part development of the plan for the birth parents;

6. Interventions should take into account the impact of the agency on the social organization of the extended family system and include as part of the intervention members impacted by the intervention;

7. Given the longer duration of relative placements, selection of caregivers should be based on different expectations about the duration of care than with non-relative caregivers, unless the agency foresees shorter terms of care.

Adoption and Relative Guardianship

Key Definitions:

- **ADOPTION**

  Adoption is a strategy for assuring safety and permanence for children by legally transferring ongoing parental responsibilities from their birth parents to their adoptive parents.

- **RELATIVE GUARDIANSHIP**

  Relative guardianship is a strategy for assuring the safety and permanence of a child through a commitment by relatives to the permanent care of a child.

Another dynamic emerges as to the decision process of which relative will assume care for the child. At the time guardianship is assigned, the relative will have been selected, but the earlier decision for the child to live with the relative may have been made either primarily by the agency or primarily through a broader family decision process.

A third consideration is the child's self-blame for the separation and sense of responsibility for the condition of the parent leading to the separation. Pre-existing family dynamics may either compound or support the child's needs relative to these issues. Consideration of relatives should include an assessment of the history and family dynamics.

Adoption – Adoptive Family Cluster

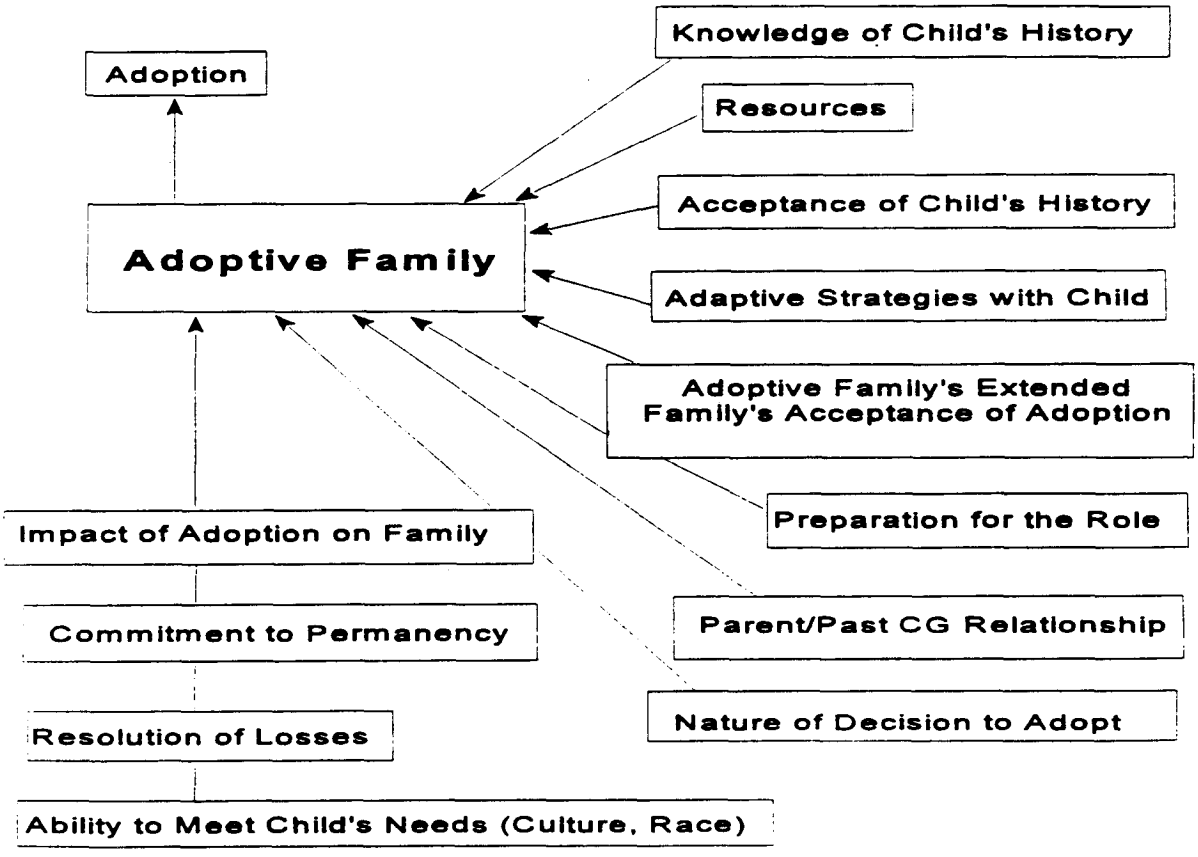

Diagram 14

6. Assuring continuity of the casework for the child, birth parents, and caregivers during the transition to adoption;

7. Preparing the birth parents to leave the child's information and other items that may be necessary to the child's future adjustment and development;

8. Supporting the birth family's loss experience;

9. Supporting the caregiver's loss experience;

10. Supporting the child's loss experience and attachment needs;

11. Assisting the adoptive family with formation of a support network specific to the needs of their family in adoption;

12. Enable the adoptive family to access resources, including adoption subsidies, that may be necessary to meet the ongoing needs of the child;

13. Coaching the adoptive family through the initial crisis of integration of the child into the family.

Decision-making About Adoption and Relative Guardianship

Children remain in care without permanence for several reasons. Prominent among these is failure of the agency to establish clear criteria with families for meeting safety needs of the child and for demonstrating the capability to do so. Frequently, case plans are developed with goals identifying tasks for families rather than behavioral change indicators.

The development of indicators should consider the child's developmental stage and needs along with the prognosis for the parent's ability to assure the safety of the child. Though public policy has used eighteen months for a determination, actual practice varies, with many children and families extending long beyond this timeframe. While there are few rules applicable to human behavior for which there are not exceptions, practice must still have guidelines. The following principles are suggested, and are consistent with current DCFS policy:

- For individual children under the age of three, the permanency option should be resolved in no longer than one year. This means that children should be in a permanent placement within two years, from entry into care;

- For children in sibling groups, in which there are children over the age of three, the permanency option should be resolved in no longer than 18 months. This means that the sibling group should be in a permanent placement within three years;

- For children who will enter relative guardianship or be adopted by their foster parents, the timeframe should be shortened by six months.

These guidelines will obviously be modified in contested procedures. But delays in court proceedings should not routinely be accepted as a reason for delay without first considering the agency's contribution to these delays.

The second and third objectives are made more difficult by the use of "rescue the child or agency" themes. Families respond and then are often told to wait. They are angered by the mixed message of "We need families desperately but we don't need your family right now."

Optimal results can be achieved when preparation and selection are combined, rather than performed separately. Results also improve when families are given clear criteria for selection that are the basis for both approval and parent development. The message is that the agency needs families who can demonstrate these capabilities, and it will invest in helping families who want to consider adoption by helping them develop these capabilities.

The process of preparation involves six interrelated components. First, families must receive information about what capabilities are needed. Second, they must be helped to acquire the skills needed to succeed in the role, while recognizing strengths from past experiences. Third, they need to use these skills in simulated activities so they can assess how this role feels. Families may be not comfortable with aspects of the role.

Fourth, they must be helped to decide if they want to perform the role. This decision is usually based on assessment of their capability to succeed and their perception that performing the role will lead to satisfaction. Next, they must be helped to decide if they want the role. For part of the adoption process, the family and agency will work as a team. It is always possible that a family may want to adopt but not through a specific agency. Finally, families must be helped to decide if they want to adopt a specific child.

Key practice strategies include:

- Base recruitment messages on the child's future needs rather than on past experiences;
- Combine preparation and selection processes;
- Base preparation and selection on criteria related to accepted child needs in adoption and implications for family strengths;
- Base approval decisions on a process of mutual selection between the family and agency;
- The preparation strategy should include skill self-assessment, skill development, on personal feelings about use of the skills and the role, and assessment of impact on family and lifestyle;
- Selection strategy should be based on clear and announced criteria, open disclosure of information to families, and mutual consideration of all information used to determine the family's fit with the agency's needs;
- Upon placement, the family should be supported with coaching rather than monitored.

Therefore, influencing the child requires direct work with the child and with the adoptive family to help them address the child's needs at future stages of development. This work takes place in several contexts. One is identity. Children in care frequently lose contact with elements of their history. They may have moved several times and lost many of the artifacts of childhood such as pictures, stories about when they did . . ., or possessions from earlier ages. Life books and similar techniques have proven useful as ways to help children reintegrate memories and deal with losses.

A second context is the transition to adoption. This means a new status and identity. Surprisingly, many children adopted by their foster families reported not knowing they were adopted. Children may have fears and questions about what it means to become adopted. Moving to a new family forces the issue of whether the child will lose contact with yet another family.

The third context is loss. There are losses and gains associated with adoption. Though gaining a permanent family, the child loses aspects of identity from the foster or relative home, friends made in the neighborhood, and the security that may have come from familiarity with surroundings. These and other losses need to be addressed.

Key practice strategies include:

- Enabling the child to express feelings associated with the transition;
- Preparing adoptive parents to address developmental grieving issues as they arise;
- Enabling foster parents or relative caregivers to express their positive feelings about the child's transition to adoption and giving the child psychological permission to leave;
- Matching the child's needs with adoptive family strengths;
- Placing the child with siblings, and if not, assuring ongoing contact and visitation to reassure the child about the well-being of siblings;
- Providing the child with information (over time) about members of the birth family who were left behind.

Influencing the Birth Parent and Family

In many cases, parental rights will be involuntarily terminated. This does not justify a lack of effort to support the birth parents' contribution to the child's future. The focus of practice should be on separating the parent's feelings about the loss of the child and the positive feelings the parent has for the child. This is accomplished by helping the birth parent focus on the child's needs in the future and their ability to make a positive contribution.

In some instances it may be desirable for birth parents and family members to have direct contact with the child. In other cases, it may be difficult to avoid. Older children may know the location and phone number of the birth family. The degree of openness in adoption should be based on a

Strategies for Child Development

Child development refers to the acquisition of cognitive, behavioral, emotional, and social capabilities needed for self-sufficiency and interdependent functioning in society. Variables influencing child development appear in *Diagram 21*. A primary reason for DCFS' and the public's concern about child maltreatment is its effect on child development. Interventions designed to interrupt the cycle of abuse and neglect presumably permits natural resiliency to take hold and allow normal development to proceed. However, the policy position in regard to child development is less clear.

There are two primary interests in child development. First, child neglect, a form of maltreatment, represents a failure on the part of caregivers to assure developmental opportunity for a child. Neglect is often referred to as an act of omission rather than commission. If caregiver actions necessary to assure minimal developmental opportunity are present, a child's failure to develop is not considered maltreatment. Therefore, the first interest rests with the presence of caregiver behavior rather than with the condition of the child. The child's condition will be a factor in determining the extent of the maltreatment.

The second interest arises when children enter the custody of DCFS and live in DCFS care arrangements. Here DCFS has assumed responsibility for meeting the child's developmental needs. When DCFS has taken custody and the child is in the care of a DCFS approved or licensed caregiver, there is responsibility to assure optimal development within the child's range of developmental capabilities. For children adopted from DCFS' custody, adoption subsidy establishes the precedent for financial participation in services designed to support the child's development.

There are inherent conflicts in either position. Assumption of responsibility requires significant resources. Avoidance of responsibility may only defer ultimate responsibility and at higher costs. In either case, no practice model may be achievable until the matter of public policy is clarified in regard to DCFS' responsibility.

Given the general agreement on some responsibility for children in custody, some assumptions are possible. Parents and other caregivers are the primary socializers of children. In modern society, their capacities are supplemented by institutional resources such as schools. For children above the age of five, peers, neighborhood and school may have the greatest influence on social development. These three variables, along with family functioning and caregiver individual functioning, may account for the most variance in child development, and therefore would be the best targets of intervention.

Influencing Child Development

Parents (or those who perform the parental role) are the single most significant source of developmental opportunity for a child. Following parents are school and neighborhood. The focus of DCFS' responsibility for child development is twofold. The first is to assure that the family of origin meets a minimal threshold of behavior to assure the child minimal developmental opportunity. When this does not occur and the child is placed with others, a

Variables Influencing Child Development

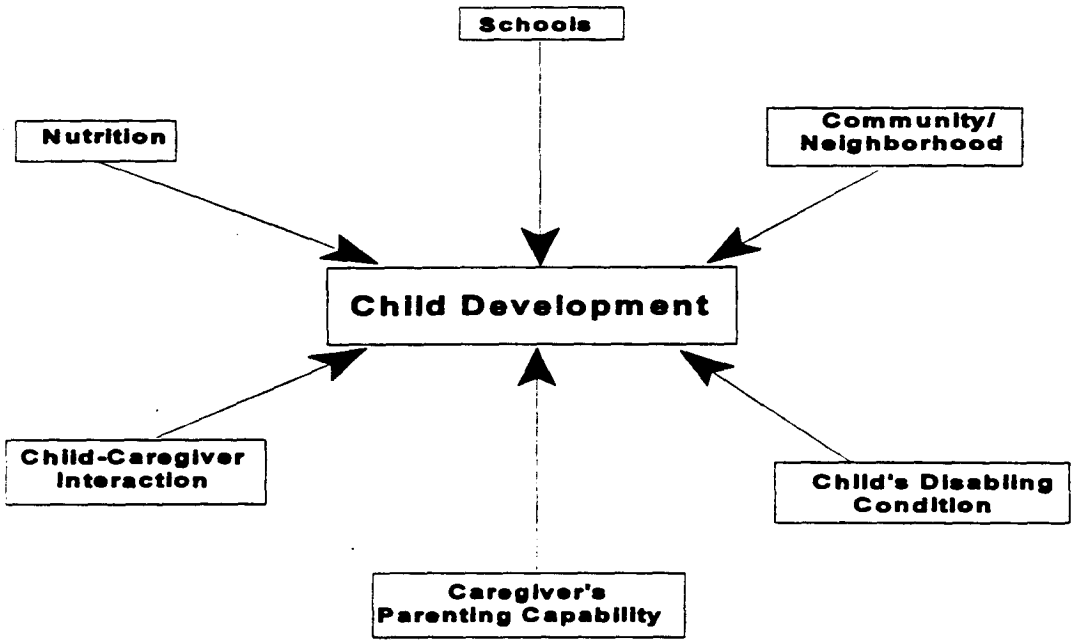

Diagram 21

5. Provide resources to support the physical and financial needs of the youth during transition;

6. Enable the youth and foster family, or youth and relative caregivers, to negotiate roles and boundaries for the relationship following the youth's exit from care.

Effects of Maltreatment

The principal clusters of impact variables for ameliorating the effects of maltreatment are displayed in *Diagram 22*. The clusters are the caregiver's relationship with the child; the caregiver's extended family and network's response to child's needs; resources available to meet the child's physical, emotional, social, and cognitive developmental needs; and the child's cognitive/behavioral adaptations to prior abuse and neglect experiences.

Influencing the Effects of Maltreatment

Research on resiliency in children suggests that an important factor in recovery from traumatic life events is a positive relationship with an interested, caring adult. The adult frequently is not an immediate family member. This finding punctuates the important role foster parents and caseworkers can play in a child's recovery from the effects of maltreatment.

Effects of maltreatment can be separated into physical, cognitive, and emotional impacts. Physical impacts include trauma requiring medical treatment and delayed physical development requiring a combination of social, medical and nutritional interventions. They are visible and commonly receive attention. Cognitive impacts are most frequently expressed as developmental delays. Individualized work with the child to accelerate development of skills and capabilities can overcome many such delays. Psychological impacts are more difficult to determine. Symptoms of these effects may not be visible for years. In other cases, they may be immediately obvious.

Effective practice should include assessment of the impact of maltreatment on the child in each of these areas and development of a plan with alternative caregivers to remedy the observed impacts. Responsibility for implementation should be transferred to the birth family upon reunification, and should be a specific part of work with the family where the goal is reunification. If the goal is adoption or relative guardianship, responsibility for future work will be transferred to the adoptive family or guardian.

The key components of practice in treating the effects of maltreatment include:

1. Determining the physical, cognitive and emotional impacts of prior maltreatment;

2. Determining the child's needs that exist as a result of these impacts;

3. Developing specific intervention plans with caregivers to meet the child's needs;

Variables Influencing Effects of Maltreatment

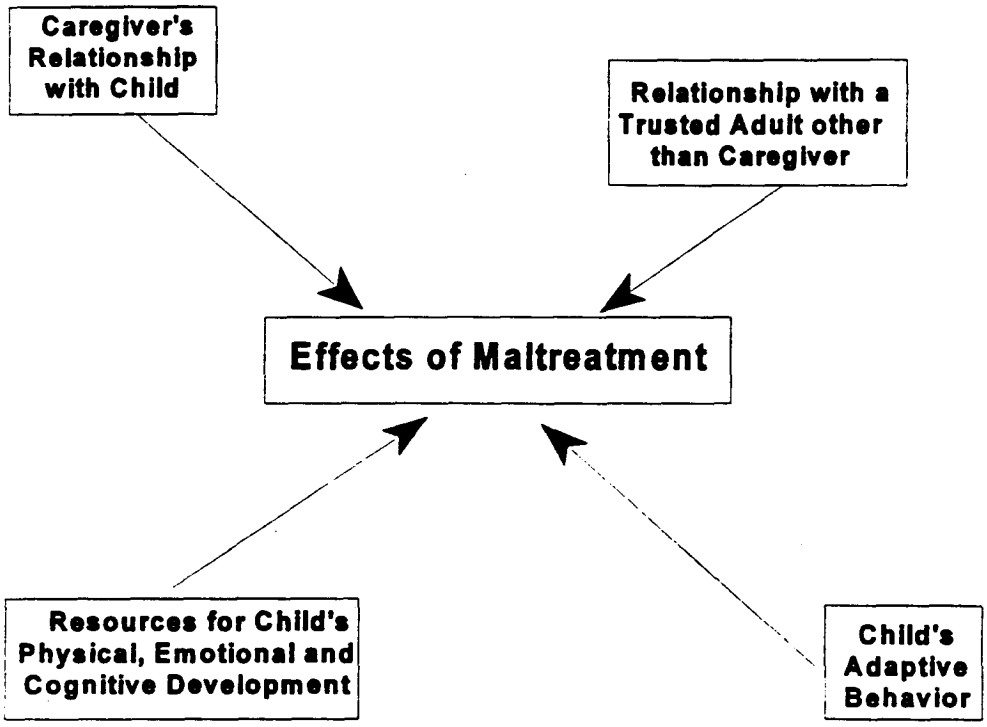

Diagram 22

The caseworker responding to an allegation of abuse or neglect is the family's first contact with that part of the helping system designed specifically to assure the long-term safety and development of children at risk. The presenting conditions of children and families and the timing with which they present themselves are largely unpredictable. DCFS must be equipped to provide a sufficient response to the child's safety concerns and to protect the family and child's openness to intervention.

The first critical decision concerns the degree of safety of the child and whether the threat to safety is created by caregiver maltreatment. The second decision concerns the timing of DCFS physical response to the child's need for protection. Absolute verification of safety is difficult within the limits of information provided by reporters, so policy should error on the side of physical verification. This implies a standard of reason to believe that a child may be or become unsafe without immediate intervention. It also requires staff flexibility in the response to assure sufficient time to make a reasonably valid determination.

Responding child protection investigators who feel pressured to make quick decisions will probably err on the side of agency safety in the name of child safety. As a result children will enter out-of-home care who might be safely maintained at home and who may avoid the loss of emotional security derived from separation and placement.

It is recommended that DCFS differentiate its initial response, moving from an investigatory model to an approach that distinguishes circumstances necessitating an investigation from those better approached with a safety assessment. In either case, if severe physical injury with criminal intent or severe sexual abuse is not suspected, a safety assessment approach should be the basis of initial contact with the family.

This requires that DCFS risk compromising investigations by seeing the caregiver before the child, where circumstances do not indicate that immediate access to the child is necessary to assure the child's safety or that the family does not leave the jurisdiction with the child before intervention can occur. The result will be the greater acceptance by caregivers of the role DCFS may play in aiding the safety and development of their children.

The role of the hotline worker will remain similar to the present role, of determining which reports to accept and setting priorities for response. However, there are distinctly different expectations for the role of the worker who follows this decision.

The second worker may be considered a member of a *child safety assessment team*. This worker's role is to engage the caregivers in a preliminary assessment of safety, determine the need for law enforcement involvement and a possible investigative response, share investigative responsibilities as necessary with law enforcement, determine with the family any necessary safety response, implement any required safety responses, and engage a *family service team* member if preliminary assessment information suggests ongoing intervention with the family.

Similarly, the family service specialist would retain responsibility for children having the goal of independent living. In effect, the same worker would follow the child throughout the life of the service relationship.

Support to the Casework Role

Core recommendations are listed below:

1. Align core training with the DCFS model of practice;

2. Develop or revise core training so that practice application level competencies are developed in training sessions rather than in lower-level verbal information competencies;

3. Structure OJT experiences to support transfer and generalization of training, as well as learning about and applying DCFS policy and procedures. Further, OJT should be a protected and adequately supervised experience;

4. Shorten time spent in core training during the first six months, moving specialized training to a follow the end of probationary employment;

5. Assure that supervisors have equal or greater practice competence in the same areas as caseworkers, and that caseworkers have access to supervision and clinical consultation;

6. Prepare and select foster families, adoptive families, and relative caregivers who are able and willing to work within the DCFS model of practice;

7. Restructure case review as a form of utilization review and as a clear component of the agency's quality assurance strategy;

8. Develop on-line, computerized client and agency information management technologies to support casework decision-making and information sharing;

9. Develop locally-based staff capacities, separate from the specialist and supervisor roles, designed to support teams in areas of clinical assessment of cases, application of need-based and family-centered practice principles, and with specialized service needs such as placement, termination of parental rights, diagnosis of mental illness, etc.;

10. Provide line discretion for the use of wrap-around funds necessary to meet unique service needs of families;

11. Provide local staff with a direct role in negotiating and evaluating services provided by local purchase of service agencies;

12. Restructure management practices to parallel preferred practice with children and families.

Peter Block wrote that the "essence of supervision is helping people to trust their instincts and take responsibility for the success of the organization." This is also true with families. Making them independent of the agency requires that their instincts in parenting be developed, that they learn to trust these instincts and that they take responsibility for the success of their family and the safety of their children. Doing so ultimately requires that DCFS learn to trust the family's instincts. It is difficult for caseworkers to achieve this trust in an organizational context that doesn't trust their instincts and help them take responsibility for the success of DCFS.

To this end, DCFS must align its management practices, information systems, and internal relationships to model and reflect the practice relationship it seeks with families. This means replacing blame with problem-solving and compliance mandates with developmental assistance. Central office must work in partnership with local offices in the same manner that local offices are expected to work in partnership with communities.

Assuring Quality

DCFS is currently developing a new strategy for quality assurance. As the American auto industry faced loss of market share and declining quality, it came to a simple realization. There is no stronger component of quality assurance than the person who does the original work. As quality dropped, auto companies added more inspectors to the assembly line in an effort to catch more errors. To their dismay, more inspectors resulted in more defects, not fewer. As they examined Japanese methods they discovered two important differences that seemed to account for higher quality in Japanese auto production. First, the employee felt responsible for the product and didn't rely on someone down the line to catch errors. Second, each employee had the discretion to stop the line and make it right.

DCFS cannot assure quality until it has the commitment of line caseworkers and supervisors. They are the first line of quality. Future DCFS strategy should be to alter the organizational culture that currently rewards persistence, but not achievement. Even the most sophisticated research institute cannot substitute for the discretionary will of a single caseworker. Unlike surgery where many professionals are present, DCFS most often must rely on the observations, interpretations and judgments of a single person, the caseworker. Secondary reviews do not always benefit from information provided by other observers. Because of this reality, DCFS remains critically dependent of the powers of observation and judgment of its front line staff.

Limitations and Risks

Human systems are dynamic. Observations and judgments made on any given day may only hold true until the next experience occurs within a family. Consequently, predicting the human behavior remains more art than science. No model of practice will assure perfect performance. Any procedure, no matter how perfect, can be subverted by the will or malfeasance of an individual.

Competencies for Practice

Because the primary service transaction occurs between the caseworker and the family, the competency of the caseworker is essential to the success of DCFS' mission. Accomplishing the mission depends on achieving the outcomes stated earlier. Competence implies the ability to get these outcomes. Actual performance depends not only on ability, but on opportunity and motivation as well. A part of motivation is the self-confidence derived from competence.

DCFS core training should be based on competencies or abilities directly tied to accepted outcomes. The practice model implies a range of decision, behavior change, and environmental condition change outcomes. These support the broader outcomes. Following are core abilities, along with supporting enabling abilities, that are directly related to the identified DCFS outcomes.

Competence is built through a hierarchy of enabling abilities. Robert Gagne identifies five types of learned behavior. These are intellectual skills, cognitive skills, verbal information, motor skills, and attitudes. Intellectual skills make it possible for individuals to respond to their environment through symbols, such as language and numbers. Words stand for objects or can represent relationships between objects. Gagne identifies a hierarchy of five intellectual skills, with each higher level skill dependent on a fabric of lower level skills. The five skills are:

Problem Solving

which requires the formation of

Higher-Order Rules

which require as prerequisites

Rules and Defined Concepts

which require as prerequisites

Concrete Concepts

which require as prerequisites

Discriminations

A **discrimination** is the capability of making a different response to stimuli or objects that differ from each other along one or more physical dimensions, a simple example being that arms and legs are both long but differ physically. A **concrete concept** is a capability that makes it possible to identify something as a member of a class, for example recognizing marks as burns. **Defined concepts** are acquired when an individual can demonstrate the meaning of a particular class of objects, events, or relations. A defined concept in child welfare would be the designation of a child as maltreated. **Rules** have been learned when the learner is able to respond to a class of relationships among classes of objects or events. An example of this type of learning would be the determination that a maltreated child is also unsafe. Finally, **problem-solving** occurs through

DCFS Outcomes and Supporting Abilities

Outcome 1.0: Family care of a child is at or above a threshold of safety and developmental opportunity.

Core and Enabling Abilities

1.1 Given a family in which maltreatment is suspected or known, a caseworker is able to determine the need for immediate or ongoing intervention to assure that a child is not in imminent danger of significant harm.

To demonstrate this core ability, the caseworker should be able to:

1.1.1 Engage family members, network members, and persons having knowledge of the child's and family's condition for the purpose of disclosing information relevant to determining the child's safety.

1.1.2 Determine the nature and extent of threats to the child's safety.

1.1.2.1 Determine if the caregiver's behavior is violent and out of control.

1.1.2.2 Determine if the caregiver acts toward the child in predominantly negative terms or has extremely unrealistic expectations.

1.1.2.3 Determine whether the caregiver has caused or has made a plausible threat that has or would result in serious physical harm to the child.

1.1.2.4 Determine the child's whereabouts.

1.1.2.5 Determine if there is reason to believe that the family is about to flee or refuse access to the child.

1.1.2.6 Determine that the caregiver has not or will not provide sufficient supervision to protect the child from potentially serious harm.

1.1.2.7 Determine if the caregiver has not met or is unable to meet the child's immediate needs for food, clothing, shelter, and medical care.

1.1.2.8 Determine whether the caregiver has previously abused or maltreated the child.

1.1.2.9 Determine the severity of prior maltreatment.

1.1.2.10 Determine the caregiver's response to prior instances of maltreatment.

1.1.2.11 Determine if the child is fearful of living at home.

1.2.1.4 When in court, present factual testimony and information in support of the agency's recommendation for founding or unfounding the allegation and the disposition of the case.

1.2.1.5 Engage parents, family members, and others in a positive alliance on behalf of the child's needs for safety, developmental opportunity, and emotional security.

1.3 Given a report of maltreatment, determine the need for an investigation.

1.4 Given the need for law enforcement involvement, work collaboratively with law enforcement to complete an investigation and/ or implement a safety plan.

1.4.1 Given a report of maltreatment, determine the need for law enforcement involvement.

2.1.1.17 Determine the caregivers' motivation to seek help.

2.1.1.18 Determine the caregivers' acceptance of the intervention(s) as a desired approach to meeting family needs.

2.1.1.19 Determine the maltreator's access to the child.

2.1.1.20 Determine the intent of the parent with respect to the child and the caregivers' acknowledgement of responsibility.

2.1.1.21 Determine the severity of the child's abuse and/or maltreatment.

2.1.1.22 Determine the history of abuse/maltreatment of the child by present caregivers.

2.1.1.23 Determine the caregiver's level of maturation and developmental task achievement.

2.1.1.24 Determine the caregiver's parenting capability.

2.1.1.25 Determine the caregiver's level of acceptance of responsibility for the child's needs.

2.1.1.26 Determine the caregiver's attachment to the child.

2.1.1.27 Determine the behaviors used by the caregiver to express needs to the child.

2.1.1.28 Determine barriers to the caregiver's availability for the caregiving role.

2.1.1.29 Determine the presence and contribution of the caregiver's disabling conditions to performance of the caregiver role.

2.1.1.30 Determine the caregiver's access to environmental resources necessary to meet the child's needs.

2.1.2 Determine the family's view of its needs relative to identified risk influences.

2.1.2.1 Determine the caregiver's current response to the child's expression of needs.

2.1.2.2 Determine the caregivers' current strategies to meet the family's and child's needs for maintenance and development.

2.1.3 Determine the family's view of which interventions would meet risk related needs and needs created by the use of the interventions themselves.

2.1.3.1 Determine earlier successful interventions.

2.1.19 Execute interventions to meet caregiver developmental needs that interfere with the caregivers' ability to meet the child's needs.

2.1.20 Execute interventions in a manner that is culturally responsive and congruent with the family's beliefs and values.

2.1.21 Mediate relationships between the caregivers, extended family, and network members in order to facilitate agreement on interventions to meet the child's needs.

2.1.22 Provide feedback to family members about their contributions to the child's safety and development.

2.2 Determine the nature of the child's response to the caregiver in interactions that lead to maltreatment of the child.

2.2.1 Determine the child's temperament.

2.2.2 Determine the effect of maltreatment on the child's response to the caregiver.

2.2.3 Determine the nature of the child's attachment to the caregiver.

2.2.4 Determine the nature of the child's trust in the caregiver.

2.3 Enable the child to take courses of action that lead to self-protection.

2.3.1 Determine the child's age.

2.3.2 Enable the child to form a trusting relationship with a protector.

2.3.3 Enable the child to distinguish between acceptable and unacceptable caregiver-child interaction.

2.3.4 Implement safety responses that counter the effects of the child's disabling conditions on the child's ability to protect self.

2.3.4.1 Determine the effect of the child's disabling conditions on the child's ability to protect self.

Outcome 4.0: When the birth family (original caregivers) will meet the child's needs for safety and developmental opportunity, the child will be returned to the family.

Core and Enabling Abilities

4.1 Given a birth family capable of meeting the child's needs for safety and developmental opportunity, the caseworker is able to re-integrate the child into the birth family.

In order to demonstrate this core ability, the caseworker should be able to:

4.1.1 Determine the nature and extent of threats to the child's safety (see 1.2).

4.1.2 Determine the nature, extent, and interaction of risk influences within the family (see 2.1).

4.1.3 Enable the family to determine its needs relative to returning to the role of direct care of the child.

4.1.4 Enable the family to determine the child's needs relative to leaving the alternative caregiver and re-entering the birth family.

4.1.5 Coach the family in their response to problems and crises following reunification.

4.1.6 Generate reports and other materials necessary for a judicial determination of return home.

4.1.7 Present oral information in court in support of the agency's recommendation of return home.

4.1.8 Negotiate with the alternative caregiver and birth family a plan for meeting the child's and birth family's needs following reunification.

4.1.9 Enable alternative caregivers and the birth family to execute the plan for support of the child following reunification.

Outcome 6.0: The child and birth family demonstrate emotional security in relation to the agency's interventions.

Core Abilities

6.1 Assure the physical safety of family members.

6.2 Design and execute interventions to minimize the loss of emotional security for child and family.

6.3 Identify behavior by a child or family member that indicates loss of emotional security.

6.4 Demonstrate empathy, warmth, and genuineness.

6.5 Enable a child or family member to express security needs and to identify interventions that would meet these needs.

6.6 Demonstrate behaviors necessary for development of trust in the relationship with the child and birth family.

6.7 Preserve elements of family members' identity necessary to a sense of emotional security.

6.8 Execute interventions that preserve attachments necessary to family members' emotional security.

6.9 Execute interventions to maintain all aspects of family and child autonomy not necessary to assuring the safety of the child.

6.10 Carry out interventions that enhance the child's ability to protect self from further maltreatment.

6.11 Execute interventions that alter the child's adaptive responses to past maltreatment that would place the child at risk of future maltreatment.

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