Florida Family Connections Collaborative

Family Connections Intervention Manual

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Adapted with permission from the Original Family Connections Intervention Manual (DePanfilis, Glazer-Semmel, Farr, & Ferretto, 1997 and the 2003 version).

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Chapter
1

MISSION, STATEMENT OF NEED, BEST PRACTICES, AND INTRODUCTION

MISSION

Family Connections (FC) is a multi-faceted, community-based program that works with vulnerable families in their homes, in the context of their neighborhoods, to help them meet the basic needs of their children, to prevent child maltreatment, and achieve safety, well-being, and permanency. FC offers services to help families build skills and stabilize their situation to provide a safe, nurturing home for their children, thereby preventing out-of-home care.

Florida Family Connections Collaborative (FL-FCC) program staff is dedicated to providing a continuum of services that offer help and hope to families that need assistance to stabilize and strengthen their families and provide for their children's safety and stability. KIDS Central and Partnership for Strong Families have been providing family services for over 10 years to assist families that struggle with poverty, homelessness, underemployment, unemployment, health issues, substance use, incarceration, child abuse/neglect, and family breakdown.

STATEMENT OF NEED

Fiscal Year 2013 - 2014 statistics for Florida revealed 223,587 reports of alleged child abuse and neglect were recorded by DCF Child Welfare (Florida Safe Families Network, Department of Children and Families, 2015). 187,721 reports received investigations to assess for child safety and involved 226,031 children in investigations of abuse, neglect, and abandonment. Maltreatment can harm children's physical, psychological, cognitive, and behavioral development. Its consequences can include difficulties with forming healthy relationships, developmental delays, and learning deficits, to name a few. In addition, clinical conditions associated with abuse/neglect can include depression, anxiety, and post-traumatic stress disorder. Adding to the needs of families, Florida's poverty rate continues to rise, reaching 17 percent in 2013 (U.S. Census Bureau, American Community Survey, 2013, Table B17001), and exceeding the national average of 14.5 percent (2013). The child poverty rate in Florida is 24 percent for children in related families who had incomes below the poverty line in 2013 (U.S. Census Bureau, American Community Survey, 2013, Table B17006). Continued work with families in Florida is vital to promoting healthy child development, increasing the ability of families to meet the basic needs of their children, and reducing maltreatment incidence.

BEST PRACTICE COMMUNITY SERVICE PROGRAMS

The FL-FCC through KIDS Central and Partnership for Strong Families adopted the Family Connections model to implement evidence-based and outcomes-oriented family services. This is consistent with DCF's Safety Methodology, which determines the safety of children conducting the DCF Family Functioning Assessment (FFA). For families where the FFA determines the children to be safe but at risk of maltreatment, FL-FCC works with families to decrease the likelihood of future maltreatment.

Florida's Service Array model through DCF calls for Family Support Services to be available on a voluntary basis for families after an investigation for child abuse and neglect if the completed FFA assesses the children as safe and the family has a high or very high level of risk for future child maltreatment as determined by a standardized risk assessment tool completed at the conclusion of an investigation. Family Support Services include case coordination throughout the life of the case targeted at building a families protective factors and addressing barriers to long-term safety. FC was

specifically designed and tested to help families reduce risk factors associated with child maltreatment and to strengthen protective factors that help them meet the basic needs of their children and keep them safe. The core practice components of FL-FCC also align with Safety Methodology. Thus, FL-FCC fits Safety Methodology and Florida's service array model as FC-FCC targets services to families with children assessed as safe, family risk level assessed as high or very high, and meeting eligibility criteria for the program. FC strives to reach families early, before problems become entrenched or have evolved to the point of needing further intervention in the child welfare system or entry into care.

The Family Connections Program has been adopted to support our work with families in their homes and communities. Family Connections has been established as a demonstrated effective program by the US-DHHS, Office on Child Abuse and Neglect, a Promising Practice by the California Evidence-Based Clearinghouse for Child Welfare and the Pew Charitable Trust, and as an approved Evidence Based Preventive Intervention by the CA Department of Mental Health, the NYC Administration for Children's Services, and the Texas Department of Family and Protective Services, and was chosen in an effort to meet best practice standards for service delivery to vulnerable families in Central Florida. Federally funded research from the original and replication Family Connections demonstrations in diverse communicates across the country have established that families that receive this intervention with fidelity demonstrate a reduction of risk factors and an improvement in protective factors over time and achieve child safety and well-being outcomes.

Across all jurisdictions that have implemented Family Connections, the essential components of FC practice are: (1) Intake and Screening; (2) Outreach and Engagement; (3) Concrete/Emergency Services; (4) Comprehensive Family Assessment, including the use of standardized assessment instruments; (5) Outcome Driven Service Plans with SMART goals; (6) Change Focused Intervention; (7) Evaluation/Progress Assessment; and (8) Case Closure.

INTRODUCTION TO THIS MANUAL

The purpose of this intervention manual is to provide information and clear direction to Lead Agency (CBC) and System of Care (subcontract) direct provider staff (collectively referred to as "collaborating partners") as they engage families as partners in the Family Connections' intervention. The manual documents the evidence based FC program as it is intended to be delivered by the collaborating partners. It is the foundation for the competency building intervention strategies emphasized in the Family Connections Foundational Training program and are supported through weekly coaching and supervision and on-going training for program staff. Collaborating partners adhere to the intervention presented within this manual as replication sites for Family Connections. Subcontract direct provider staff are responsible for maintaining practice according to the fidelity criteria to ensure high quality services to families in order to prevent child maltreatment, keep children safe, and prevent unnecessary placement in foster care.

The Manual's Organization

The manual is organized to address the topics as outlined in Table 1-1. An introduction of the purpose of each chapter follows this table.

Table 1.1 – Outline of Chapter Topics

Chapter	Topics
2	FC history, synthesis of research
3	Overview of prevention science, FL-FCC logic model, implementation science
4	Theoretical base to FC intervention
5	FC philosophical practice principles
6	Determining eligibility; implementing the intake and screening process
7	Outreach and beginning the family partnership
8	Responding to families' concrete and emergency needs

9	Conducting the comprehensive family assessment
10	Developing outcome-driven family plans with SMART goals
11	Delivering change focused intervention strategies and services
12	Evaluating change and progress
13	Determining when services to families can be closed; conducting the ending process
14	Fidelity, documentation, and administrative expectations

The manual is made available to staff in electronic form and in a loose-leaf binder so that information may be added from training, coaching, and supervision on an ongoing basis. This is not a manual to be read once. Rather, it should be actively used as a day-to-day resource to guide work with families. A brief overview of each chapter follows.

Chapter 2: Family Connections History and Synthesis of Research

This chapter provides an overview of the history of Family Connections, a summary of research on the efficacy of FC (DePanfilis & Dubowitz, 2005; DePanfilis, Dubowitz, & Kunz, 2008; Filene, Brodowski, & Bell (in press); and James Bell Associates, 2011).

Chapter 3: Prevention Science, Florida FC Logic Model, and Implementation Science

This chapter provides an overview of prevention science (DePanfilis, 2009) and how FC is intended to enhance protective factors and decrease risk factors related to child maltreatment and placement in foster care. It further introduces the FL-FC logic model and draws the connection between the FC intervention components and the intended outcomes for implementing FC in Florida. The logic model guides our practice of the multi-dimensional community service providing in-home services to families, in collaboration with community organizations, to enhance the lives of children who are at risk of neglect or other types of maltreatment. The program design is intended to provide a presence in a high risk community by working collaboratively with formal and informal community organizations, attending to families' emergency and concrete needs, and providing individualized strengths-based intervention and social support. Utilization of this design will then lead to increased protective factors, and decreased risk factors, both of which, in turn, will have a positive impact on child safety and well-being. Finally, the chapter provides a brief overview of implementation science (Kaye, DePanfilis, Bright, & Fisher, 2012; Fixsen, Blasé, Naoom, & Wallace, 2009) as the planning framework for the replication of FC.

Chapter 4: Theoretical Base

Effective and accountable social work practice is grounded in solid theory. Family Connections operates from an ecological developmental model (Belsky, 1980) and draws on concepts articulated in 11 theoretical perspectives. Chapter 4 provides an overview of these theoretical perspectives and highlights how each is used in FC practice. Family Connections' family focused and community-based intervention draws from: (1) Psychosocial Theory (Robins & Kaplan, 2011); (2) Problem-Solving Theory (Shier, 2011); (3) Life Model Theory (Gitterman, 2011); (4) Crisis Theory (Ell, 1996; Regeher, 2011); (5) Systems Theory (Andrae, 2011); (6) Role Theory (Kimberley & Osmond, 2011); (7) Cognitive Behavior Theory (Thomlison & Thomlison, 2011); (8) Cognitive Theory (Lantz, 1996; Chatterjee & Brown, 2011); (9) the Empowerment Approach (Dunst, Trivette, & Deal, 1988; Lee & Hudson, 2011); (10) Attachment Theory (Page, 2011; Sroufe, Egeland, Carlson, & Collins, 2005); and (11) the Trans-theoretical Model of Change (Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992).

Chapter 5: Philosophical Practice Principles

This implementation is a replication of the Family Connections model of practice. The program design is family-centered, community-based, preventive, comprehensive, and flexible and employs a set of

practice principles that have evolved from what research has proven works best with vulnerable families (Dunst, Trivette, and Deal, 1988; Hopps, Pinderhughes, and Shankar, 1995; Kinney, Strand, Hagerup, & Bruner, 1994; and Schorr, 1989). This chapter provides an overview of nine philosophical practice principles that guide FC intervention: (1) community outreach; (2) family assessment and tailored interventions; (3) development of a helping alliance; (4) empowerment approaches; (5) strengths perspective; (6) cultural competence; (7) developmental appropriateness; (8) outcome-driven family plans; and an (9) emphasis on positive attitudes and qualities of helpers. In addition, the FL-FC team added critical thinking as a core principle. These principles drive the *way* we work with families and support practitioners to implement FC intervention with fidelity.

Chapter 6: Determining Eligibility and Implementing the Intake Process

The purpose of FC, as applied by the Florida Family Connections Collaborative, is to serve children in the most appropriate, least restrictive setting, decrease the recurrence of child maltreatment, and address factors related to child maltreatment in order to decrease the risk of out-of-home placement. To achieve this, the intake process must accurately identify families at risk of maltreatment and screen out those not at risk of maltreatment. This chapter describes the FL-FCC eligibility criteria, the process for gathering information and applying eligibility criteria, and the skills needed to effectively determine who is eligible for FC. It also explains intake documentation requirements and provides a copy of the FL-FCC Intake form.

Chapter 7: Outreach & Beginning the Family Partnership

The helping alliance is the vehicle through which change with families occurs. This chapter provides information about how to communicate empathy, respect, and authenticity with clients and describes steps for preparing for and conducting the first family visit, a crucial opportunity to start building an effective partnership with the family. Tips for using active listening skills to develop the helping relationship are also provided.

Chapter 8: Responding to Concrete and Emergency Needs

Chapter 8 provides an overview of how FC assesses for and responds to concrete and emergency needs. A core component of Family Connections includes addressing concrete needs often associated with living in poverty that affect the quality of care provided to children. Concrete services are provided at any point when families need these types of services in order to meet the basic needs of their children. Assessment of need begins with the first visit and is part of each subsequent visit. In addition, FC assesses for and responds to three types of emergencies: (1) identification of possible child maltreatment; (2) psychosocial risk that includes concrete needs that may need to be addressed immediately; and (3) psychiatric crisis of a caregiver or child, including the threat of harm to self and/or others. In addition, Kids Central and Partnership for Strong Families have supplemented this chapter with their specific protocols for assessing and addressing concrete and emergency needs.

Chapter 9: Conducting the Comprehensive Family Assessment

Family Connections stresses the importance of conducting a comprehensive family assessment process to drive planning and provision of individualized, tailored interventions. This chapter outlines the family assessment process, including methods of gathering information, use of the Family Assessment Form (Children's Bureau of Southern California, 1997), and skills that staff should use to collect information and conduct the assessment process, including motivational interviewing and exploring skills. In addition, this chapter provides an outline of the content areas for assessment and discusses how assessment results inform selection of one or more Florida FC intervention outcomes for each family: (1) living conditions; (2) financial conditions; (3) supports to caregivers; (4) caregiver/child interactions; (5) developmental stimulation; and (6) caregiver to caregiver interaction.

Chapter 10: Developing Outcome Driven Family Plans with SMART Goals

Family Connections is guided by tailored interventions based on time-limited, individualized service plans, known as the family plan in Florida FC. The family plan facilitates goal and outcome achievement to reduce the risk of child maltreatment and unnecessary foster care placement. This chapter describes the steps and elements of creating meaningful, collaborative, realistic family plans that are based on findings from the comprehensive family assessment and the selection of specific outcomes. Families are involved in collaborating on the development of SMART goals that match specific outcomes and selecting specific intervention strategies and services.

Chapter 11: Delivering Change Focused Intervention Strategies and Services

An important part of Family Connections is the process in which staff members work directly with families to support families to achieve individualized outcomes and SMART goals. This is done through face-to-face, purposeful change focused intervention that occurs at least one hour per week with the family. The goal of change focused intervention—to help families within communities meet the basic needs of their children—entails providing a mix and intensity of services appropriate to each family's need. This chapter provides examples of interventions that staff may directly provide or locate for families in the community.

Chapter 12: Evaluating Change and Progress

Ongoing consideration and determination of change is a key element of FC. During all interactions with the family, staff review progress on goals, discuss this progress with family members, and target change focused intervention strategies to support goal attainment. While ongoing assessment of progress is important, a formal reassessment in conducted 90 days after the development of the family plan is partially based on a re-administration of the Family Assessment Form (Children's Bureau of Southern California, 1997). This supports an objective determination of progress related to the behaviors and conditions that have been the target of change strategies. This chapter describes the elements and expectations for evaluating change and progress. The chapter also discusses how FC staff and families work together to determine if child maltreatment risk factors have been sufficiently reduced and protective factors sufficiently increased and, if not, work together to develop new or revised goals and interventions.

Chapter 13: Determining when Services can Close and the Process of Endings

This chapter discusses how to make appropriate case closure decisions, implement a positive process of ending with families, and document case closure. It discusses the importance of staff facilitating ongoing conversation with families that FC is a time-limited intervention with ongoing check-ins on progress toward meeting goals and outcomes in the specified time duration. In Florida, staff members also develop an aftercare plan with families as part of the process of ending.

Chapter 14: Fidelity, Documentation, and Administrative Expectations

This chapter highlights the FC fidelity process as well as overarching documentation and administrative standards. Determination of fidelity helps to measure FC as it is actually being practiced and identify strengths and areas needing additional learning, development, or capacity building. To ensure that FC is implemented and practiced consistently and as expected in Florida, fidelity criteria have been identified and operationalized. They are detailed in this chapter along with case documentation requirements, and administrative expectations.

References

This section provides references for all citations.

Appendices

Appendix A - Program Information

Family Connections Program Brochure

Appendix B – FL-Family Connections Collaborative Program Forms

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Reassessment/Closing Summary Report screenshot
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Appendix D – Agency-Specific Policies

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KCI Incident Report Form
KCI Request for TANF-Flex Funding Policy

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Chapter

2

HISTORY OF FAMILY CONNECTIONS, SYNTHESIS OF RESEARCH

This chapter provides an overview of Family Connections' history and research.

Family Connections History

Family Connections (FC) is a multi-faceted, community-based service program that works with families in their homes and in the context of their neighborhoods to help them meet the basic needs of their children and prevent child maltreatment. Family Connections was developed following a study of the epidemiology of child maltreatment recurrences (DePanfilis & Zuravin, 1999a, 1999b, 2001, 2002) that examined patterns and predictors of child maltreatment recurrence for 1207 families who were followed prospectively over five years after a substantiated report of child maltreatment. Findings from the study were used to develop the FC intervention with the intent to reach families at risk of maltreatment early to support them to avoid the likelihood of maltreatment.

The program was developed in 1996 through collaboration between the University of Maryland Schools of Social Work and Medicine through support from the USDHHS, National Center on Child Abuse and Neglect (now named the Office on Child Abuse and Neglect) with matching dollars provided by Annie E. Casey Foundation. The study on recurrences and a literature review on child maltreatment interventions led to the development of a theory of change and logic model. A prevention science lens for addressing risk and protective factors (DePanfilis, 2009) in families at risk of child maltreatment was used to construct the components of intervention operationalized in the first intervention manual (DePanfilis, Glazer-Semmel, Farr, & Ferretto, 1999). In addition, key approaches demonstrated in the early 1980s and the skills needed for successfully engaging families as collaborative partners were integrated into the conceptualization of the intervention (DePanfilis, 1982; 1984). Table 2.1 describes some of the early projects that contributed to conceptualization of this intervention.

Table 2-1. Background leading to the development of Family Connections

Year	Milestone
1979	Three year demonstration to test methods of encouraging families to self-refer to Child Protective Services – US Department of Health & Human Services, National Center on Child Abuse & Neglect
1981	Three year demonstration to test methods for improving the quality of child protective services - – US Department of Health & Human Services, National Center on Child Abuse & Neglect
1982-1984	Multiple evaluations of child welfare practice, sponsored by American Humane Association helped to craft an understanding about what works and what could work better to support families to adequately care for their children.
1984-1990	Contributed to the development of a child welfare practice model – The Child At Risk Field Decision-Making System and the first Safety Evaluation System – with ACTION for Child Protection. Supporting implementation & testing of intervention in multiple states. (Note: The safety evaluation system developed and tested during this time serves as the foundation for Florida's safety framework).
1990-1995	Implementation of studies of child maltreatment known by CPS, including a five year prospective study of the epidemiology of child maltreatment recurrences funded by the US Department of Health & Human Services, National Center on Child Abuse & Neglect. Findings pointed to understanding what contributed to preventing

Year	Milestone
	recurrences.
1996	Literature reviews on the role of social support with maltreating families (DePanfilis, 1996) and reviews of child maltreatment interventions.

Since the first demonstration project (DePanfilis & Dubowitz, 2005), the program has been replicated in large and small, urban and rural communities across the country and delivered by community agencies as well as public child welfare systems. Key milestones of this history are depicted in 2.2 beginning with the first demonstration project in 1996.

Table 2.2 – History of Family Connections

Year	Milestone
1996-2002	Five year demonstration – US Department of Health & Human Services, National Center on Child Abuse & Neglect
1999-2000	Testing FC adaptation targeting reunification when children placed in foster care – Baltimore City Department of Social Services
1999-2002	Family Connections' family strengthening initiative – US DHHS, Substance Abuse & Mental Health Services Administration (SAMHSA)
2003-2009	Selected as "demonstrated effective program" by US DHHS, Office on Child Abuse & Neglect; federal replication funding for 8 sites (CA-2, MD, MI, TN, Tx-2, WV); Adaptation with kinship caregivers in Maryland
2007	SAMHSA award to develop Family Informed Trauma Treatment (FITT) Center; Trauma Adapted Family Connections (TA-FC) developed
2008-2009	Rated as a promising practice – CA Evidence-Based Clearinghouse for Child Welfare & the Pew Charitable Trust report; Special Issue of *Protecting Children;* JBA preliminary cross-site findings presented
2010-2012	Replications in CO, MD, NM, NJ, TX, Los Angeles; development of SAFE-FC; NYC-ACS selects FC as an evidence based model for conversion of preventive services
2011	James Bell Associates Cross Site Evaluation Released
2013-2014	Implementation of FC through two collaborative partnerships: (1) NYC – nine preventive service programs in the Bronx, Manhattan, and Brooklyn and (2) FL – two Community Based Care (CBC) partners – Kids Central and Partnership for Strong Families

Family Connections Research

What do we know about the efficacy of Family Connections? There has been extensive research documenting that families who receive the core components of Family Connections are successful in reducing risk factors and enhancing protective factors associated with child maltreatment. These findings have been published in reports and peer reviewed journals and presented at national and international conferences. The highlights are summarized here in question answer format.

What risk and protective factors have been demonstrated to change over time?

Families in the original demonstration were found to increase protective factors (parenting attitudes, parenting competence, social support) and decrease risk factors (parental depressive symptoms, parenting stress, life stress) Intake until closure and these changes were still evident six months after case closure (DePanfilis & Dubowitz, 2005). Results of the James Bell Associates (2011) cross site evaluation on 8 replicating sites found enhancement in protective factors (social support and parenting attitudes) and decreases in risk factors (parental depressive symptoms, parenting stress, risk factors related to family functioning) from Intake until closure. Most changes were also noted at the six month follow-up. All of these changes over time were statistically significant.

What outcomes have been demonstrated to change over time?
Child Safety (observation). The original demonstration project found significant improvement in child safety (observation of physical and psychological care of children) and parental self-report of child behavior between Intake and Case Closure. The observational assessment of child safety could not be implemented at the follow-up because it depended on the worker having been in the home.

Child Behavior. In the original demonstration, child behavior (externalizing and internalizing) was found to improve between baseline and case closure and these changes were sustained at the six month follow-up. In the cross site evaluation, change over time was noted for externalizing behavior but not internalizing behavior. Secondary analysis comparing boys and girls (Lindsey, Hayward, and DePanfilis, 2010) found that boys appeared to experience a larger decrease in internalizing and externalizing behaviors over time than girls.

Child Safety (CPS reports. Families served in the demonstration project were matched with CPS reports and compared prior to intervention and at six months following intervention. Although approximately 56.5% of families had received reports of child maltreatment and 38.3% had been substantiated prior to receiving FC intervention. At six months following intervention, 11% had reports of child maltreatment and 7% had substantiated incidents. It should be noted that some of these reports were made close to the beginning of the FC intervention meaning that at the same time a family was referred to Family Connections, they may have also been reported to CPS.

Even though all sites were required to match their cases with CPS data, at the time the cross site evaluation was completed, only two of the 8 sites had submitted these data. For the 243 families from these two sites, 4.6% were subjects of a CPS investigation within six months following case closure and less than 1 percent had a substantiated incident. Because of these small numbers, the cross-site analysis could not compare treatment and control groups on CPS reports.

How has length of service affected risk and protective factors and outcomes?
The original demonstration randomly assigned families to FC intervention for 3 or 9 months. Results showed that for all risk and protective factors, the 3 month group achieved the same statistically significant change as families assigned to the 9 month group. The 9 month group demonstrated greater improvement over time in improved child behavior.

The cross-site evaluation compared seven of the eight sites that randomly assigned families to shorter versus longer intervention and found the same results. Families served for shorter times achieved the same change as families served for a longer period of time. JBA 2011 concluded, *regardless of the duration of FC, families receiving the FC intervention experienced improvements over time across multiple outcome domains. Outcome trajectories for families assigned to three months of FC were not different from families assigned to longer interventions* (p. 137).

As a result of the findings on duration, most programs that implement Family Connections today choose a shorter intervention – one month for assessment and three months of change focused intervention. This is the model selected by the FL-FCC.

What length of service is most cost effective?
A cost effectiveness analysis from the original demonstration project (DePanfilis, Dubowitz, & Kunz, 2008) determined that the three-month intervention was more cost effective than the nine-month intervention in relation to positive changes in risk and protective factors and child safety. However, cost effectiveness analysis indicated that the nine-month intervention was more cost effective (CE ratio=$276) than the three-month intervention (CE ratio=$337) in relation to unit changes in the child's behavior between baseline and six months after service closure.

Since most programs implementing Family Connections are primarily targeting reduction in the risk of maltreatment, it is likely more cost effective to implement the shorter intervention.

What contributes to successful completion of the program?
Secondary analysis from the demonstration project (Girvin, DePanfilis, & DePanfilis, 2007) found that families in the three month intervention were statistically significantly more likely to finish the program. Families that completed were more likely to have larger numbers of children and to report a more positive helping alliance with their workers than families who dropped out before the end of their assigned service period. In addition, families with caregivers with higher depressive symptoms were also much more likely to finish services than families whose caregivers did not report depressive symptoms. The replication study from Tennessee (Theriot, O'Day, & Hatfield, 2009) also looked at differences between families who completed versus not completed intervention. Their results indicated that families assigned to the program for 3 months compared to 9 months were 10 times more likely to finish the program even when controlling for other predictors (caregiver and family characteristics).

How does fidelity impact outcomes?
The JBA (2011) cross site evaluation explored whether programs with higher fidelity as measured by a multi-dimensional process to observe the degree to which the program was implemented as intended would also have greater case level improvements in risk and protective factors and outcomes. Results indicated that families experienced greater change over time in parenting stress, parental depressive symptoms, and social support when programs had higher fidelity scores on components of the practice (termed program structure criteria). Higher scores on consistency in use of the philosophical principles was related to greater change by families in social support. Families at sites with higher administrative activities scale scores demonstrated significantly greater reductions in child internalizing behaviors and improvements in parental attitudes.

What does qualitative research tell us about Family Connections?
Cultural adaptation. A study from one of the Los Angeles project sites concluded that FC is easily adapted to cultural groups (Wu, Mimura-Lazare, Petrucci, Kageyama, & Suh, 2009). They demonstrated success using community based recruitment strategies to engage families, using staff matched by language and culture, and educating at the community level to gain acceptance and diminish the shame that some families may have experienced by "accepting help".

Emphasis on the helping alliance and concerted efforts to reach families sequentially and support them to move through the stages of change increased the likelihood that families would stay involved in intervention. This approach also illustrates how important it is to empower families to solve their own problems and for the program to respond to concrete needs before expecting families to be ready to change parenting behaviors were other key lessons from the Detroit project's success in engaging families to increase safety for children (Stephens, Mills, Williams, Bridge, & Massie, 2009)

Use of collaborative therapeutic assessment. Family Connections requires the use of standardized assessment instruments to tailor intervention and to engage families to observe their success to change behaviors and conditions that may place their children at risk of maltreatment. One of the Texas projects (Zaid, Earnes, Driver, and LeGendre, 2009) conducted a qualitative study to explore the perception of staff and families to using this process. Reports from staff and families indicated that use of assessment instruments became a platform to more easily discuss difficult issues (e.g., drug use or parenting attitudes) than would have been possible by have an open-ended conversation alone. They also reported the benefit of narrowing the focus of intervention on the most important risk or protective factors identified through instruments. This helped to reduce how overwhelmed families may have felt in their situation. They also concluded how powerful it was for caregivers to observe the changes in behaviors and conditions by comparing scores before and at the end of intervention.

Walking the talk. Grandparent caregivers in the Maryland replication (Sharpe, DePanfilis, Strieder, & Gregory, 2009) reported the benefit of Family Connections for building support and services, skill building, and helping to create affect and behavior changes (Sharpe, DePanfilis, Strieder, & Gregory, 2009). Grandparents reported great benefit from being connected to other grandparents raising their grandchildren. They also reported having much more energy to work on their interaction with their grandchildren after the program first helped them with resources to take care of basic needs. They also reported greater confidence in their parenting skills and improved family functioning.

Chapter

3

PREVENTION SCIENCE, FL-FCC LOGIC MODEL, & IMPLEMENTATION SCIENCE

This chapter provides an overview of Prevention Science, the Florida FC logic model, and implementation science. These concepts are foundational to the FC intervention and its implementation. Prevention Science guides the core components of the FC intervention to reduce child maltreatment risk factors and increase protective factors. The logic model details the theoretical connection among the identified client/family need, FC objectives, critical program activities, and expected outcomes. Lastly, the section on implementation science summarizes research on what it takes to implement FC effectively.

Prevention Science

The principles of Prevention Science (Mrazek & Haggerty, 1994; Schinke,et al., 1986) suggest that child maltreatment preventive programs should reduce risk factors and promote protective factors (DePanfilis, 2009; DePanfilis & Dubowitz, 2005; English, Bangdiwala, & Runyan, 2005). This is especially important for selective prevention programs (Mrazek & Haggerty, 1994) that target families whose children are identified with risks of child maltreatment. **Risk factors** are characteristics that elevate the probability of an undesirable outcome such as substance abuse, parental depressive symptoms, and everyday stress (Masten & Wright, 1998). Interventions aim to reduce the presence of specific risk factors in the life of that individual or family. **Protective factors** are characteristics that promote resilience or that moderate the effect of risk factors such as parenting attitudes, parenting competence, and social support (Masten & Wright, 1998). Therefore, preventive intervention is designed to help clients develop or promote existing protective factors to offset or reduce the effect of risk factors. For example, helping a parent strengthen a relationship with someone trusted to be there for her through thick or thin would be an example of an intervention to promote social support as a protective factor.

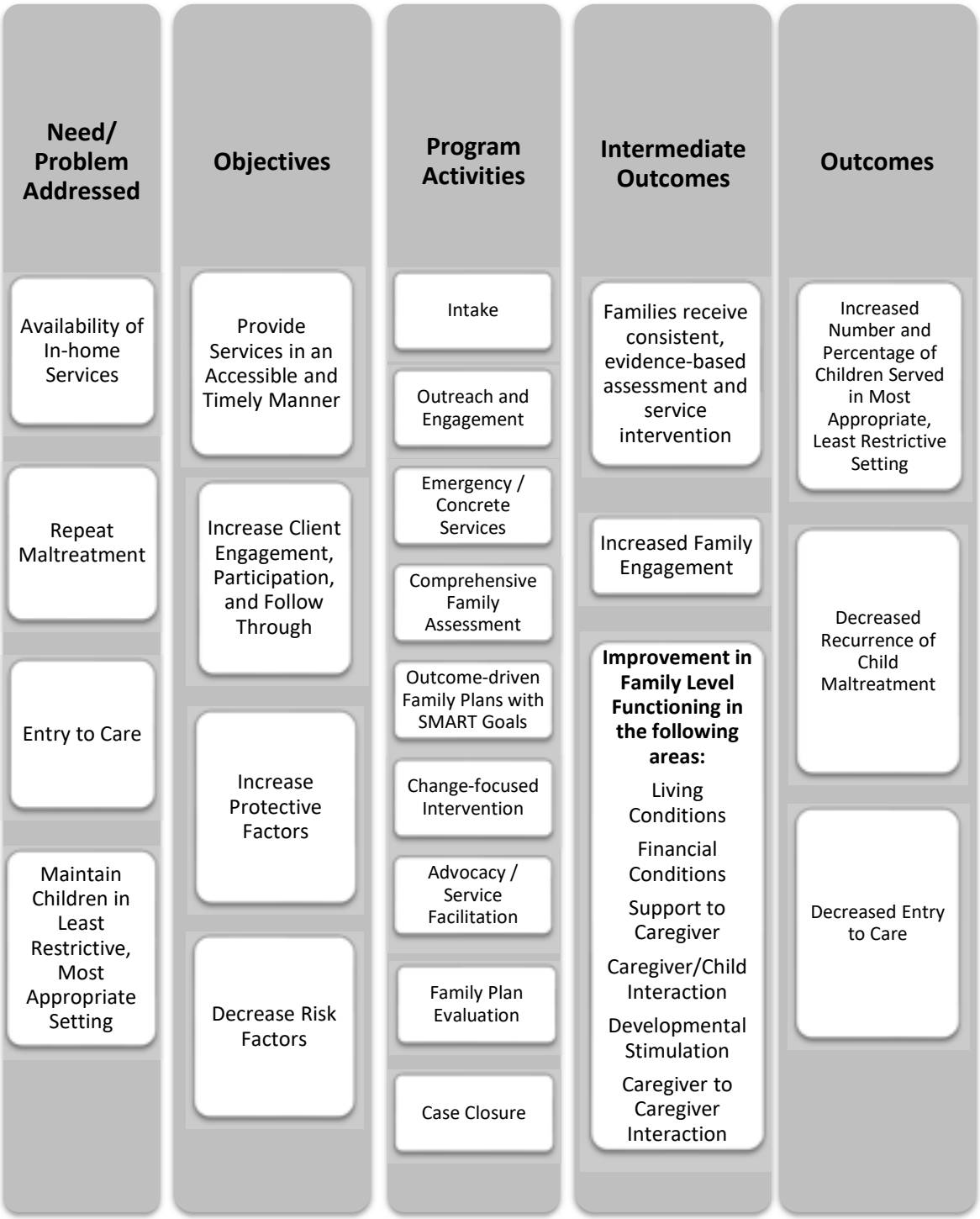
It is widely accepted among professionals that a complex set of risk and protective factors are associated with the occurrence of child abuse and neglect (Brown, J., Cohen, P., Johnson, J.G., & Salzinger, S. (1998). Because Family Connections uses an ecological framework (see Chapter 4) to understand the meaning of these factors in the lives of children and families, our comprehensive family assessments consider risk and protective factors about the child, family, and environment. Family Connections was developed through a prevention science lens since it followed the stages of prevention science to first explore the nature of the problem, identify risk and protective factors that contributed to the problem, and construct intervention components to directly respond to these factors (DePanfilis, 2009). Since each family is unique, we do not assume that all risk and protective factors will be relevant for all families – instead we individually assess so that we can tailor our intervention responses to the unique risk and protective factors experienced by each family.

Florida Family Connections Collaborative Logic Model

A logic model is a visual representation of how an intervention is expected to work, the need it aims to address, and how its objectives and activities flow together to reach its desired outcomes. Logic models can be a helpful communications tool to share with staff, providers, clients, and other stakeholders. The Florida Family Connections logic model suggests that “locating in a high risk community; collaborating with formal and informal community organizations; attending to emergency and concrete needs; and providing individualized, strengths-based intervention, and social support will increase protective factors

and decrease risk factors that will eventually lead to increased child safety and child well-being" (DePanfilis & Dubowitz, 2005). The FL Family Connections Collaborative developed the logic model depicted in Figure 3-1 based on the combined experience of Kids Central and Partnership for Strong Families with families in high risk communities in Florida.

Figure 3-1. Florida Family Connections Collaborative (FL-FCC) Logic Model



Implementation Science

While the attention to and number of evidence-based programs over the past decade have increased, their use in practice has been weak (Fixsen, Blase, Metz, and Van Dyke, 2013). Many researchers have begun focusing on the factors that lead to successful implementation of evidence-based programs in real world settings (Meyers, Durlak, & Wandersman, 2012). The theory is that both the actual intervention and *how* it is implemented are important for achieving the desired outcomes.

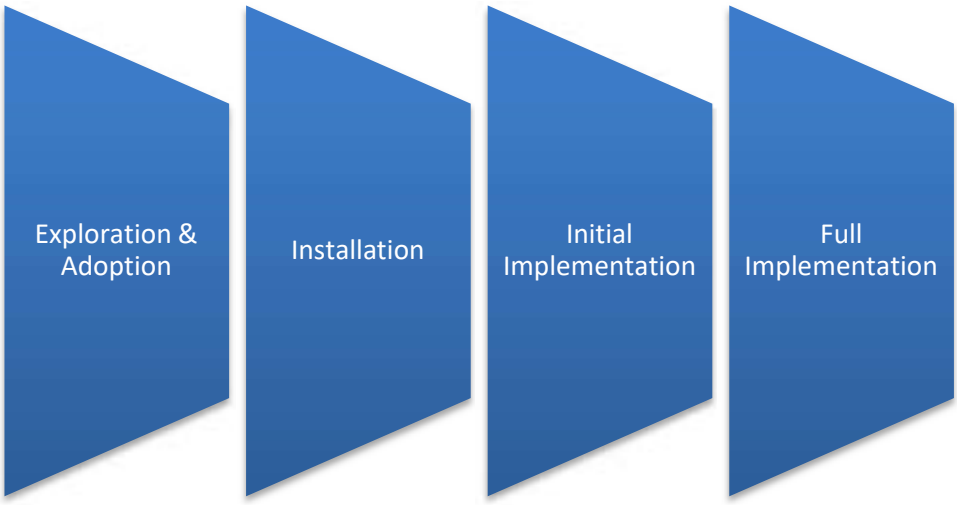
> *Implementation is a specified set of activities designed to put into practice an activity or program of known dimensions. According to this definition, implementation processes are purposeful and are described in sufficient detail such that independent observers can detect the presence and strength of the specific set of activities related to implementation. In addition, the activy or program being implemented is described in sufficient detail so that independent observers can detect its presence and strength* (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005, p. 5).

The National Implementation Research Network's (NIRN) implementation science framework (Fixsen, et al., 2005) offers a strategic, purposeful approach to managing change, fulfilling intervention objectives, carrying out program activities, and increasing the success of the new intervention. Used by child welfare systems (Kaye, DePanfilis, Bright, & Fisher, 2012) as well as in the fields of education and juvenile justice, the framework has guided FC's implementation in Florida. Specifically, the FL-FCC Training and TA Team has used the framework's implementation stages, drivers and teams to guide development of implementation work plans, activities, and ways of organizing. This section describes how Florida has applied the principles of implementation science in its implementation of Family Connections.

Implementation Stages

Implementation is a process, not a one-time event. Implementation happens over time (it typically takes 2-4 years for the new practice or intervention to become routine or institutionalized) and NIRN identifies four main stages of implementation, with sustainability being part of every stage. The stages usually do not move forward in a tidy, linear progression; rather, work in one stage might overlap with work in another stage or activities thought to be "done" might need revisiting. The stages are shown and described in Figure 3-2 along with a summary of the primary activities that have occurred or are planned to occur in each to implement FC in Central Florida.

Figure 3-2. Stages of Implementation



Exploration and Adoption – During exploration, organizations identify the need for the intervention, garner leadership and stakeholder support, convene and develop implementation teams to support the work, and mobilize information and resources. A decision to proceed (i.e., to adopt a particular intervention or model) is made based on exploration activities.

Exploration occurred in Winter and Spring 2013 by the FL FCC. The FC Training and TA Team presented to initial members of the FL FCC in February, had further conversations during the Spring, and convened the initial planning meeting in June 2013. Conversations between Kids Central and Partnership for Strong Families eventually led to expanding the FCC beyond Kids Central and its provider agencies to also include Partnership for Strong Families. The decision by both CBCs to proceed with implementing FC occurred in July 2013.

Installation – Installation occurs after a decision to proceed with a particular intervention or model is made and resources are allocated to support it. Practical activities occur in this stage to prepare the staff and organization for the new intervention, such as developing implementation plans, preparing supervisors and staff for change, training staff, developing communication and feedback mechanisms, and considering strategies to align organizational structures to support implementation.

Installation activities began in July 2013 and proceeded through May 2014. The FCC Implementation Team developed a work plan related to each of the installation activities and has meet regularly to carry out tasks that will support effective implementation. Some of the installation activities included: developing a charter and outline of roles and responsibilities for the Implementation Team; selection of standardized assessment instruments (i.e., the Family Assessment Form); identification of standard FL FCC outcomes; development of the FL FCC logic model; integration of current case record requirements; development of this intervention manual; preliminary development of fidelity assessment plans and instruments; and implementation of an organizational workforce survey to assess the organizational culture, climate, and readiness for implementation to inform implementation plans.

Initial Implementation – This stage occurs as the new intervention is put into practice. Initial Implementation is the most challenging stage, as a new intervention can feel awkward for staff and can challenge an existing system. Critical is the use of continuous improvement strategies and feedback mechanisms to gather information on implementation and barriers to service and to identify solutions and use data to guide decision-making. It is vital to develop strategies to attend to Initial Implementation challenges, as many attempts at new innovations seriously falter during this stage.

For FC in Central Florida, Initial Implementation began with the first and second practicum integrated into the training process. Supervisors and leadership have provided critical roles to support staff during this stage as feedback is solicited and barriers to implementation are identified and addressed. Communication protocols are used during this stage to create bi-directional communication pathways to internal and external stakeholders. Fidelity monitoring also begins during this stage to gather data to adjust implementation strategies and maximize fidelity results.

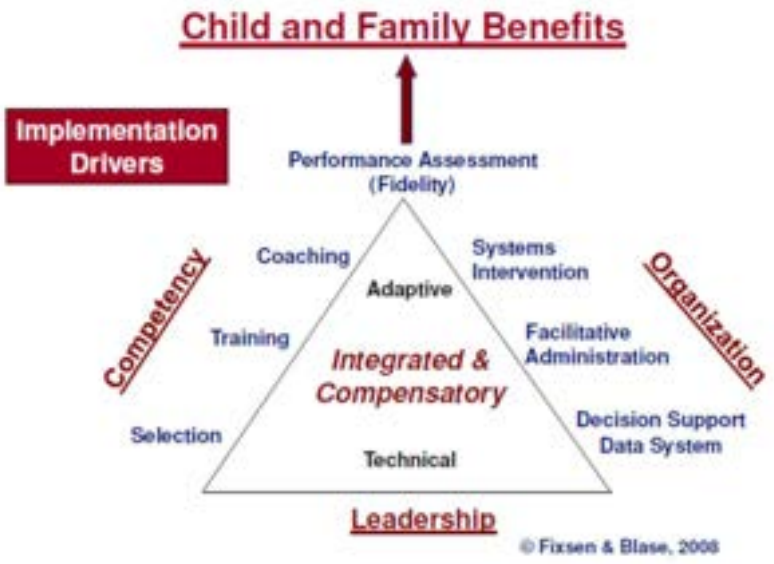
Full Implementation – Organizations and projects reach Full Implementation once the practice becomes integrated into the organization; staff feel confident in using the practice with *every* family; supervisors *continually* support and coach staff; stakeholders are adapted to the practice; procedures and processes of the intervention are routine; and practice change is observable. In Full Implementation, implementation components are sustained, and the intervention outcomes for families are realized. Full Implementation is usually achieved 2-4 years after Initial Implementation.

Implementation Drivers

The Implementation Drivers are core components identified by NIRN's synthesis of implementation literature (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). There are three types of Drivers: Competency,

Organization, and Leadership. The drivers are depicted in the triangle in Figure 3-3. Each driver is described along with its specific application in the Florida FC implementation process.

Figure 3.3. National Implementation Research Network's Implementation Drivers



Competency Drivers are those components of implementation that develop, improve and sustain one's ability to implement an intervention with fidelity and benefits to clients. There are four Competency Drivers: Selection, Training, Coaching and Supervision, and Performance Assessment.

- Selection – Focuses on strategies for identifying specific personnel characteristics to assess at time of hire as well as recruitment, interviewing, and redeployment strategies that promote thoughtful selection of qualified staff (Metz & Bartley, 2012).

- Training – While training alone does not result in sustained practice change, it is essential for introducing new practices and allowing practitioners to try new skills in a safe, supportive environment. Training is an important part of implementation as it introduces the theory and underlying values of a program, uses adult learning theory, and allows staff to explore questions related to a specific model.

- Coaching and Supervision – Critical to building staff competency and confidence to use the intervention with all families. Coaching and supervision should be systematic, use multiple sources of data to provide feedback, and feedback from coaching/supervisory sessions should be provided to guide improvements to other drivers.

- Performance Assessment (Fidelity) – The end result of effective implementation components. When the Leadership, Competency, and Organization Drivers are working well, sufficient performance assessment measures should be reached. Performance assessment measures are used to not only provide feedback to staff on the strengths of their practice and opportunities for improvement, but should also be used to inform feedback on the functioning of the other drivers.

The FL FCC Training and TA Team uses the Competency Drivers to increase the capacity of the agencies' workforces to implement FC practice. For example, training materials and activities were informed by best practices of training in the literature. Supervisors were taught coaching skills that they could use with their caseworkers to support their learning and critical thinking and to model how to communicate effectively with families. Supervisors also received one-on-one coaching from the FCC Training and TA Team to consider how to use coaching in their day-to-day work to promote transfer of learning among their staff. Fidelity assessment instruments and the review process have been drafted with the FL FCC Implementation Team so that they are practical and useful.

Organization Drivers are the components of implementation that create and sustain hospitable organizational and systems environments for effective services. There are three Organization Drivers: Decision Support Data System, Facilitative Administration, and Systems Intervention.

- Decision Support Data System – Supports the ongoing use of data to guide decision-making at every level of the system, from frontline workers and supervisors through managers and administrators. Data is used to guide discussion around implementation or practice challenges and assessment of improvements. It is important for data to be reliable, reported frequently, and supported in use in daily practice (Metz, & Bartley, 2012).

- Facilitative Administration – Refers to the efforts and attention of the agency's administration to fix implementation barriers and create an administratively hospitable environment for staff. It includes activities such as making sound internal policy decisions, procedural changes, and funding allocations to facilitate implementation. It also involves creating a process(es) for feeding information to the right decision-makers who can take action to improve internal structures.

- Systems Intervention – This driver encompasses strategies to work with external systems and both internal and external stakeholders to sustain the financial, organizational and human resources necessary to the ongoing practice. Often leadership takes the responsibility to identify and attend to external system level barriers and facilitators. While these aspects of implementation can be unwieldy, it is necessary to identify and maintain focus on these issues as implementation proceeds through the stages. One aspect of FC implementation is developing a community advisory committee to guide implementation that includes representation of an array of stakeholders, including those who bring the consumer voice to the table.

The FL FCC Training and TA Team works with the Collaborative to identify ways of integrating the Organization Drivers into the implementation plan development and ongoing work. The FL FCC Organizational Survey results will be used to inform aspects of implementation planning and barrier identification related to the Organization Drivers. Ongoing organizational assessment will be used to guide feedback and planning around the organizational components.

Leadership Driver – This driver acknowledges that there are different leadership strategies for different challenges. It is based on Heifetz and Laurie's (1997) identification of two types of challenges: technical and adaptive. Technical challenges are those with high level of agreement about the challenge and high levels of certainty on the solution. Adaptive challenges are those where problems are not clear and solutions are elusive. It is vital for leaders to correctly identify whether the challenge is adaptive, technical, or contains elements of both before solutions are conceived of and carried out. The FL FCC Training and TA Team works with the Collaborative to diagnose the types of challenges that arise and identify collaborative strategies to address them. Table 3-1 provides general examples of technical and adaptive challenges:

Table 3-1. Examples of Technical and Adaptive Challenges

Technical Challenges	Adaptive Challenges
Developing the communication message	Communicating the message to stakeholders
Writing policy	Implementing the policy
Issuing memorandum of understanding for interagency collaboration	Collaborating with interagency stakeholders
Providing language translation services	Practicing with cultural competence
Making logistical arrangements for parents to attend case planning meetings	Engaging parents to participate in case planning

Implementation Teams

To effectively implement a program or intervention, organizational capacity has to be put into place to support and sustain the work. NIRN identifies Implementation Teams as one way to organize internal capacity to support the ongoing work required by evidence-based programs (Metz & Bartley, 2012). Implementation Teams provide a focused and accountable structure to increase the likelihood that the program or intervention will be sustained over time.

Implementation Teams are a "core group of individuals who are representative of the stakeholders and the 'system' and who are charged with guiding the overall implementation from exploration through full implementation" (National Implementation Research Network, 2010) Implementation Teams focus on (Metz & Bartley, 2012):

1. Increasing "buy-in" and readiness
2. Installing and sustaining the implementation infrastructure
3. Assessing fidelity and outcomes
4. Building linkages with external systems
5. Problem-solving and sustainability

The FL FCC Training and TA Team works with the Collaborative to develop and promote a competent Implementation Team comprised of representatives tasked to guide and facilitate successful implementation. The team was created in the summer of 2013, they developed their mission and charter in September 2013 and have been meeting on a regular basis to guide the successful implementation of Family Connections. Additional teaming structures may be identified as necessary for each CBC and partners as well as the Collaborative as implementation proceeds.

Chapter

4

THEORETICAL BASE

This chapter describes the theoretical base for Family Connections. It is important that staff and supervisors understand the social work theories that underlie the FC model and that there is purposeful alignment with them at each level of FC implementation and practice.

People are individually and uniquely created with different experiences, thoughts, and perceptions that influence one's behaviors and outlook on life. Families are complex entities that perpetually influence individual members' well-being within the family system context. A change in one individual's behavior affects the system as a whole. Encouraging positive change in families, such as change that increases family functioning, is complicated and must consider each individual's needs and strengths. Furthermore, an individual's integration, influence, and culture of his/her community systems must also be taken into account for the best results associated with such change. The FC model expects staff to regard these considerations as integral components of the practice and to view each individual in the context of his/her family, community, and culture. For example, the circuits covered by KIDS Central and Partnership for Strong Families are comprised of mostly rural communities.

Ecological Developmental Framework

Family Connections uses multiple social work theories to guide the understanding of families' needs and to drive specific intervention strategies. In general, FC operates from an ecological developmental framework that views child abuse/neglect within an at-risk familial system associated with protective factors interacting across four levels: (1) the individual or ontogenic level, (2) the family microsystems, (3) the exosystem, and (4) the social macro system (Belsky, 1980). This framework, first formulated in Bronfenbrenner's Theory of Social Ecology, is described in Table 4-1.

Table 4.1. Ecological Developmental Framework

Levels of Interaction	
Ontogenic (Individual)	• Individual characteristics like personality, age, gender, education, health, skills, and talents. • Changing developmental stages of family members (infant, toddler, adolescence, young adult, etc.)
Family Microsystems (Familial)	• Family environment • Parenting styles and past experiences of each family member that influence the family system • Family interactions and rules
Exosystem (Communal)	• Community • Parental workplace • School and peer groups • Formal and informal social supports • Services available to family • Family income • Employment and job availability
Social Macrosystem (Cultural)	• Cultural values and beliefs

To be most effective, FC intervention should be directed at these multiple levels—which interact with and influence each other, affect family functioning, and impact child safety and well-being—and focus on the specific needs of each family and each family member. In addition, FC draws from several other social work theories and models including: (1) Psychosocial Theory; (2) Problem-Solving Theory; (3) Life Model Theory; (4) Crisis Theory; (5) Systems Theory; (6) Role Theory; (7) Cognitive Behavior Theory; (8) Cognitive Theory; (9) Empowerment Approach; (11) Attachment Theory; and (12) Trans-Theoretical Model of Change. Each is summarized below.

Psychosocial Theory

Psychosocial theory recognizes *the influences of biological factors, internal psychological and emotional processes, external social and physical conditions, and the interplay among these* (Robinson & Kaplan, 2011, p. 387). It also recognizes that the developmental evolution of the individual occurs within a social context and the tasks and demands an individual addresses vary with his/her stage of development. For example, FC staff use psychosocial theory when helping families reduce problems that arise from disequilibrium between families and their environments. In particular, FC assessments are geared toward understanding the "person-in-situation" so that we develop meaningful service plans that are specific to the unique needs of each family and that consider how the family functions within its larger social or environmental context.

Problem-Solving Theory

Problem-solving theory, originally conceptualized by Perlman (1957) and more recently articulated by Compton, Galaway, & Cournoyer (2004), and Shier (2011), involves helping clients through a problem-solving process to first define their problems and needs and then to mutually develop goals, resources, and plans to implement strategies that will address them. An important assumption of problem-solving theory is that life's problems do not represent weakness or failure on the part of families, but rather are the outcome of a natural process of human growth and change. It is further assumed that if problems can be carefully defined, the capacity to solve them can also be developed.

In Family Connections, problem-solving theory is used to mutually define family needs, conduct a family assessment, develop a service plan, and implement action steps to accomplish outcomes and goals, evaluate progress, and eventually reach decisions about closure. People who are overwhelmed by their experiences often need additional support and encouragement to effectively problem solve. FC staff help families address each of the obstacles in the change process through development of a collaborative relationship that motivates and supports clients' thinking and feeling processes (Turner & Jaco, 1996). Problem-solving theory can help families describe and "put words to" the problem, allowing them to then focus on developing solutions and action steps.

Life Model Theory

Life Model theory helps us to understand that individuals and families experience unique developmental pathways. Over the life course, people strive to improve the level of fit between their expectations and existing environmental supports, in order to buffer against stressors and facilitate greater access to desired resources (Gitterman, 2011). When people feel positive in their ability to fulfill their needs and aspirations and when they view resources as available, both they and their immediate environments enter into a reciprocal relationship that creates a sustained condition of adaptedness (Gitterman, 2011). For example, a child left with the task of parenting younger siblings because of the death of a parent may have negative feelings and perceptions of "being out of sync" with peers as they feel they are missing out on typical childhood experiences. In FC, Life Model theory is used to consider difficult life transitions, traumatic life events, environmental pressures, dysfunctional interpersonal processes, and the degree to which the environment is supportive through both formal and informal systems.

Crisis Theory

Crisis theory suggests that stressful life events can precipitate a state of crisis from being overwhelmed. A particular situation may be experienced by some as a crisis, but not by others – even within the same family system. For others, the traumatic event or crisis may become a significant risk factor for other problems. Because Family Connections targets families who are at risk of child maltreatment, it is likely that many families will be in crisis when service is initiated. Crisis theory in FC is applied when families are provided with immediate emotional, informational, and/or concrete aid. Some families may need immediate relief before they will be able to fully participate in services. Still other families may periodically experience crises at later stages of the FC intervention. The goal is to help clients function in difficult situations in a comfortable, growth-enhancing way by reducing stress and restoring, at a minimum, the previous functional level (Regehr, 2011). When crises occur, it is important to apply nine principles of crisis intervention (Ell, 1996):

1. Aid is provided as quickly as possible, often through outreach to families
2. Crisis interventions are time-limited and brief
3. The practitioner role is active
4. Symptom reduction is a primary goal
5. Practical information and tangible support are provided
6. Social support is mobilized
7. Expression of feelings, symptoms, and worries is encouraged
8. Effective coping is supported to restore a sense of competency as early as possible
9. Cognitive issues about reality testing and confronting the experience are addressed

Systems Theory

Systems theory provides a conceptual framework that shifts attention away from a cause-effect relationship between two variables and instead views a person and his/her situation as an interrelated whole. Systems theory *studies reciprocal relationships among individuals, groups, organizations, and communities and mutually inter-influencing factors in the environment. Behavior change is conceptualized to occur by examining interacting components* (Andrae, 2011, p. 242). This suggests that we need to study the entire system to understand the dynamic interactions, transactions, and organizational patterns that are critical to the functioning of both the individual and situation. This theoretical framework partly explains why FC staff work with families in their community and why their networks of support become part of the family plan and intervention process. Further, since FC staff work with a family as the family members define it, the principles of systems theory should be applied (Andrae, 2011, p. 246), including:

1. *The family system represents a subsystem of the larger community.*
2. *The whole is greater than the sum of its parts.*
3. *Changing one part of the system will lead to changes in others parts of the system.*
4. *Families organize and develop over time. Families are always changing, and, over the life span, family members assume different roles.*
5. *Families are generally open systems in that they receive information and exchange it with each other and with people outside the family. Families vary in their degree of being open and closed, which may vary over time and according to circumstances.*
6. *Individual dysfunction is often reflective of an active emotional system. A symptom in one family member is often a way of deflecting tension away from another part of the system and hence represents a relationship problem.*

There are four essential domains of environmental interactions for individuals and families, including the micro-, meso-, exo-, and macro- levels. For example, for a child, the *micro* system is the actual setting in which the child experiences and creates reality. At first, the micro- system is quite small – the home environment. However, as the child develops, the micro-system includes a broader base of activities in which the child plays, works, and learns to love others. In contrast, the *meso* systems are the relationships between contexts in which the

developing person experiences reality. The richness of meso-systems for the child is measured by the size (quantity) and depth (quality) of connections (Garbarino & Eckenrode, 1997). For example, the connection between home and school constitutes an important meso-system. Homes that do not value the benefit of schooling and the usefulness of books and reading nor stimulate children to participate in learning can jeopardize the child's academic development. However, when all these links are strong, the odds favor the development of academic competence. Exo-systems are all of the situations that influence a child but where the child does not directly participate, e.g., workplaces of parents, school boards, and other sources of power. Macro-systems include both meso-systems and exo-systems that are set within the broad ideological and institutional patterns of a particular culture or subculture (Garbarino & Eckenrode, 1997).

Family systems are governed by rules, for the most part unstated, which have typically been developed and modified through trial and error over time. Functions of individual family members are inextricably connected and a degree of reciprocity is essential in maintaining relationships in a system. Family systems are open or closed depending on the degree to which they are organized and interact with the outside environment.

Each family system has boundaries that separate it from the outside or non-family members. Family systems are dynamic and must maintain their continuity while tolerating change. However, systems always strive to maintain a stable equilibrium. A positive change in one member of the system can have a destabilizing effect and may be perceived as a threat by other members of the family. The system must be helped to frame the change as positive and desirable.

Role Theory

Role theory is used in *social work practice from a sociological understanding of how much of our functioning is shaped by modifiable role patterns developed throughout life* (Kimberley & Osmond, 2011, p. 413). Role theory helps us understand how a person's perceptions of role affect behavior and interactions with other family members. For example, individuals who experienced maltreatment may bring behaviors and expectations to the family situation because it is their understanding and experience of the role they are in rather than their choice. Some parents who are challenged to adequately care for their children are influenced by their inability to accept a parenting role. Frustration and stress can occur when roles are not well defined or the person does not have adequate resources to fulfill their role. This is especially important to remember since many of the reasons that some caregivers have difficulties meeting the basic needs of their children are not due to personal problems, but due to a lack of access to adequate resources that enable them to fulfill their caregiving role.

Cognitive Behavior Theory

Behavior theory assumes that all behavior is learned and can be both defined and changed. Clients learn that when they alter their behavior, they will receive a different response. Behavior theory suggests that looking at what happens before or after a behavior and changing one reaction or response, may change the outcome and consequences. Through reinforcement, clients' behaviors are shaped (Thomlison & Thomlison, 2011). *Build on three waves of behavioral theory, this approach holds that with active client participation, behavior can be modified through a wide range of tested techniques* (Thomlison & Thomlison, 2011, p. 77). Cognitive behavior theory posits the idea that if you can change the way you think, you can change the way you feel.

Since families come to FC with a range of presenting needs and challenges, some of them will be best addressed through cognitive behavioral techniques. In particular, the treatment of social, emotional, and behavioral problems of children, adolescents, and adults fit well with cognitive behavior therapy (CBT). Specific issues that may lend themselves to cognitive behavioral strategies include: child behavior at home and school, parent/child interaction, stress management, social skills, addictions, developmental disabilities, depression, couple problems, or family violence. Cognitive behavioral interventions can foster feelings of competence and control, and can instill hope.

Cognitive Theory

A cognitive approach to social work practice is based upon the idea that our thoughts affect our emotions and then our behavior. As a result, it is suggested that if you can influence thinking patterns that lead to dysfunctional patterns, then you can help clients experience different emotions which in turn affect behavior. For example, if a child is crying because he is teething, yet your thought pattern is that the child is deliberately crying because he does not love you and wants to punish you, you might feel less nurturing and comforting toward the child. Cognitive theorists and cognitive social work models of interventions believe that good social work treatment will include considerable effort directed toward helping the client identify, challenge, and change thinking patterns that result in dysfunctional forms of emotion, behavior, and problem solving (Lantz, 1996). Emerging from sociology, cognitive theory *helps us to understand how an individual, group, family, community, or organization thinks about a social reality and how such thoughts influence behavior* (Chatterjee & Brown, 2011, p. 103).

FC staff may choose to use cognitive interventions in any situation in which the comprehensive family assessment suggests that the problem is at least partially the result of thought processes. Cognitive strategies may be particularly relevant when caregivers have experienced deprivation in their own childhood. Described by Polansky, Chalmers, Williams, and Buttenwieser (1981) as "apathy-futility syndrome" or as "psychological complexity" by Pianta, Egeland, and Erickson, 1989, neglectful caregiving may be related to a failure of caregivers to have received nurturing when they were children. Cognitive interventions may help such caregivers change dysfunctional self-perceptions incorporated as a result of early experiences of neglect and abuse and break the intergenerational cycle of maltreatment (Egeland & Erickson, 1990).

Empowerment Approach

The empowerment approach focuses on empowering people as individuals, families, groups, and communities, to develop potential and assets (Lee & Hudson, 2011). The empowerment approach asserts that people in poverty and oppressed groups seldom have a goodness of fit with their environments. Empowerment involves assisting clients to develop a more positive sense of self, helping them achieve an understanding of their social and political realities, and facilitating their cultivation of resources and strategies to attain personal and collective societal goals. Empowering families is basic to the Family Connections approach. Our goal is to carry out interventions in a way that enables family members to acquire a sense of control over their lives because of their efforts to meet their needs (Dunst, Trivette, & Deal 1988). To accomplish this, we assume the role of working “with” the family, not “for” the family. This requires working hand-in-hand with clients to promote their sense of self-efficacy as they strive for independence.

In addition, over the long term, we may empower families by advocating for policy initiatives that focus on the social conditions that oppress large segments of the population—segments comprised by the poorest of the poor who, as a result of their poverty, may have difficulty providing minimally adequate care for their children. As we get to know the families in their neighborhoods, we may choose to help them advocate for policies and programs such as affordable child care, increased education and employment opportunities, adequate low-income housing and rent subsidies, and large scale drug prevention and treatment initiatives (Nelson, Saunders, & Landsman, 1993).

Attachment Theory

Attachment theory, developed by John Bowlby (1982), *focuses on the form, quality, and strength of human attachments made in early life and their effect on development and pro-social behaviors* (Page, 2011, page 30). Attachment theory as applied to Family Connections focuses on parental/caregiver attachment to their children and how the historical styles of relating to others, experienced by the parent, influence the parent’s capacity to form secure attachments with their own children (Erickson, Egeland, Simon, & Rose, 2002; Egeland, 2007; Sroufe, Egeland, Carlson, & Collins, 2005). Attachment theory informs work with both children and caregivers. Early attachments with primary caregivers form the basis for later adult and caregiver-child relationships. When

these attachments are severed, inconsistent, or affected by trauma or maltreatment, the capacity to build adult relationships and caregiving skills may be impaired.

Despite the potentially deleterious effect of early psychosocial deprivation on humans, many maltreated children show resilience and are able to build positive working models and securely attached relationships. The ability to form a coherent understanding and narrative of early childhood experiences has been related to successful adult attachment relationships and parenting. For example, in one study, adults who reported negative attachment relationships in childhood but were able to later form secure attachments in adulthood showed similar parenting ability to those with continuous positive experiences throughout the life course (Roisman, Padron, Sroufe, & Egeland, 2002).

Trans-Theoretical Model of Change

The Trans-Theoretical Model assesses an individual's readiness to act on new behaviors and provides strategies for change to guide the individual through the stages of change (Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992). The degree to which clients are ready to change varies over time and has been described as following a pattern that includes:

- Precontemplation: not seeing the need to change
- Contemplation: considering change but also rejecting it
- Preparation: wanting to do something about the problem and may have begun small steps to change
- Action: taking steps to change
- Maintenance: maintaining goal achievement
- Termination: sufficient change has occurred

Although not a specific stage, relapse should also be considered as it involves a return from Action or Maintenance to an earlier stage. Rarely do clients follow these stages sequentially; rather, they are more likely to be at different stages in addressing different aspects of their behavior. In Family Connections, we try to understand how ready clients are to change by assessing their comfort with the status quo and asking them to consider the pros/cons of making particular changes. We then use techniques to try to instill hope that the situation can be different. We continually assess motivation, how it is connected to the client's core values, and whether their goals are realistic.

Chapter

5

GUIDING PRACTICE PRINCIPLES

This implementation is a replication of the Family Connections model of practice. The program design is family-centered, community-based, preventive, comprehensive, and flexible and employs a set of philosophical practice principles that have evolved from what research has proven works best with vulnerable families (Dunst, Trivette, and Deal, 1988; Hopps, Pinderhughes, and Shankar, 1995; Kinney, Strand, Hagerup, & Bruner, 1994; and Schorr, 1989). This chapter provides an overview of nine philosophical practice principles that guide FC intervention: (1) community outreach; (2) family assessment and tailored interventions; (3) development of a helping alliance; (4) empowerment approaches; (5) strengths perspective; (6) cultural competence; (7) developmental appropriateness; (8) outcome-driven family plans; and an (9) emphasis on positive attitudes and qualities of helpers. In addition, the FL-FC team added critical thinking as a core principle. These principles drive the *way* we work with families and support practitioners to implement FC intervention with fidelity. A brief summary of how each of these principles supports our work follows.

Importance of **Outreach** and Community

Families with children whose basic needs are at risk of being unmet are typically poor and lack adequate financial support and access to resources (Gaudin, 1993; Smale, 1995). Further, these families and are more likely to be socially isolated, experience loneliness, and lack social support (DePanfilis, 1996). Finally, the available literature shows that traditional, in-office, one-to-one counseling by professionals has not been proven effective in reducing the risk of child maltreatment (Cohn & Daro, 1987).

> Family Connections intervention includes aggressive outreach and advocacy and is designed to mobilize concrete formal and informal helping resources.

As Family Connections' staff, we believe that it is essential to engage, support, and provide services to families within their homes, neighborhoods, and communities. As we gain knowledge of the neighborhood or community, we are in a better position to understand family members in their daily environment and to respond to most families' natural resistance to change (Anderson & Stewart, 1983). Working with each family in its natural setting allows staff to do a more accurate family assessment and develop a more meaningful and achievable family plan.

A central focus of the FC intervention is to use each family's strengths and community resources to achieve mutually agreed upon goals. Community supports may include schools, churches, day care services, legal aid, health centers, other social service providers, relatives, and friends. As community partners are identified, our goal is to help the family develop and manage beneficial relationships to meet their on-going needs. In addition to including community partners in the assessment and service planning processes, these connections are established to ultimately benefit the community as a whole.

Importance of Family **Assessment** and Tailored Intervention

Effective intervention to reduce the risk of child maltreatment is based on a comprehensive, individualized, collaborative assessment of the family. The assessment considers the *types* of maltreatment that may occur without our intervention and the *specific contributing risk factors* at the individual, family, neighborhood, and community levels.

> Family Connection intervention involves individualized family assessment and tailors services to meet the unique needs of each family.

When available, this individualized assessment is undertaken in conjunction with other service providers to form a comprehensive picture of the individual, interpersonal, and societal pressures on the family members - individually and as a group. This holistic approach takes both client competencies and environment into consideration (Whittaker, Schinke, and Gilchrist, 1986) and views the environment as both a source of and solution to families' problems (Bronfenbrenner, 1979; Garbarino, 1982).

For both practice accountability and empirical usefulness, staff incorporate the use of standardized clinical measures of risk and protective factors (Children's Bureau of Southern California, 1997), in their assessment of specific family needs and problems. These identified needs are then translated into specific intervention outcomes that form the basis of time-limited, individualized family service plans. This process involves tailoring services to the unique needs of each family.

Family Connections staff work with each family to develop an individualized family assessment to identify risk and protective factors to guide the development of individualized tailored intervention. Each family is considered an expert of its family and is treated with dignity and respect. Each family is encouraged to invite other providers involved with the family to participate in the assessment, allowing us to get a more comprehensive view of the family in their community. The assessment considers the family as a whole and each family member as an individual as they relate to each other and to their community. This holistic approach takes both client competencies and environment into consideration (Whittaker, Schinke, & Gilchrist, 1986) and views the environment as both a source of and solution to families' challenges (Bronfenbrenner, 1979; Garbarino, 1992).

Because each family is unique and families who are at risk of child maltreatment are heterogeneous, no particular method of intervention will lead to desirable outcomes for even a majority of families (National Research Council, 1993; Wolfe, 1993). Further, because of the many different types of family systems, it is important that intervention be geared to the family's own definition of family and to culturally based differences and strengths (Lloyd and Sallee, 1994). Mainstream efforts with families in the past have focused too exclusively on mothers and have not explored the roles of fathers and other primary caregivers.

Importance of Developing a Helping Alliance and Partnership with the Family

Many families at risk for child maltreatment may not have had positive experiences with formal systems. However, an essential component of many effective programs was the creation of a helping alliance and partnership with the family (Dore and Alexander, 1996; Kenemore, 1993).

> Family Connections staff members develop helping alliances with families as a primary mechanism for supporting and strengthening family functioning and change, acknowledging the family's voice and perspective, and demonstrating approaches to communication and interaction that are positive and validating.

This requirement is sometimes challenging because some caregivers, whose children may be at risk of maltreatment, may have difficulty forming and sustaining mutually supportive interpersonal relationships (Dore and Alexander, 1996; Gaudin and Polansky, 1986). One of the essential challenges for practitioners is to form positive connections and partnerships with families so that they will have an opportunity to tackle the difficult challenges in their lives (McCurdy, Hurvis, and Clark, 1996). Successful engagement with families, who may be resistant to intervention, requires an ability to feel and demonstrate empathy with caregivers (Siu and Hogan, 1989) despite their initial resistance to intervention.

Building relationships with caregivers, models conflict resolution and how they may in turn build harmonious relationships that nurture the development of vulnerable family members. (Bowlby, 1988; Crittenden, 1996). Crittenden, (1996) suggests that when the practitioner sensitively attends to the affective communication of family members, a pattern of feedback loops leading to mutual accommodation and assimilation is established. These dialogues acknowledge and support caregiver strengths and provide family members with a secure base for developing communicative skills (Bowlby, 1988). Through this process, practitioners can create interventions tailor-made to each family's needs and competencies (Crittenden, 1996).

Research has shown that effective engagement can be facilitated through evidence-based engagement practices that are designed to help families identify and overcome obstacles through participation in services (McKay, et al., 2004; Lindsey, Korr, Broitman, Bone, Green, & Leaf, 2006). The helping alliance begins to be established with the first intake contact and first face-to-face meeting with the family. Engagement strategies have been shown to increase continued participation in services and help develop a strong therapeutic relationship that addresses the goals the family deems most important (McKay, et al 2004). To be effective over time, the intervention must help families develop more sustaining relationships with others. If intervention is neighborhood based, then these relationships will have a greater chance of enduring after intervention ends.

Importance of Empowerment Based-Practice

Empowerment is both a theory and a practice. It is also a process as well as an outcome (Lee & Hudson, 2011). To decrease child maltreatment risk, interventions must help families learn to effectively manage the multiple stresses and challenges in their families and neighborhoods. Ultimately, families should be empowered to resolve their own problems and avoid dependence on the social service system (Lloyd & Sallee, 1994).

> Family Connections empowers family members to acquire a sense of control over their lives as a result of their efforts to meet their own needs.

Empowerment denotes a partnership between the practitioner and the family and involves the development and use of capcities of the individual, family, organization, and community (Fraser & Galinsky, 1997). Drawing on these capacities helps families fully realize their own abilities and goals (Cowger, 1994; Guitierrez, 1990; Guitierrez, GlenMaye, and DeLois, 1995; Simon, 1994). The role of the helper becomes one of partner, guide, mediator, advocate, coach, and enabler.

Importance of Emphasizing Strengths

The strengths-based perspective can be applied with diverse populations (Saleebey, 1996; Trivette, Dunst, Deal, Hamer, & Prompst, 1990) and has particular relevance to families at risk for child maltreatment (DePanfilis, Okundaye, Glazer-Semmel, Kelly & Swanson-Ernst, 2002; DePanfilis & Wilson, 1996).

> Family Connections provides the opportunity to build on a family's existing competencies to respond to crises and stress, to meet needs, and to promote, enhance, and strengthen the functioning of the family system.

Strengths-based practice involves a shift from approaches that emphasize problems, deficits, and pathology to one that fosters a positive partnership with the family. The focus on assessment is on the complex interplay of risks and strengths (protective factors) related to individual family members, the family as a unit, and the broader neighborhood and environment. This is not to suggest that staff avoid addressing problems or needs, but helps us step back and put them into the larger context of family and community, *while* considering strengths to help improve the family's functioning. The focus of FC intervention is not on the correction of a problem through deficit thinking. It is on recognizing the conditions within the family and community that may be contributing to the problem and helping the family to identify strengths and resources within it and the community to meet its needs.

Importance of Culturally Competent Intervention

Risk and protective factors for child maltreatment may differ according to race and ethnicity. Furthermore, it is well established that families of color, and especially African American families, are disproportionately represented in the child welfare system (Leashore, Chipungu, & Everett, 1991; Chibnell, , et al., 2003). Often these families are poor, poorly educated, and disadvantaged in the economic mainstream of the larger society (Jackson & Brisett-Chapman, 1997; Chibnell, et al., 2003). It is also well documented that children from African American, Hispanic, and non-Caucasian racial and ethnic backgrounds are subject to direct and indirect effects of discrimination, which increases their risk for many kinds of problems (Fraser & Galinsky, 1997).

> Family Connections strives to prepare staff to engage in culturally competent practice so that they may understand the worldview of their clients, accept and respect cultural differences, and empower families to create intervention goals that are congruent with their culture.

Culture is a set of beliefs, attitudes, values, and standards of behavior that are passed from one generation to the next. It includes language, worldview, dress, food, communication styles, notions of wellness, healing, spirituality, child-rearing, and self-identity (Abney, 2001). Human beings create culture, and each group develops its own over time. Culture is dynamic and ever changing. It changes as the conditions of people change and as their interaction with larger society changes. Every culture has a set of assumptions made up of beliefs that are so accepted by the group that they do not need to be stated, questioned, or defended. Cultural competency is the ability to understand, to the best of one's ability, the worldview of our culturally different clients (or peers) and adapt our practice accordingly. To best meet the needs of culturally diverse families, FC staff must use empathy, notice differences, and reflect on the uniqueness of each family (Wu, et. Al., 2009).

Developmental Appropriateness of Interventions

> Family Connections practitioners are trained to consider the developmental level of children, caregivers, and the family as a system in their assessments and intervention strategies.

Children whose basic physical and emotional needs have been unmet may suffer significant developmental delays. Interventions may need to focus on developmental remediation, (e.g., therapeutic day care), while at the same time address attachment relationships between caregivers and children. Caregivers may bring a host of developmental issues to the family, such as unresolved losses, abuse, or deprivation during childhood, and/or may have difficulty assuming parental roles. Described by Polansky, Chalmers, Williams, & Buttenwieser (1981) as "apathy-futility syndrome" or "psychological complexity" by Pianta, Egeland, & Erickson (1989), maltreating

caregiving may be related to caregivers having themselves experienced inadequate nurturing in their own childhood. Cognitive interventions can help such caregivers change dysfunctional self-perceptions incorporated as a result of early experiences of abuse/neglect and break the intergenerational cycle of maltreatment (Egeland & Erickson, 1990).

Families may be suffering stress due to their developmental stage as a system (e.g., blended, young) or due to conflict in roles when families are comprised of caregivers across generations (e.g., grandparents, parents, children, grandchildren, and great-grandchildren). For example, our society is increasingly seeing grandparents raising their grandchildren due to neglect by the parents. These newly constituted families often lack security due to informal arrangements and inadequate resources (financial and physical) to provide adequately for children. Further, the life cycle stages through which families evolve (Carter & McGoldrick 1988) are interrupted, and caregivers who thought that their child rearing days were concluded are unexpectedly unable to look forward to fewer demands during their later years. An essential FC practice principle is that our interventions target the specific developmental needs of children, caregivers, and the family as a system.

Outcome Driven Intervention

John Schuerman, a former Professor at the University Of Chicago School of Social Services Administration, suggests that the future of the social work profession will depend on the ability to specify and measure the outcomes of social work practice (Mullen & Magnabosco, 1997). Similarly, Shanti Khinduka, the former Dean of the George Warren Brown School of Social Work at Washington University, suggests that measuring the results of interventions is an essential component of social work practice today (Mullen & Maganabosco, 1997). Almost twenty years after these statements, there is a general consensus that social workers must be able to collaborate with clients to mutually define outcomes; develop goals, objectives, and family plans to achieve outcomes; and define adequate measures for evaluating the degree to which families are successful at achieving outcomes. It is essential that FC programs clearly measure the results of their work in order to determine what is working well and what needs to be developed or improved to benefit families.

> Family Connections intervention is geared to help families achieve outcomes that will strengthen family functioning and reduce the risk of neglect.

FC interventions are geared to help families achieve outcomes that strengthen family functioning and reduce maltreatment risk. As noted in the FL-FCC logic model (see chapter 3), Florida FC staff work with families to target interventions toward one or more core intermediate outcomes: (1) living conditions; (2) financial conditions; (3) support to caregiver; (4) caregiver/child interaction; (5) developmental stimulation; and (6) caregiver to caregiver interaction. If achieved, the FL-FCC leadership team believes that program outcomes will also be achieved: (1) children served in the most appropriate least restrictive setting; (2) decreased recurrence of child maltreatment; and (3) decreased entry to care.

Positive Attitudes and Qualities of Helpers

To be effective delivering FC intervention, staff must possess specific qualities and skills including: concern for others; feel a commitment and obligation to the families they serve; communicate acceptance and expectation in their work with families; convey empathy and genuineness in all interactions with their clients; demonstrate comfort with authority and power; and accept and focus on the purpose of FC intervention.

> Family Connections promotes the development of positive attitudes and qualities and effective ways of helping by selecting staff with these qualities and skills and providing coaching and supervision to build and sustain a professional approach to FC practice. .

Selecting staff with core helping skills and building competency in FC practice through training and supervisory coaching is a strategic implementation expectation of FC (see Chapter 3). In particular the learning and coaching approach including weekly individual and group supervision is expected to support staff to develop and strengthen effective ways of helping:

(1) a skillful use of self;

(2) flexible and caring attitudes with clients;

(3) an interest in and ability to engage clients and form meaningful relationships with families;

(4) a profound belief in a family's ability to change;

(5) empowerment skills to develop client behaviors that improve the use of personal power, foster self-esteem, take care of personal problems, and set and pursue personal goals;

(6) tolerance/acceptance of race, ethnicity, and gender and serve as a role model for respect and tolerance of diversity;

(7) skills that involve the family in planning and in every stage of the Family Connections case process; and

(8) the ability to advocate for clients to obtain needed resources from community organizations.

Emphasis on Critical Thinking Skills

The FL-FCC Implementation Team added critical thinking skills to the core list of FC practice principles. Critical thinking as defined by the National Council for Excellence in Critical Thinking (undated) *is the intellectually disciplined process of actively and skillfully conceptualization, applying, analyzing, synthesizing, and/or evaluating information gathered from, or generated by, observation, experience, reflection, reasoning, or communication, as a guile to belief and action.*

> Family Connections emphasizes the importance for staff to focus on, collect, and document critical information about a family or individual in a consistent and accurate manner.

While there are many professional tools, some of which are discussed in this manual, available to assist with the assessment of families, it should be recognized that these tools are intended to enhance the decision-making process and should not be used in the place of critical thinking and/or clinical judgment (CalSWEC, 2011). Unlike professional tools, critical thinking most often stems from personal experiences, new research and/or professional knowledge and training, and may include input from other professionals or supervisors. As a practice principle, FC staff use critical thinking skills while evaluating and serving families and actively seek additional facts where there are gaps or inconsistencies in available information. This will help ensure that accurate, well-informed decisions are made on behalf of the families being served.

Chapter

6

ELIGIBILITY AND INTAKE

Initial Intake: The Importance of Accurate Screening

The purpose of Family Connections, as applied by the Florida Family Connections Collaborative, is to serve children in the most appropriate, least restrictive setting, decrease the recurrence of child maltreatment, and address factors related to child maltreatment in order to decrease the risk of out-of-home placement. To achieve this, the intake process must accurately identify families at risk of maltreatment and screen out those not at risk of maltreatment.

FC was specifically designed and tested to help families reduce risk factors associated with child maltreatment and to strengthen protective factors that help them meet the basic needs of their children and keep them safe. For FC to have the greatest chance of success in serving families, accepted intake referrals must match families who can benefit from this level of intervention. When families are screened in that are not a good candidate for FC, we reach families who do not need this level of intervention. We also increase the likelihood of families dropping out of the program, having an unclear intervention focus and unclear outcomes, and promoting families' dependence rather than independence.

Staff that considers referrals to FC must employ a systematic process to gather and analyze information in order to make appropriate decisions about who is eligible for FC. They must also document the process and rationale for their decisions, and supervisors must be involved to support thorough information gathering and appropriate decision-making.

Family Connections Eligibility Criteria

During the intake and screening process, the Department of Children and Families (DCF) gauges the appropriateness of the family for FC after the completed Family Functioning Assessment (FFA) concludes that the children in the household are safe—as defined through the Florida Safety Methodology—and may be at risk for additional maltreatment. The DCF referral source, typically the Child Protective Investigator (CPI), may refer the family for FC screening.

For FC to have the greatest chance of success in serving families, the family must be willing to participate. Once the CPI discusses FC with the family and the caregiver expresses a willingness to participate, the CPI starts the intake process through the appropriate Community Based Care (CBC) staff. The designated CBC staff gathers and analyzes information, including having a discussion with the CPI, to determine FC eligibility.

Two levels of eligibility criteria must be considered and met. During the intake process, CBC staff interview the CPI and gather information to determine whether information about the family meets both levels of eligibility criteria prior to accepting a family to receive FC.

Level I Eligibility Criteria

Families must meet all Level I criteria to proceed to the next level of screening:

- Family resides in the geographic catchment area, and
- Family has at least one child between the ages of birth to 17 who resides in the home, and
- Family is referred by DCF, after the completed FFA has concluded the child(ren) are safe and risk assessment is high/very high[1], and
- Family is willing to participate in Family Connections

GEOGRAPHICAL CATCHMENT AREA – The Florida FCC defines its geographic boundaries to be within the catchment area served by the CBC. This permits the program to develop collaborative relationships with neighborhoods and communities and to empower families to access existing services close to home.

HOUSEHOLD COMPOSITION – We serve diverse families that vary by composition and size. However, a criterion for inclusion in Florida FC is that at least one child between birth and 17 years of age resides in the household.

FAMILY REFERRED BY DCF, FFA CONCLUDES CHILDREN SAFE AND RISK ASSESSMENT IS HIGH/VERY HIGH – DCF must refer the family for FC. The completed FFA by the CPI must conclude with a determination that the children are safe as defined in the Safety Methodology. The SDM Actuarial Risk Assessment completed by DCF must also identify the family risk level to be high or very high. FC strives to reach families early, before problems become deeply entrenched or have evolved to the point of needing further intervention in the child welfare system or entry into care.

FAMILY IS WILLING TO PARTICIPATE – Services are voluntary. Prior to initiating the intake and screening process, the CPI discusses the FC program with the family to confirm it is interested in receiving services.

Level II Eligibility Criteria

To be eligible for FC, all families must meet this Level II requirement: At least two of these criteria must be met from any given category. In addition, the risk factor(s) must be at a level that currently impacts the adequacy of the care of a child and is likely to continue to present maltreatment risk in the future:

Primary Caregiver (challenges that currently impact caregiving)

- *Employment*
  - *Unemployed:* parent or caregiver does not have work or a paid job or may be employed, yet income is insufficient to manage the household.
  - *Overemployed:* parent or caregiver is "willing but unable at their current job(s) to reduce the amount of time they devote to earning an income," (Golden, 2003). The parent or caregiver may hold several jobs to meet financial needs.
  - *Newly employed:* parent or caregiver has recently obtained work or a job or has returned to work or a job after a length of time of being unemployed.
- *Mental Health Problem:* parent or caregiver has a prior or existing diagnosis of a mental disorder (e.g., major depression, bipolar disorder, anxiety disorder, schizophrenia) or symptoms of mental disorders that may not meet the criteria to merit a diagnosis of a mental

[1] See Chapter 6 addendum if the referral is made in a district that has not yet converted to using the FL Safety Methodology.

disorder (e.g., low self-esteem, excessive worrying, confused thinking) (Maryland Department of Health and Mental Hygiene)

- *Alcohol or Substance Abuse Problem:* parent or caregiver uses a substance(s) (alcohol or other drugs) leading to difficulty in fulfilling responsibilities at school, home, or work; physically hazardous situations; legal problems; recurrent social and interpersonal problems; or all of these. The individual may experience substance dependence and use a substance despite significant substance-related problems including tolerance, withdrawal, and compulsive use. (American Psychiatric Association, 2000).

- *Serious Health Challenge:* parent or caregiver has an illness, injury, impairment, chronic health condition, or physical condition that impacts their functioning.

- *Teen Parent:* parent or caregiver of a child is under the age of 20 or a parent under the age of 20 is expecting the delivery of a child and already is caring for a child.

- *Developmental Disability:* a parent or caregiver has a severe, chronic disability that is attributable to one or a combination of a mental or physical impairment, begins before the individual obtains age 22, is likely to continue indefinitely, and results in substantial functional limitations in three or more areas of major life activities including self-care, receptive or expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. There is also a need indicated for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are planned and coordinated for that individual. [Developmental Disabilities Assistance and Bill of Rights Act, Section 102 (8), 2000]. Examples of developmental disabilities include Autism, Cerebral palsy, Down syndrome, Fetal alcohol syndrome, Spina bifida, and intellectual disabilities.

Family (challenges that make it more difficult to meet the basic needs of children)

- *More than 3 children in household:* family or home with 3 or more children residing together as part of the same family unit, household, or dwelling.

- *Homelessness:* a lack of housing, including when the primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and residents in transitional housing. Individuals without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. [Section 330 of the Public Health Service Act (42 U.S.C., 254b), 1996]. A family may be considered to be homeless if the family is “doubled up,” a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. Recognition of the instability of an individual’s living arrangements is critical to the definition of homelessness. (HRSA/Bureau of Primary Health Care, Program Assistance Letter 99-12, Health Care for the Homeless Principles of Practice). The family may be at risk of becoming homeless (e.g. family received an eviction notice).

- *Domestic Violence:* a pattern of assaultive and/or coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners. (Schechter and Edelson, 1999).

- *Single Parent:* families with children under age 18 headed by a parent or caregiver who is widowed or divorced and not remarried, or by a parent who has never married. (www.healthofchildren.com, 2014).

Child (challenges that make caring for specific children more difficult)

- *Behavior or Mental Health Problem:* child has a prior or existing diagnosis of a mental disorder (e.g., attention-deficit/hyperactivity disorder, depression, anxiety) or symptoms of mental disorders that may not meet the criteria to merit a diagnosis of a mental disorder (e.g., low self-esteem, distractibility, excessive worrying). (Maryland Department of Health and Mental Hygiene, Missouri Department of Mental Health, and National Council for Community Behavioral Healthcare, 2012). Child may also have noted behavior problems (e.g., truancy, aggression, stealing, extreme tantrums, disruptive in class).

- *Physical Disability:* a child with any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine. (Americans with Disabilities Act, 1990).

- *Developmental Disability:* a child with a severe, chronic disability that is attributable to one or a combination of a mental or physical impairment, begins before the individual obtains the age of 22, is likely to continue indefinitely, and results in substantial functional limitations in three or more areas of major life activities including self-care, receptive or expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. There is also a need reflected for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are planned and coordinated for that individual. For infants and young children under the age of five-years-old, children who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities [Developmental Disabilities Assistance and Bill of Rights Act, Section 102 (8), 2000]. Examples of developmental disabilities include Autism, Cerebral palsy, Down syndrome, Fetal alcohol syndrome, Spina bifida, and intellectual disabilities.

- *Learning Disability:* a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. (Individuals with Disabilities Education Act, 2004).

- *Alcohol or Substance Abuse Problem:* child uses a substance or substances (alcohol or other drugs) leading to difficulty in fulfilling responsibilities at school, home , or work; physically hazardous situations; legal problems; recurrent social and interpersonal problems; or all of these. The individual may experience substance dependence and use a substance despite significant substance-related problems including tolerance, withdrawal, and compulsive use (American Psychiatric Association, 2000).

- *Serious Health Challenge:* child has an illness, injury, impairment, chronic health condition, or physical condition that impacts their functioning.

Stages of the Intake Interview Process

Intake staff that interview the referral source should follow three stages in conducting the interview, which is intended as a two-way conversation:

1. **Introduction:** Intake staff introduce themselves and the FC program and engage the referral source in an open, interactive discussion. For example, Intake staff might ask the referral source how they heard about FC or what they know about it. Intake staff should explain that the interview will take about 10-15

minutes in order to gather as much information as possible and to provide the referral source adequate opportunity to ask questions. Intake should initiate the information gathering process by asking an open-ended question, such as "Please tell me why you are calling today?, What are your concerns? Would you please tell me about the family you're calling about?" Intake staff should succinctly gather basic demographic information—at this point in the process, the information can generally be limited to names, household address, and contact information—and should confirm that the parent/caregiver has provided permission for the referring source to make the FC referral and has indicated its willingness to participate in FC. Intake staff might pose any of the following questions: "How have you described FC to the family? What does the family know about FC? How have you determined the family's willingness to participate?"

2. **Exploration:** This is the stage in the interview where Intake staff gather additional and more detailed information on the reasons for the referring source's concerns about the family. The purpose of Exploration is to collect sufficient relevant information to flesh out the family's risk factors for child maltreatment, the extent to which the risk factors are affecting the children's care and basic needs, and the family's eligibility for FC. Intake staff may use the Intake screening form to guide exploration but should not simply pose close-ended questions or ask questions in a scripted manner that sounds like a checklist. Rather, Intake staff should use open-ended questions and other skills (detailed below) to flesh out what the referral source knows about the family and is concerned about.

3. **Closing:** The concluding stage involves Intake staff using summarization to do a final review and confirmation of the information that has been collected during the interview. The parent's/caregiver's willingness to be referred to FC and participate in FC should be confirmed again. In addition, Intake staff should state the next steps that will occur (i.e., FC staff will attempt to schedule the first visit with the family and, during the visit, confirm the family's voluntary participation in FC). Intake staff should also clarify what role, if any, the referring source will have with the family.

Skills Employed During the Intake Process

CBC staff, who talks with the referral source over the phone or in person, use skills that support the CPI's ability to share relevant information about the family so that eligibility can be assessed. Whether in person or over the phone, it is very important that staff approach this process using a calm, open demeanor and employ specific interviewing skills as they gather information about the family. These skills are described below.

Open-Ended Questions

It is usually best to begin by asking the referral source, "Please tell me why you are calling today" and to gradually elicit information about why the referring party is concerned about the family. Rather than going through the screening criteria like a checklist and using only close-ended questions, which can sound interrogatory and can sometimes constrain or limit the information that is shared, intake staff should use open-ended questions to encourage the source to talk freely about the family so staff can gather sufficient information to assess whether the family meets eligibility.

Close-Ended Questions

Certain information lends itself to using close-ended questions. This is often straightforward, factual, or yes/no information. Examples include: *Please tell me the names of the parents, address, and phone number. When was the last time you saw the family? What are the ages of the children?*

Paraphrasing

Paraphrasing is a technique for clarifying statements, opinions, or concerns expressed by the referring source. It involves summarizing the source's own words to clarify or highlight a key point made by the source. Examples:

You said that the last time you saw the child, he told you he was scared when his parents fought. You shared several concerns about family…It seems like your biggest worry is that the father gets drunk on weekends and take his anger out on the kids.

Verbal Encouraging and Probing

These techniques, which can be framed as statements or questions, encourage the source to provide more information. Examples: *Please go on. Uh-huh…I see. Did you happen to ask when the last time something like that happened? You mentioned that the children often miss school; have you ever noticed a pattern or trend when they're more likely to miss school?*

Reflective Listening

This involves you interpreting what a referral source believes, thinks, or feels based on what she/he has said so far. You would state your interpretation back to confirm whether you heard or understood correctly. Example: *From what you said, the family relies on you to provide back-up childcare. And you've been willing to do this from time to time but not every day and certainly not at the last minute without advance planning.*

Summarizing

Similar to paraphrasing, this technique can be used to check in with the source to confirm you have understood the key points of what they have said and to give them the opportunity to correct, confirm, or otherwise amend anything that they shared. This technique is especially helpful to use at the end of the Intake interview to summarize the source's primary concerns and reasons for making the referral.

Receiving Referrals

Referrals to FC come from one primary source: DCF, specifically following a determination by the CPI that a family is a good match for the program. Families must meet all eligibility criteria. Each CBC will have staff designated to manage referrals, engage in the intake process with the referral source, and determine eligibility. FC referrals will be received Monday through Friday during office hours and addressed within one business day. Described below are the procedures for responding to a FC referral.

Referrals from Department of Children and Families

Family Connections is a partner in child protection through preservation services to families. We maintain contact with DCF to promote FC for families who are deemed safe at the completion of the FFA, risk has been identified as high or very high, and the family may be appropriate for this level of intervention. DCF refers families to FC when the family may be at risk for future maltreatment and the family is willing to participate voluntarily. FC staff along with other appropriate CBC staff ensure that DCF staff understands the FC eligibility criteria.

Following the initiation of the intake and screening process by DCF, which will typically be by the CPI, the designated CBC staff will contact the CPI to understand the reasons for the referral, gain information needed for intake, confirm the family's willingness to participate in FC, and identify when the family expects to be contacted if it is determined eligible for FC. The CBC FC Intake Supervisor will review and confirm eligibility. The CBC determines eligibility. If the family is eligible for FC, the CBC will approve services and provide the detailed intake information to the FC Supervisor as well as any other designated FC staff. The family will be assigned to a FC staff member. Once it has been determined that the family meets FC eligibility criteria by the CBC approving services and the FC supervisor has received the referral, the assigned FC staff schedules and holds a face-to-face contact with the family within one business day. A joint visit between the FC staff and CPI with the family may occur but is not required.

If during the intake process or discussion with the referral source it becomes apparent that FC is not a good fit for the family or the family does not meet eligibility criteria, the referral source will be provided

with information about other potential options, including but not limited to alternative services, that may better meet the strengths and needs of the family.

Intake and Screening Form

The Intake and Screening Form (Appendix B) is used with the referral source to establish eligibility for FC participation. When receiving intake information, the designated CBC staff should ask for the information outlined in the Intake and Screening Form and enter it in the form.

The Intake and Screening Form is designed to guide the process to gather information on the referral source, family, presenting concerns, risk factors identified, supporting explanation for how and why the family meets eligibility criteria, and the referral decision. All of these sections should be completed with supporting explanation that justifies the selection of the specific eligibility criteria. The designated CBC staff that completes the Intake and Screening Form ensures that the CBC FC Intake Supervisor reviews the intake, confirms eligibility, and approves the referral decision. The completed Intake and Screening Form will be uploaded to the Florida SACWIS system, Florida Safe Families Network (FSFN).

ELIGIBILITY AND INTAKE ADDENDUM

Implementation of Florida's Safety Methodology, the framework and practice model for child welfare investigations and case management in Florida, is taking place across Florida and specifically in geographical areas that will be served by the Florida Family Connections Collaborative. However, implementation of Safety Methodology is occurring in phases with some local areas applying practice sooner than others as part of a planned implementation of the practice model. The current and ongoing implementation of Safety Methodology in some areas, and not others, has implications for the FC intake and eligibility process, particularly Level I Eligibility Criteria and the interview screening process, that are discussed in this addendum.

For areas that have not implemented Safety Methodology yet, the Department of Children and Families (DCF) Child Protective Investigators (CPI) will not be completing the Family Functioning Assessment (FFA) during the course of their investigation. Without the completion of the FFA by the CPI, there will be no determination of the children as safe or unsafe as defined by the Safety Methodology. Therefore, modification to the FC Level I Eligibility Criteria and considerations for the interview to determine eligibility for FC will be made when accepting referrals from sites not currently practicing the Safety Methodology. The use of this addendum and alternate eligibility criteria will only be used in areas not practicing the Safety Methodology. When implementation of Safety Methodology occurs in an area, modifications to the criteria discussed in this addendum will no longer be needed.

Family Connections Eligibility Criteria – Areas Not Practicing Safety Methodology

During the intake and screening process, the Department of Children and Families (DCF) gauges the appropriateness of the family for FC at the completion of the Child Safety Assessment (CSA) and concludes that family is appropriate for prevention services—and may be at risk for additional maltreatment. The DCF referral source, typically the Child Protective Investigator (CPI), may refer the family for FC screening. The completion of the CSA is important as FC strives to accept families to the program who can benefit from the level of intervention the program provides. FC cannot accept cases when the CPI may still be conducting their assessment or waiting for additional information in order to make a determination of pathway (i.e. shelter/legal action, in-home supervision, or diversion in areas not practicing Safety Methodology). Families with active safety plans or with children considered conditionally safe with the provision of a safety plan would also not be appropriate for referral to Family Connections. The heart of the FC intervention is engagement and the facilitation of a change process with families along with the other core service provision components and practice principles. Monitoring of a safety plan is not a focus of FC and not an appropriate activity for FC staff. Chapter 8 Responding to Emergency and Concrete Needs provides information for staff on the identification and reporting of child maltreatment.

For FC to have the greatest chance of success in serving families, the family must be willing to participate. It is also helpful for the family to be aware of the typical duration and time commitment for the program. Consideration should be given to the family's ability to meet face-to-face each week and any known plans the family may have for the expected length of the program, approximately four months (e.g. if it is known the family plans to move out of the CBC catchment area at any time during the anticipated duration of the services, it is not appropriate for referral to FC). Once the CPI discusses FC with the family and it is willing to participate, the CPI starts the intake process through the appropriate Community Based Care (CBC) staff. The designated CBC staff gathers and analyzes information, including having a discussion with the CPI, to determine FC eligibility.

Two levels of eligibility criteria must be considered and met. During the intake process, CBC staff interview the CPI and gather information to determine whether information about the family meets both levels of eligibility criteria prior to accepting a family to receive FC. This addendum addresses Level I Eligibility Criteria only, as it includes changes specifically designed for determining eligibility when receiving referrals from sites not practicing Safety Methodology. See the complete chapter for Level II Eligibility Criteria as it remains the same.

Level I Eligibility Criteria

Families must meet all Level I criteria to proceed to the next level of screening:

- Family resides in the geographic catchment area, and
- Family has at least one child between the ages of birth to 17 who resides in the home, and
- Family is referred by DCF, after the completion of the CSA and no active safety plan open with a determination that the family is appropriate for prevention services and not in need protective supervision by the CBC, and
- Family is willing to participate in Family Connections

GEOGRAPHICAL CATCHMENT AREA – The Florida FCC defines its geographic boundaries to be within the catchment area served by the CBC. This permits the program to develop collaborative relationships with neighborhoods and communities and to empower families to access existing services close to home.

HOUSEHOLD COMPOSITION – We serve diverse families that vary by composition and size. However, a criterion for inclusion in Florida FC is that at least one child between birth and 17 years of age resides in the household.

FAMILY REFERRED BY DCF, CSA COMPLETED & NO ACTIVE SAFETY PLAN – DCF must refer the family for FC. The completed CSA by the CPI must conclude with a determination that the children and family are appropriate for prevention services and not in need of protective supervision and case management by the CBC. There should be no active safety plan in place at the conclusion of the CSA (an open safety plan may indicate present or impending danger and the possibility of the need for further assessment by CPI, or transfer of the case to the CBC for services, or resolution of the safety plan). FC strives to reach families early, before problems become deeply entrenched or have evolved to the point of needing further intervention in the child welfare system or entry into care.

FAMILY IS WILLING TO PARTICIPATE – Services are voluntary. Prior to initiating the intake and screening process, the CPI discusses the FC program with the family to confirm it is interested in receiving services.

Receiving Referrals - Areas Not Practicing Safety Methodology

Refer to the complete chapter for comprehensive information regarding skills employed during the intake process and receiving referrals. The information in this section specifically refers to considerations for the intake interview and determining Level I Eligibility Criteria when receiving referrals for FC from DCF sites not practicing Safety Methodology.

After the initiation of the intake and screening process by DCF and during the course of the CBC staff interviewing the CPI to gather information to determine eligibility, added emphasis should be given to exploring with the CPI that they have gathered adequate information to complete the CSA and conclude that the family is appropriate for prevention services. It is helpful for CBC staff to ask, “Have you finished

your investigation?" or "Are you waiting on any additional information from the Child Protection Team or other sources before finishing your investigation?" Questions such as these may provide additional information as to the ongoing nature or conclusion of the investigation. If additional information is needed to conclude the investigation, the case presumably is not appropriate for FC at this time, but may be later depending on the outcome and findings of the investigation. Cases planned for transfer to the CBC for dependency case management services including shelter, direct file, or in-home supervision cases are also not appropriate for the level of intervention that FC provides. Florida FC strives to reach families early, before problems become deeply entrenched or have evolved to the point of needing further intervention in the child welfare system or entry into care. CBC staff conducting the intake interview may ask, "Are you planning to transfer or do you think there is a chance this case will be transferred to the CBC?" or "I'm wondering if you feel this family needs ongoing protective supervision?" to gain more information and ensure that there are no plans to transfer the case to the CBC for dependency services.

Of importance, CBC staff should also ask, "Was there a safety plan put in place?" or "Is there a safety plan currently in place?" during the intake interview when receiving referrals from areas not implementing the Safety Methodology. There should be no active safety plan or children considered conditionally safe with the provision of a safety plan at the conclusion of the CSA for a family to be eligible for FC. A safety plan in place with a family indicates that the family is not appropriate for the type of intervention FC provides. A safety plan would signal that there may be present or impending danger or existing safety issues and a need for supervision and monitoring of the safety plan. It is not a focus of FC services or FC staff activity to monitor compliance with a safety plan. If there is a safety plan in place, CBC staff should explore the reasons with the CPI. If the CPI determines that a safety plan can be remedied and discontinues the safety plan with the family, the CPI can reinitiate the intake and screening process for FC. CBC staff conducting the intake and screening process should always consult with a supervisor as questions or issues arise when screening referrals for eligibility for sites not implementing the Safety Methodology.

Intake and Screening

All sections must be completed. If a section does not apply, please write that the section is not applicable and the reason, if one exists.

Date of Request: _____ Referral Source Name: _____

Referral Source Phone: _____ Referral Source Email: _____

Family and Household Information

FSFN Case Name: _____ FSFN Intake #: _____

Primary Client Name: _____

Client Address: _____

Client Phone: _____

Medical Insurance/Medicaid: _____

County of Service: _____

Additional directions to home: _____

Engagement Considerations (scheduling, best time to call): _____

Family Names	Date of Birth/Age	SS#

Intake and Screening

Presenting Concerns

Documentation must include information that supports decision-making regarding screening for eligibility. Include information for each risk factor that is currently impacting adequate care of a child.

Summarize the family's complete understanding of Family Connections. Include what was explained to the family by the referral source and the family's response. Documentation must include information regarding the family's willingness to participate in Family Connections.

Eligibility Criteria

Level I Criteria

Family resides in the geographic catchment area	Yes ☐	No ☐
Family has at least one child between the ages of birth to 17 who resides in the home	Yes ☐	No ☐
Family referred by DCF, FFA concludes children safe and risk assessment high/very high	Yes ☐	No ☐
Family is willing to participate in Family Connections	Yes ☐	No ☐

Level II Criteria

Check all that apply. At minimum two of these criteria must be met from any given category. In addition, the risk factors must be at a level that impacts the adequacy of the care of a child and is likely to present a risk of maltreatment in the future.

Primary Caregiver

- ☐ Unemployed/Overemployed/Newly Employed
- ☐ Mental Health Problem
- ☐ Alcohol or Substance Abuse Problem
- ☐ Serious Health Challenge
- ☐ Teen Parent
- ☐ Developmental Disability

Child(ren)

- ☐ Behavior or Mental Health Problem
- ☐ Physical Disability
- ☐ Developmental Disability
- ☐ Learning Disability
- ☐ Alcohol or Substance Abuse Problem
- ☐ Serious Health Challenge

Intake and Screening

Family

- ☐ More than 3 children in household
- ☐ Homelessness
- ☐ Domestic Violence
- ☐ Single Parent

Screening and Intake Decision

Referral accepted: Yes ☐ No ☐

If no, reasons referral was not accepted:

- ☐ Level I Criteria not present
- ☐ Level II Criteria not present

Referral source notified of screening and intake decision: Yes ☐ No ☐
Date CPI notified:

If referral is accepted, describe issues or emergency needs that may require immediate attention (basic resources, health, etc.).

Intake Staff Signature: _____ Date & Time: _____

Intake Supervisor Signature: _____ Date & Time: _____

Disposition (Approval/Denial) Date: _____

Chapter

7

OUTREACH & BEGINNING THE FAMILY PARTNERSHIP

Outreach & Engagement: Key Elements of Building a Working Relationship with Families

Family Connections focuses on preventing child maltreatment and addressing risk factors that may create a risk for out-of-home placement. A crucial ingredient in achieving prevention goals is building effective partnerships with families. This process begins during the very first contacts with families.

Why is this important?

Successful intervention relies on the quality of the interpersonal relationship (also known as the "helping alliance" or working relationship) between the case worker and client (DePanfilis, 2000). Forming positive connections with families will support staff's ability to help them overcome challenges and reach goals. The success of Family Connections depends on staff's ability to engage and work with the family to identify concerns and risks, develop goals, and work toward goal attainment. The family's trust of and rapport with staff is paramount to this. This chapter reviews the critical steps, skills, and elements of effectively reaching out to and engaging families in a working relationship. It focuses on the first face-to-face visit between the family and the FC staff, which is crucial to establishing a positive, constructive tone for the ongoing working relationship.

First Face-to-Face Visit with the Family

Families seeking or needing services are typically overwhelmed, frustrated, and sometimes angry or embarrassed about their circumstances. Many families at risk for child maltreatment may have had past difficulty in forming positive interpersonal relationships and had negative experiences with formal systems or agencies (DePanfilis, 2000). FC staff should make every effort to reach out to families to overcome past experiences, fear, anxiety, shame, and other barriers to service. Reaching out to clients, communicating concern for them, and responding to their questions can foster a positive helping alliance. It is critical for staff to convey a comfortable, accepting presence, as well as authenticity and attentiveness (Dawson & Berry, 2002).

Some families may require several visits before they are comfortable proceeding with the FC process. There is no set number of visits for a family to reach its comfort level. The number is determined on a family-by-family basis. The first visit is critical because it is an opportunity for the FC staff to immediately set a positive, supportive, and respectful tone. Given its importance, this chapter is devoted to how to prepare for and conduct the first visit.

Arranging the First Visit: Determining "When" and "Where" with the Family

The main goal in the first contact is to begin building rapport. Again, the relationship with the family is key to successful outcomes. In establishing the first contact, staff protect the family's confidentiality. If staff are unable to reach a client and need to leave a message, they are careful in the amount of information that is shared, which may only be a name and number for a return call. If a phone contact is not possible, staff may send an introductory letter with information about FC, the office address, and a contact person. Letters will not be mailed with letterhead on the envelope.

Stopping by the client's home, at different times of the day, is the most time-consuming method of first contact, but may be the only way to reach some families. Staff stay only if the family indicates it is receptive to the visit and limit the time to ensure we do not overstay our welcome. It is important that we do not inconvenience the family and that we initially try to schedule a mutually convenient time and place to meet. For some families, an unexpected visit might feel like a caring gesture that shows willingness to go out of the way to help. For others, it might be experienced as intrusive or invasive. It is important to read the family's verbal and nonverbal cues during this first encounter, and adjust the amount of time spent with the family accordingly.

If the family is not home, staff may leave a note that provides the name and telephone number for the family to call. Staff should not leave any information that identifies them in connection with FC.

Preparing for the First Visit

The first visit is purposeful and preparing for it is crucial. Preparation will help foster a helping alliance between staff and the family and better position staff to understand the client's situation. This benefits both parties because clients will not have to repeat information that they previously provided if they made a self-referral. It allows more efficient use of time, and helps clients feel that what they have said is heard and remembered. This is especially important if the client has an emergency, concrete need, such as the need for food, and the FC staff is able to immediately address the need.

Preparing for the first visit involves three key steps:

1) FC staff, with the supervisor's support, reviews the referral and all other available documentation and develops a plan for the first visit, including acknowledging and managing the staff's assumptions or feelings about the family.

2) FC staff considers the primary purposes of the first visit:

    - Connect with the family (first and foremost)
    - Determine the initial expectations of family members and staff
    - Summarize the process for working together
    - Plan a regular schedule of visits and a goal for the next visit

3) FC staff anticipates responding to any emergency needs the family identifies.

The most important goal of the first visit is to make a positive connection with the family. The first visit will be the foundation for all future work that follows. Preparing to meet families involves using the skill of ***centering*** or ***tuning in*** (Schulman, 2012). The key to centering is finding a way to manage one's personal feelings so they do not interfere with one's work with families and to do so without having to minimize or deny the feelings and issues (Cournoyer, 2011). This process entails addressing any personal factors that might affect staff's ability to provide quality services to clients. Personal factors could be assumptions, thoughts, emotions, biases, doubts, or gut feelings that could interfere with staff's provision of services and supports to the family. Questions that might be asked during centering/tuning include:

- How am I feeling about this client's situation? Do I feel empathy or do I want to blame or otherwise judge the client for his/her situation? Do I have mixed feelings?

- Are there issues about this situation that I may be uncomfortable about because of my own personal history, experience, bias, or values?

- Might the client hold a worldview or a cultural point of view that differs from mine? If so, what do I need to understand about this viewpoint to be sensitive and responsive to the client?

- What do I know about this client's neighborhood or housing circumstances? Am I nervous or concerned to go there by myself?

- What can I do to ready myself and help me feel more comfortable with having the first visit?

Staff should consult with their supervisors about questions like these and any other personal factors that could influence their work with a family at both the start and throughout the working relationship. Sometimes, clients are unwilling to share information about themselves until they have greater trust in the staff. As a result, staff may surface discrepancies or inconsistencies between what clients have initially expressed and what they later share when better acquainted with staff. It is vital that staff have an open mind during the preparatory phase and accept clients' fluctuating thoughts and feelings.

Protocol for Conducting the First Visit

The FC staff's first visit with a family will have several phases, which are detailed below: beginning, seeking introductions, describing the initial purpose, outlining the staff's role and the client's role, discussing policy and ethical factors, and seeking feedback (Cournoyer, 2011). Following these phases will help staff communicate respect and begin to develop the helping alliance with families. In addition, there are specific skills that can be used to conduct the first visit and ensure its success. These will be described after the phases.

Phases of the First Visit

Beginning and Seeking Introductions - At the beginning of any first visit, FC staff should identify themselves by name, position, and agency. As an example, staff might say,

> Staff: Hello Ms. Brown. I am _____, a staff member from *[XXX Agency]*. I understand you talked yesterday with [XXX] and she gave you my name. I work with families in this area who may need help with their children. Your name is Ms. Danielle Brown. Is that right? Am I pronouncing your name correctly? How would you like me to address you?

Non-verbal communications, such as facial expressions, eye contact, posture, and type of handshake, can greatly impact clients' perception of their first contact with FC staff. The content of dialogue also plays a pivotal role. Staff might consider making a few informal comments about the weather or other non-threatening topics to help set parents and other family members at ease and break the ice. However, staff must be sensitive to individual and cultural factors. For example, some clients may perceive informality as premature or rude. In addition, over-doing the "small talk" might frustrate clients who have urgent needs (Cournoyer, 2011).

It is important to closely attend to how a client wants to be addressed. Because it reflects a courteous and respectful tone, this process of clarifying names and titles can increase the likelihood that the working relationship starts on a positive note.

Describing the Initial Purpose - Following introductions, FC staff should clearly describe a tentative purpose for the visit. If clients do not understand the visit's purpose or do not begin to get a general idea about how they and the staff will work together, they are likely to feel even more uncertain, anxious, and ambivalent about a process that may already be stressful (Cournoyer, 2011). Asking for and accepting help are not easy. In particular, sharing personal information with a stranger is very difficult. It is the staff's responsibility to help clients feel as comfortable as possible during the initial visit. One way to do this is to ask clients what they want to get out of or expect from the visit. Doing so signifies to the client that FC is about them making choices and voicing their own preferences and priorities. An example of this approach follows:

> Staff: The purpose of today's visit is for us to meet each other and for you to decide if you'd like to participate in Family Connections. It is my understanding that you gave [Ms. Redwood] permission to call Family Connections on your behalf. I want to hear from you about what's

working in your family and in what ways Family Connections might be helpful to you and your family.

If you have any expectations of the program or me, I'd like to hear them. I also want to work out a schedule of meetings with you (and other members of your family) over the next several weeks so that together we can plan how we will work together. As we get to know each other over the next several weeks, we will set specific outcomes and goals that you would like to achieve through our work together. Do you have questions about my visit today? Or, where do you want to start?)

Defining Roles - During the beginning stages of a professional helping relationship, clients often experience uncertainty and anxiety about what is expected of them. Initially, clients are frequently concerned about the problems that led them to seek assistance or be referred to a preventive program, but many are also worried that they may not know how to improve the situation or resolve the problem. In addition, clients are often uncertain about how they may best help FC staff to help them. High rates of disengagement or client withdrawal from a program are often due to clients' ambiguity about what they are supposed to do. Several research studies have revealed that when a family and case worker have different expectations that are not acknowledged, there is a higher likelihood of client dropout from the program or intervention (Norcross, 2011; Swift & Callahan, 2011). FC staff may increase engagement by eliciting clients' expectations and clarifying discrepancies between them and what realistically can be offered along with the expected length of intervention.

Similarly, it is important that staff clarify the kinds of services that FC will provide directly versus the kinds of services provided through case management, (e.g., help in finding housing, with dealing with school problems, in talking to health care providers, in finding specialized services in the community that might be needed by a family member). It is also important that families understand that the relationship is a partnership. Therefore, in the first few weeks of working together, staff and families will define together how clients may best use the services. Then staff and families will develop a written plan that defines intervention outcomes and goals, the services to be provided or arranged, and the roles for the staff and specific family members for accomplishing tasks that will help families achieve their outcomes and goals. Defining roles can help minimize confusion over "who will do what," fosters mutual accountability, and relieves client anxiety about what will happen.

Discussing Policy and Ethical Factors - During the first visit, staff should discuss relevant legal, agency policy, and ethical issues (Cournoyer, 2011). This helps facilitate the establishment of an authentic and honest relationship. Staff are also bound by professional standards to explain these factors in performing their duties.

One specific issue that needs to be explained is the responsibility of FC staff to act if they are ever concerned that family members present a danger to themselves or others, including reporting any suspected incident of child abuse or neglect to the Department of Children and Families (DCF). Since the program serves families with risk factors for child maltreatment, it is likely that at some point staff will be faced with situations where a report will need to be initiated. Should this occur, staff should discuss with supervisors the necessity of initiating a formal DCF report. If a report is necessary, we continue to serve the family unless the family wishes to withdraw from services.

Another important issue addressed with clients is that all client information will be held in strict confidence unless clients provide permission to share information with other service providers. The exception to this rule is when clients disclose or staff observes a risk to self or others (suicide or homicide) or suspected child maltreatment.

In addition, staff should refer to and apply the Code of Ethics of the National Association of Social Workers (NASW) (2008) when working with families. The NASW Code of Ethics describes the core values and ethical principles and standards that should guide social work practice, including FC practice. The FC model particularly reflects the following core values: the client's dignity and worth, the importance of human relationships, and the integrity of social work professionals.

Seeking Feedback - FC staff should ask caregivers if there was anything that was said that they do not understand, or if they have questions or concerns. By soliciting feedback FC staff initiate the process of informed consent (Cournoyer, 2011). Seeking feedback also reinforces that the FC relationship will be mutual and reciprocal. Ways to seek feedback include asking, "How does that sound to you?" or "What questions or comments do you have?" (Cournoyer, 2011; McKay, McCadam, & Gonzales, 1996). Often clients ask questions that allow staff to respond in greater detail to their concerns. Most importantly, clients will usually feel respected and informed when their input is sought.

Provider-Specific Documentation

The information reviewed in the above phases could be confusing and overwhelming for the family, especially during the initial visit. The goals of the initial session are to begin to understand the family and providing them with information to maximize their comfort in engaging with the program. Completing program-specific documentation is pertinent for the treatment provider, but could also serve as a way to review the information disclosed. Documentation completed during the initial visit might include but is not limited to:

1. Client demographic form. Used to keep track of the family's current demographic and family information.
2. Consent for treatment. Participation in the FC program is a voluntary decision for the family. Upon the family's agreement to participate, this form is signed to acknowledge its understanding of the benefits and risks of participating, what participation in the program entails, and acceptance of services.
3. Authorization for release of information. Staff should explain the limits of confidentiality and answer any questions or concerns the family has. The family signs this form to authorize the disclosure of protected health information, in accordance with state and federal laws.
4. Notice of privacy practices. This document informs the family of the privacy practices of their treatment provider, including their privacy rights relating to their personal health information.

Concluding the First Visit: Setting Expectations

At the end of the first visit, the FC staff and family should mutually determine a date, time, and location for the next visit. Staff should review with the family what it can expect to happen before the next visit, which may include work toward meeting its immediate, concrete needs (see Chapter 8).

Skills Used During the First Visit

There are several skills that FC staff can use to ensure a successful, productive visit. These skills can be practiced or enhanced during supervision and peer-to-peer learning through demonstrations, role-plays, observations, and other means.

Communicating Empathy

Empathy is the act of understanding, experiencing, and responding to the emotional state of another person. There are two dimensions of empathy. First, FC staff must accurately and sensitively identify clients' inner feelings. Second, they must accurately reflect or respond to their clients' emotions so that clients feel understood and validated. Possessing and using a rich vocabulary of affective words and phrases that reflect clients' feelings is a skill that staff should strive to develop. The words that staff use should be ones that clients use to express their feelings and circumstances. Essentially to be an effective helper you must be able to picture yourself as the recipient of another's help (Stephens, Mills, Williams, Bridge, & Massie (2009). Doing so conveys understanding. Example:

> Staff: A few minutes ago, you said that you have good days and bad days with the kids and that sometimes you "need a break." I think every parent has felt that way at some point or another - - it just isn't' easy being a parent, especially doing it alone.

Communicating Respect

A key component of social work practice and a core FC value is to communicate respect for clients. We should view every human being as unique and inherently valuable. To convey this, FC staff should show respect for the personhood of all clients, regardless of their views, actions, or circumstances. In addition, staff must respect clients' rights to self-determination—meaning, their fundamental right to make their own decisions.

FC staff can communicate respect for clients by operationalizing four core values of the social work profession (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2009):

1. All human beings deserve access to the resources that they need to deal with life's problems and to develop their potential for responding appropriately to life's problems.
2. All human beings have intrinsic worth and dignity.
3. Each individual person's uniqueness is of value.
4. Given appropriate resources, human beings are capable of growth, change, and should be supported to make choices to solve their problems and direct their own lives.

Communicating Authenticity

Authenticity refers to a sharing of self by behaving in a natural, sincere, spontaneous, real, open, and non-defensive manner. It involves relating to others personally in a non-contrived way. It is a skill and trait that can foster a productive, trusting working relationship. Being authentic helps clients perceive the FC staff as interested, honest, neutral, caring, and relatable. Authenticity does not mean that staff have the right to say whatever they are thinking or feeling (Cournoyer, 2011). Rather, it is a way to support clients and work toward mutually agreed upon goals. Hepworth, et al., (2009) suggest that in responding authentically to clients, staff expresses their feelings and ideas as clearly being their own. Example:

> *Staff: I'm worried if we don't help Calvin with his reading, he'll continue to get Fs and might even fail 3rd grade. How have you tried to work with him? What has worked best?*

To communicate authentically, staff might need to disclose information about their own experiences. The social work profession reflects varying opinions about when and how much self-disclosure is appropriate in the context of professional helping relationships. However, FC believes that the conscious and intentional revelation of information about oneself through verbal and/or nonverbal behaviors can encourage clients to reciprocate with trust and openness. In any event, self-disclosure should be done judiciously and should not include the sharing of personal problems or shifting the focus from the clients' situation to one's own. In addition, staff are urged to discuss instances of self-disclosure with their supervisor. Here is an example of careful and intentional use of self-disclosure:

> Client: *I'm angry with my husband because he never does anything around the house. All he does is make a mess and expect me to clean up.*
>
> Staff: *When a family member doesn't chip in, it's frustrating and could make anyone angry. My kids constantly leave dirty laundry and dishes lying around. It's like I'm their maid! I get resentful? It sounds like we have had similar feelings.*

<u>Using Active Listening Skills</u>

Active listening combines talking and listening skills that enable clients to feel understood and that demonstrate that the FC staff has accurately heard and understood what the client has communicated. In addition, it provides

a means through which clients are encouraged to express themselves. It is important for staff to reflect their understanding or interpretation of what clients have communicated. Staff responses should mirror information provided by clients. In general, if feelings are expressed, the active listening response should convey the feelings at an equivalent intensity (Cournoyer, 2011).

The skill of active listening is used when staff closely observe clients and carefully listen to what is said. After listening, the staff reflects back what the client expressed. Some examples of phrases that can be used when reflecting back are, "What I think I hear you saying is…" and "It sounds like..." When staff check their understanding with the client, it can increase the client's positive regard for the staff and the professional relationship. Active listening also decreases the likelihood that staff misunderstand, distort, or misrepresent what clients are trying to convey.

There are some pitfalls associated with active listening that staff should take care to avoid. They include mimicking or repeating verbatim what the client said, misconstruing clients' comments or behaviors, and focusing only on a part of what was communicated rather than attending to what the message as whole was conveying (Cournoyer, 2011).

Requests from Clients for Personal Information

Clients may ask staff personal questions. Examples include: "Do you have any children?" "How old are you?" "What is your religion?" "Are you married?" Answering such questions may or may not be appropriate depending on the staff's assessment of the client's motivation for asking a particular question. If the question is presumed to reflect a natural desire for information, natural curiosity, or an attempt to relate to or break the ice with the staff, it may be most appropriate to answer and move on. In other instances, it may be best to answer but follow up with a clarifying question. For example:

> Client: *Do you have children of your own?*
>
> Staff: *No, I don't. I have a fair amount of experience with kids (due to my brothers or sisters, with babysitting, from course work), but I'm going to have to look to you to help me understand what being a parent is like for you. Why do you ask? Are you concerned that I can't understand your situation because I have not been a parent myself?"*

Hepworth, et al., (2009) suggest that as a general rule, if FC staff have questions regarding clients' motivation for making personal inquiries, they might provide either open-ended or empathic responses prior to or in place of disclosing their personal information or viewpoint. If a client asks a question that staff do not feel comfortable answering, it is best to decline politely while attempting to understand the client's reason or need for asking the particular question. Staff might also consider discussing such instances with the supervisor.

Overcoming Barriers to Engagement – Evidence-based engagement strategies ensure that initial meetings with clients, whether over the phone or face-to-face, find a balance between gathering the information necessary to complete agency paperwork and assessments and meeting client's needs as the helping alliance is developed. Two important steps for fostering engagement include identifying "concrete, practical issues that can be immediately addressed" and developing plans "to overcome barriers to ongoing involvement with the agency" (McKay et al., 2004).

FC staff should come to the first visit with background information provided by the referral source on potential needs and barriers that can be explored during the visit. These may include concrete issues, such as lack of time, transportation, and financial resources. During the first visit staff should use problem solving skills to help the family identify the most pressing concrete concerns it is facing and explore ways to immediately begin to address the concerns. This demonstrates to the family that the staff is committed to helping it meet its needs as defined by the family, not the agency or staff, in order to overcome any immediate crisis situations. One of the FC core components is a continued recognition of the primacy of

concrete needs throughout the provision of services. Helping families address their most urgent concrete concerns demonstrates the FC staff's openness to the family deciding and prioritizing what is important to it and enables the family to move onto addressing other concerns that are no less important but may feel less urgent or less concrete. Chapter 8 discusses how to respond to families' concrete and emergency needs.

Staff come to the first visit with information about previous difficulties the family has had with service providers (based on information that may have been provided over the phone). These barriers may include concrete issues, such as lack of time or transportation and financial resources that will inherently be addressed by the flexible, community based work. However, staff should also seek out information on more difficult barriers such as previous negative experiences with other helping professionals and the caregivers' attitudes and beliefs about receiving assistance. Past experiences with racism or discrimination at other agencies as well as past experiences with trauma may also create barriers to engagement as they may make it difficult for caregivers to trust service providers (McKay et al., 1996). Exploring these issues during the first interview sets a tone that this service stands apart from past negative experiences and can truly be a collaborative helping alliance.

When Families Decline FC Services

Some families will decide that the FC program is not the right match for their needs. While we want to reach out to families, engage them in discussion of what the program has to offer, and encourage them to work with us toward their goals, we never "pressure" or "sell" families to accept services. A family may, at any time, request that we cease attempts to contact them. If this request comes during a telephone or in-person conversation, staff should acknowledge the family's decision and encourage the family to contact us if their situation changes. If this request comes in writing (by email, fax or letter), no further attempt at contact will be made.

Some families will be open to discussing FC services but will ultimately decide not to participate. Our goal in these situations is to ensure the family has a good understanding of our program, trusts we are genuine in our desire to work with them, and has enough time to consider whether they want to proceed or not. Once a family decides to not move forward, FC staff should provide it with referrals to other community organizations relevant to its needs, including tribal or local Indian organizations for families with a child(ren) identified as, or is eligible for membership in, a federally recognized tribe, and encourage the family to contact the FC program office in the future if its situation changes.

Chapter

8

Responding to Concrete and Emergency Needs

A core component of Family Connections includes addressing concrete needs often associated with living in poverty that affect the quality of care provided to children. Emergency and concrete services are provided at any point when families need these types of services in order to meet the **BASIC** needs of their children. *Examples* of concrete services provided in conjunction with other community organizations include: emergency food or clothing; financial assistance to prevent eviction or other family disruption; household furniture and supplies; and cleaning and repair services when the household is unsafe or unsanitary creating a hazardous home environment for children. Family Connections emergency services also include responses in response to suspected child maltreatment and threats to harm self or others

Why is this important?

We know that it is hard to consider changing behaviors and conditions if a family has insufficient resources to meet the day-to-day basic needs of the children. Maslow (1943) was one of the first to propose that physical and safety needs must be addressed before individuals can be motivated to address more complex needs.

Providing Concrete Services

Assessing and addressing the concrete needs of families within their own neighborhoods begins during the first contact and at any point during the service delivery process. Sometimes, a risk related to nutrition, apparel, finances, or housing is concerning but not an emergency. Acknowledging Maslow's hierarchy, it is important to work with the family to try to develop and implement a plan that will prevent the risk from becoming an emergency. That said, the family might not be able, for various reasons, to work preventively, or the necessary resources might not be available in a timely manner.

When food, clothing or shelter present as significant and immediate needs, community resources should be identified and exhausted as quickly as possible. Enlisting the help of colleagues and supervisor, as well as the client if appropriate, to make the necessary phone calls may be an efficient strategy. If all reasonable efforts have been made and no community resources are available, staff should consult with their supervisor about pursuing alternative resources, such as Flexible Funding through the CBC.

The CBC has emergency funds available; if staff and supervisor agree that the fund is an appropriate source of help a Flex Fund request may be submitted for review. Example of acceptable requests include: rent, utilities, day care, after school care, transportation, food, household supplies, school supplies, clothing, medical/dental expenses, and baby/child care supplies. Examples of unacceptable requests for funds include fines for criminal/civil violations, fines for warrants, legal fees, child support, costs associated with other than basic needs. For additional guidelines on Flexible Funding please refer to PSF policy 1403 and KCI policy 403 (PSF Attachment I) (KCI Attachments 1a, 1b, 1c,1d, and 1e).

Required Emergency Responses

While working with families, there may be emergencies that will require staff to follow a standard protocol of assessment and response. Supervisors should work with staff to clarify and define the emergency and develop an appropriate response. Besides addressing concrete needs that may be an emergency, this chapter provides information about two additional situations that may require an emergency response from FC staff: (1) identification of possible child maltreatment and (2) a psychiatric crisis of a caregiver or child, including the threat of harm to self and/or others. Responses should be guided by agency protocol.

Identification of Possible Child Maltreatment

In each state, there are specific laws and regulations that define child physical abuse, sexual abuse, emotional harm, neglect, and prescribe the mandated system response. All Family Connections staff should read, become familiar with, and understand the definitions of abuse and neglect as defined in the Florida Chapter 39 and Administrative Codes. Staff members must discuss these with supervisors to ensure that their interpretation is accurate. All staff members have the opportunity to attend training in the identification and reporting of child maltreatment. Special attention should be paid to the following:

Staff is required to report any *suspicion of* ***new and/or previously unreported*** *child abuse or neglect (ongoing safety concerns stemming from the initial abuse or neglect allegations will result in a supervisor consult, and a consult with the previous CPI, and not automatically called in to the Florida abuse hotline)*. It is not the role of the staff to determine beyond any doubt if the suspected abuse or neglect has taken place, but rather to identify facts and describe circumstances that lead the practitioner to strongly suspect that maltreatment has occurred.

If child abuse or neglect is suspected, staff does not have a choice and an official report of suspected child abuse or neglect must be made. The client's intent or presence/absence of remorse is not a factor. The client's knowledge and agreement is not a factor. The law is clear about the responsibility of all professionals to report, and the law is nonnegotiable.

Professionals are protected from criminal and civil prosecution if they report suspected child abuse or neglect in "good faith." Though clients may sometimes believe that they can sue a practitioner for libel or slander, the practitioner is protected when it is professional judgment, not personal beliefs, that guided the decision to act.

If staff is concerned that maltreatment may have occurred in a family, the staff must consult with a supervisor or his/her designee, ***immediately***. A collaborative decision will be made about whether a report will be made, and when and how to initiate the report.

All staff are required to make a telephone report to Child Protective Services (Florida telephone 1-800-96 ABUSE or 1-800-962-2873). The person making the report will be asked to identify the child(ren), date(s) of birth, address where s/he/they may be seen; parent or caregiver address; name of suspected maltreating person; information or observations leading to the suspicion that maltreatment has occurred; and any known history of maltreatment. In some situations, the person making the report may not be able to identify a suspected maltreating person; that should not be a deterrent from making the report. Staff is **required** to document the hotline call and incidents/information surrounding the report on an agency incident report that is entered into the Incident Reporting Analysis System and approved by the supervisor and administrator. For additional information on Incident Reporting please refer to PSF Policy 1406 and KCI Policy301 (PSF Attachment H) (KCI Attachments 2a and 2b).

After consultation with the supervisor, if staff feels that the client can be informed about the suspicion of abuse or neglect *without placing the child(ren) at increased risk of harm*, then it is suggested that a discussion with the client occur. The staff should share the concern for the family, the reason(s) for the suspicion, and the fact that the program has no choice in making the report. The staff should be prepared to deal with possible feelings of anger, betrayal, sadness and guilt, helplessness, fear, anxiety, and loss of trust in the relationship. It is the role of staff to help families to understand that the program will continue to work with them, in collaboration with the Child Protective Services, as indicated.

As difficult and uncomfortable as all of this may be, if the staff is open and honest with the family, it may actually strengthen the helping alliance. It will also help the client learn that adversity does not necessarily require flight; that the helping relationship can withstand serious challenge; and that the staff really are there to help the family identify, address, and resolve a wide range of challenges.

If a child(ren) was/were involved in the information gathering and assessment process, it is crucial to tell them that they have done nothing wrong; that the adult(s) have made poor choices, and it is the adult(s)

who are responsible for those choices. The children should be told that the staff will try to help them, and that they may call upon the staff if they need help. It is very important that children have the phone number for the agency working with their family. Children should be informed that adults in their family may be angry, sad or scared, but that they (the child) did not make them feel that way. Rather, it is the consequence of an adult behavior that is precipitating those feelings.

If the child resides with a non-alleged abusive caregiver, staff should inform the caregiver of the importance of helping the child feel safe and secure, and to continue in their regular routine. The caregiver should be encouraged to listen if the child wants to talk about the situation, but not to force them to do so. If the child resides with the suspected abuser who is determined to *not* be a continuing threat, staff should help the child develop a plan of what to do if they feel threatened.

If, in consultation with the supervisor, staff believes that the child(ren) *would be at increased risk* if the report was known to the family, then staff should not reveal the intent to make the report. Instead, staff should share concern for the family, and attempt to implement a short term plan to stabilize the situation. Staff should make a telephone report of suspected child abuse or neglect as soon as possible after a behavior or condition is suspected as abuse/neglect. During the reporting process, staff should clearly communicate the concern about the level of risk, as well as the fact that the client has not been informed about the intent to report.

If, in consultation with the supervisor, staff believes that the child(ren) *is/are in present danger,* efforts should be made to keep the family at the agency's office until DCF or the police arrive; return with the family to the agency's office; or phone in the report as soon as staff leaves the home, then returns to the home under another pretext. Staff should **not make a choice that might increase physical danger to self**.

Once a report has been made and accepted, DCF is mandated to respond within 3-24 hours for suspected abuse and/or neglect. During the investigative phase, the DCF worker will meet with the family members and contact community providers to determine if maltreatment has occurred, to assess risk and safety, and to develop a recommended plan.

It is crucial that FC staff cooperate and collaborate with DCF staff with and on behalf of their clients. During the investigative phase of DCF services, the DCF worker is not required to have a signed Release of Information form in order to speak with us. Our FC services continue unless DCF determines that other intervention is indicated, the child is placed in out-of-home care, or the client chooses to discontinue with the FC program.

Threats of Harm to Self or Other(s)

While working with clients, both children and adults, it is important for FC staff to take any verbal, behavioral or other expression of threat of harm to self or others, such as suicidal or homicidal ideation, very seriously. These expressions can present in a wide variety of ways, and describing all of them is beyond this manual's scope. However, the following indicators are offered to guide critical thinking about possible threats of harm and the extent to which an immediate, emergency response is required.

1. Expressions of wanting to die or kill or harm another – These may be accompanied by feelings of anger, hurt, betrayal, frustration, vengeance, or may be expressed in a calm, controlled manner. Regardless of the affect that accompanies the words, you must assume the threat is real.

2. Expressions of wanting to give up, go away, not feel so bad anymore, escape for good, etc. – These may be no more than very real and reasonable messages that the client needs a temporary respite or some other support, or they may indicate a much more serious threat.

3. Expressions of sadness or depression – When verbalizing, people use different words in different ways at different times. You must always be careful not to assign a particular meaning to the words, but rather to

enable your client to assign the meaning to his/her own words and to assess the context in which the words are said.

4. Significant changes in regular and/or observable behavior patterns – Changes in eating, sleeping, relationship, and other patterns merit further exploration and assessment. In addition, changes in affect, appearance and connectedness as observed by FC staff or as reported by significant others or other providers warrant assessment.

5. Ordering or organizing personal and professional "business" – Sometimes, people who are contemplating suicide will divest themselves of possessions and/or organize their life in such a way that they believe will make it easier/neater for others when they are gone.

If, at any time, a caregiver or child(ren) presents one, some, or many of the above characteristics, it is imperative that the FC staff immediately considers the need to call 911 and explores with the caregiver or child(ren) the extent of their distress. The following provides just a few examples of the type of information that FC staff could gather and consider to help determine if a client is at risk of harm to self or others. This is not an exhaustive list.

1. What do the parent/caregiver or child(ren) mean when they say that they are feeling bad/sad/depressed? What do they feel, what do they think, and what do they do when they have these feelings? How often and for how long at a time do they feel this way? When was the last time? What did they do to resolve it, or do they still feel this way?

2. Was there another time(s) in their life when they felt this way? How long ago, and how long did it last? What did they do? What happened?

3. Has there been any change (more or less) in their eating, sleeping, relationship, or other patterns? Have they lost/gained a significant amount of weight? Are they having trouble falling asleep, do they wake in the middle of the night, or do they wake very early in the morning, and is this a change for them? Have they lost touch with friends or family that had been close?

4. When they are feeling sad, do they ever feel like giving up for good or hurting themselves or another to escape? If yes, when? What did they think about doing? Did they have a specific plan to harm themselves or another? Did they have the means to carry out the plan? Did they attempt to harm themselves or another? What happened? Did they tell anyone else or try to seek help? What was the response?

Contact a supervisor to review the critical issues and receive guidance and support in determining the immediate, appropriate intervention. Staff must determine if the threat is real, and if the client or other person is in imminent danger.

If the threat is unclear or appears to be dangerous, you must facilitate an immediate psychiatric evaluation **whether or not the client is in agreement**. This may be done by either accompanying the client to the nearest emergency room/Crisis Stabilization Unit or by calling 911 for assistance. If the client is already known to a mental health provider, that provider should be immediately contacted and asked to participate in the emergency evaluation process. The mental health facility may have the resources to provide the necessary evaluation.

Chapter

9

CONDUCTING THE COMPREHENSIVE FAMILY ASSESSMENT

A core principle of FC is the importance of conducting a comprehensive family assessment process to drive planning and provision of individualized, tailored interventions. This chapter outlines the family assessment process, including methods of gathering information, use of the Family Assessment Form, and skills that staff should use to collect information and conduct the assessment process, including motivational interviewing and exploring skills. In addition, this chapter discusses how assessment results should inform selection of the Florida FC core intervention outcomes.

Why is comprehensive assessment important?

Intervention to reduce child maltreatment risk should be based on a comprehensive, individualized assessment of the family. Assessment in social work is the process of gathering information about the client's current circumstances, determining what is contributing to the client's strengths, challenges, and needs, and using this understanding to inform service planning and intervention. A FC core principle is that assessment is done with the client; in other words, the client and staff work together to understand the client's situation. In addition, FC recognizes that the assessment is not a one-time-only event or the result of a structured interview; rather, it is done continually and allows for incrementally building a picture of the family and making sense of its circumstances.

Information and observations are gathered in relationship with the client during visits, documented after each visit, and synthesized with FAF results. The assessment process considers the type of maltreatment that may result without intervention as well as the risk and protective factors at the individual, family, neighborhood, and community levels (Gaudin, 1988, 1993). When possible, the assessment is undertaken with other service providers to form a comprehensive picture of the various pressures on the family. This holistic approach considers family and caregiver strengths (Whittaker, Schinke, & Gilchrist, 1986) and views the family's environment as both a source of and solution to the family's needs (Bronfenbrenner, 1979; Garbarino 1992).

Family Assessment as a Process and Product

Family assessment is both a process and product. The comprehensive family assessment includes an outline of the various persons and systems that contribute to understanding the risks and protective factors in families that may increase or decrease risk of child maltreatment. It further provides information about the types of maltreatment that may result without intervention, specific areas of assessment that will help lead to a greater understanding of families' needs; clinical instruments that will help define needs, and the process of selecting intervention outcomes. This process guides development of actual written products with each being equally important. At the conclusion of the family assessment process, a family plan is developed between the family and staff.

For the FC intervention to be effective in reducing child maltreatment risk, an accurate and continuing assessment of the family's current circumstances is crucial. Assessment is an ongoing process that begins with the initial contact and continues until staff members finish working with families. Even though the process continues throughout the life of the case, it is a special focus over the first 30 days. Staff and caregivers should collaboratively arrive at how they will work together to build on families' strengths to meet their needs. This

process helps arrive at specific intervention outcomes and plans of service that will empower families to strengthen their capacity to meet the basic needs of their children.

Sources of Information. During the family assessment process, information is considered from multiple sources. While the specific sources will vary somewhat from family to family, the following are the most common (adapted from Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2009):

1. Information documented on the Intake form and in the information system. These items are used to screen the family and identify the types of maltreatment risk that may be a concern as well as risks that may be apparent with respect to a child, caregiver, or the family as a system. These items are further explored in conversations with families during the assessment process.

    a. Staff should use the Family Functioning Assessment and risk assessment completed by the Child Protective Investigator to review information regarding the family.
    b. Staff should review FSFN for prior case history that would inform FC engagement.

2. Verbal reports from family members. The family assessment protocol calls for meeting with the family as a group, and for meeting and talking with family members on an individual basis. Staff members are interested in what family members tell them about their strengths and needs and their feelings, views, and thoughts about what they hope to achieve with the assistance provided by FC staff.

3. Direct observation of nonverbal behavior. Part of the assessment involves observing the nonverbal behavior of family members that may be cues of emotional states and reactions such as anger, hurt, embarrassment, and fear. These observations may be within the family or with others outside the family, if available and appropriate.

4. Direct observation of the interaction between family members – between adult caregivers, between caregivers and children, and between the family and other household members who may not have a direct caregiving role.

5. Collateral information from relatives, friends, physicians, teachers, employers, and other professionals. Others are involved in the assessment with the families' knowledge and consent. In some situations, others may have critical information about the family's needs.

6. Psychological tests, Mental Health Assessments, or Substance Abuse Assessments. When mental health or substance abuse problems of a caregiver or child may increase the risk of maltreatment, it may be necessary for staff to enlist the assistance of other professionals to help in the assessment of the family. If additional services and/or assessment are warranted, staff will follow the protocol established by the CBC.

7. Physical health evaluations of chronic/acute illness. To gather an overall picture of the needs of the family, staff needs an understanding of the physical health status of its members. Staff members should obtain information about the routine health care of family members and, if indicated, help the family obtain needed health care evaluations. For example, the primary caregiver may report that she is chronically tired but she may not have seen a doctor for years. Before assuming that she is depressed, staff must rule out the possibility of a health problem that could be impairing her overall physical functioning.

8. Observational assessment measure. Staff gathers all available information about the strengths and needs of families (from all of the above sources). The Family Assessment Form (FAF; Children's Bureau of Southern California, 1997) is used to assist in the measurement of the behaviors and conditions that may affect the likelihood of future child maltreatment and the level of family functioning and care giving capacity as observed during the assessment process.. The FAF instrument is

completed at the beginning of intervention (within the first 30 days) and at the completion of intervention to measure change. When intervention continues beyond 4 months (1 month assessment, 3 months intervention), the FAF is completed at least every 90 days.

Planning the Family Assessment Process

After the first visit with families, staff—with supervisory support and feedback—develops a plan for how the assessment process will occur, then propose the plan to the family and seek its input. In general, it takes 4-6 weeks to "get to know" families enough to gather sufficient information and draw accurate conclusions. The following is considered when developing the plan for the assessment:

1. Who in the family should be involved in individual and/or joint meetings?
2. How often will meetings with family or individual family members occur?
3. Where will meetings be held and who will be involved in each meeting?
4. Are there other persons (friends, extended family, professionals, etc.) who have critical information about the family's strengths and needs? How will they be involved in the assessment process?
5. What reports may be available to provide information about a particular family member or the family as a system (e.g., school, health care, etc.)?
6. Will staff need to enlist the assistance of other professionals (e.g., arrange for psychological tests, AOD assessments, etc.)?
7. When will staff complete the FAF (e.g., as they gather information or all at once at the end)?
8. When will the family assessment process be complete?
9. When will the staff analyze the information and complete the family assessment summary?
10. How will the staff share the assessment information and finding with the family?

Family Assessment Protocol: A Phased Approach

The process of assessment occurs as staff develop helping alliances with families. While the number of meetings needed to complete the assessment will vary in each situation, the process generally follows three phases: (1) "pre-assessment" introductory meeting(s) to introduce and explain the process; (2) assessment meetings with the family as a unit and with individual family members along with collection of information from other sources; and (3) analysis and convergence between staff and families regarding selection of intervention outcomes that match families' needs.

Introductory Meetings. The first meetings that staff have with families as a whole and with individual family members focus on clarifying the purpose of the assessment, determine frequency and location of meetings and consider who needs to be involved in the process.

Early on, staff should try to arrange a family meeting to ensure that each family member knows the expectations from the beginning, that everyone's participation is judged important, and that communication is open and shared. As staff discuss the assessment process, they should use clear language and avoid jargon.

During these initial meetings, staff collaborate with families about the plan for conducting the assessment, obtain releases of information (if appropriate), and plan a schedule of meetings. Sometimes, families may only be able to plan a few days or a week in advance, so scheduling may need to be done incrementally. Staff should also attempt to gain an initial understanding of families' perceptions of their strengths and needs, their situation, and attitudes about working with the program.

Meetings and Other Methods for Gathering Information: During the middle stage of the family assessment process, staff meet with families to understand more about their risks and strengths and the specific needs that should be addressed through intervention. The focus of these meetings should be on developing helping relationships with families and on gathering information about specific aspects of families and their environments that—without intervention—may lead to maltreatment.

Through exploration, staff and clients together consider information regarding the person, problem, and situation and the particular risks and strengths that may lead to difficulty with meeting the basic needs of children. This

helps families and staff members "understand the factors associated with the origin, development, and maintenance of any problems, as well as those strengths, attributes, and resources that may later be useful in working toward problem resolution" (Cournoyer, 2011). This process, and the application of professional knowledge, results in development of a comprehensive Family Assessment Summary; subsequently, a plan of service is developed with families.

Cournoyer (2011) suggests it is essential to explore all aspects of the person-issue-situation. This involves examining the current status of the presenting problems, their onset, intensity, frequency, and duration. Further, it includes careful examination of clients' attempts to resolve, cope with, or avoid problems, as well as strengths and resources used in previous problem-solving efforts. In addition, aspects of the person must be examined that include the individual's thinking, feeling, and capacities to effectively act on their own behalf. The circumstances in which the families live must be examined to understand the social, economic and cultural aspects of their situations. This requires an understanding of familial and community networks and interaction patterns that offer physical, emotional, spiritual, and financial support. To attain a comprehensive picture of each of these, it is necessary to review the clients' perceptions of each in the present, past, and future (Cournoyer, 2011).

Convergence with the Family to Define Intervention Outcomes: In the third phase of the family assessment process, FC staff analyze the information collected, arrive at a tentative assessment, discuss these ideas with families, and develop convergence with them around targeted intervention outcomes. Throughout the process, information is gathered and organized leading to the completion of the family assessment summary. The FAF is *not* a structured interview. Information is gathered in relationship with the client during visits, documented after each visit, and then synthesized to create the full assessment over the first 30 days. The FAF is a standardized observational tool to help ensure that we address all of the areas that may be challenging the family. It is at this point in the intervention that staff use insight gained from the FAF to identify strengths and needs of the family. Specifically, the FAF allows staff to gather and analyze data related to (1) living conditions; (2) financial conditions; (3) supports to caregivers; (4) caregiver/child interactions; (5) developmental stimulation; (6) interactions between caregivers. Some of these areas might pose on-going challenges to caregivers and thus represent important targets for intervention.

Following the formulation of a tentative assessment, staff should plan a meeting or a series of meetings with families to discuss their impressions, obtain their feedback about these impressions, and work toward convergence to target specific intervention outcomes. These intervention targets should be directly related to areas of needed growth or change identified by the FAF. The results of the FAF should directly inform the selection of intervention outcomes and the development of the family plan of service with SMART goals (See Chapter 10). At least one of the following outcomes guided by ratings from the FAF should be identified to guide FC interventions.

- **Living Conditions:** The living conditions, both outside and within the family's ability to control, are healthy and safe. The household is consistently clean, free of health hazards, well maintained, and orderly. The household (inside and out) is in safe condition for children and free of safety hazards (e.g., poisons, exposed wiring, lead paint, drug paraphernalia).

- **Financial Conditions:** There are four dimensions to this outcome: (1) financial stress; (2) financial management; (3) financial problem due to welfare system/child support; and (4) adequate furniture. Families that successfully achieve this outcome have the capacity to manage financial stress and manage finances (even if they are limited) and still meet the basic needs of their children. Families also have sufficient furniture in adequate condition for children to have beds, places to eat and study, and for the family to sit together. If applicable, they are able to manage resources (provided by other systems, e.g., child support, food stamps, etc.) without problems impacting the care of the children.

- **Supports to Caregivers:** This outcomes includes six dimensions of access and appropriate use of social support resources (1) the availability of support from friends, neighbors, and community

involvement; (2) availability of sufficient and adequate child care resources; (3) caregivers make appropriate choices in the selection and use of substitute caregivers; (4) availability of health care (availability, affordability, access; (5) caregivers provide for the basic medical/physical care of their children (home health care, nutrition, personal hygiene as well as accessing well-child medical care); and (6) caregivers demonstrate the ability to maintain positive long-term relationships that support them to meet the basic needs of their children.

- **Caregiver/Child Interactions:** There are 12 dimensions to this outcome. The caregiver demonstrates an understanding of child development, implements a daily routine for children, uses non-physical methods of discipline that are consistent and appropriate, encourages appropriate attachment and independence (bonding style) with the children, expresses a positive attitude about the children and the caregiver role, takes an appropriate authority role in the family, and effectively communicates with the children. In return, the children demonstrate the ability to communicate effectively with the caregiver, cooperate and follow household rules, and demonstrate an emotional attachment to the caregiver.

- **Developmental Stimulation:** Caregiver provides an enriching/learning environment for the children and engages them in play and promotes the appropriate interaction of siblings.

- **Interactions between Caregivers:** Caregivers demonstrate with each other the ability to effectively communicate, to problem solve, to be mutually supportive, and to manage conflict and stress. They share parenting responsibilities and are consistent in their communication with their children.

Skills Used During the Family Assessment Process

To assist in gathering information and conducting the family assessment, FC staff are encouraged to use motivational interviewing skills (for more information, see the numerous resources in the FC training binder) and the following exploring skills: probing, seeking clarification, reflecting content, reflecting feelings, reflecting feeling and meaning, partializing, and going beyond what is said. These skills, considered foundational to information collection and assessment in the social work/counseling and other professions, are summarized below.

Motivational Interviewing. This is a technique that is essentially a conversation about change, particularly behavior change (Miller & Rollnick 2002). Motivational interviewing is a collaborative, goal-oriented method of communication with particular attention to the language of change. It is intended to strengthen personal motivation for and commitment to a target behavior change by eliciting and exploring an individual's own arguments for and against change. Useful during clinical assessment and treatment, it is also particularly useful for helping clients identify and establish goals for change--a technique that is especially helpful during the assessment process leading to the identification of desired outcomes and development of the service plan. This sometimes means that we explore a client's ambivalence toward making a specific change in order to facilitate moving toward change. Motivational interviewing requires an empathic, calm, and caring style, shared decision-making, and the ability to avoid arguments while handling resistance skillfully.

There are four strategies of motivational interviewing that are particularly useful in the early stages of change (i.e., pre-contemplation, contemplation, preparation). Represented by "O.A.R.S.", they are:

Open-Ended Questions – facilitate dialogue; require more than a simple yes or no; often start with words like "how," "what," "tell me about," or "describe"; usually go from general to specific; convey to clients that our "agenda" is about the client.

- Affirm – acknowledges the difficulties the client has experienced, validates the client's experience and feelings; supports and promotes self-efficacy; emphasizes past experiences that demonstrate strength and success to prevent discouragement; must be done sincerely.

- Reflective Listening – demonstrates an interest in what the client has to say and a desire to truly understand how he/she sees things; incorporates different types of statements including: (1) repeating (simplest); (2) rephrasing (substitutes synonyms); (3) paraphrasing (major restatement); and (4) reflection of feeling (deepest).

- Summarize – reinforces what has been said; shows that you have been listening carefully and prepares client to move on; often links together client's feelings of ambivalence and promotes perception of discrepancy.

Probing. Commonly, probes are used to facilitate clients' expression about themselves, their situation, and the issues they face. Probes are phrased as questions or requests. For example, after clients say they feel "stressed out," staff might say something like, "Tell me more about that…exactly what has happened this week to contribute to feeling stressed out". Probing skills are applicable and beneficial throughout the relationship. Some examples of common probes include: "What do you like best about being a parent?"; "What were your parents like?"; "How did you feel when he/she did that?" and "What would you like to be different?"

There are two types of probing questions: open ended and closed ended. A closed ended question yields specific, discrete information. The following are examples: "What's your address?", "When were you born?", and "How many children are you caring for?" Answers to such questions are brief. Sometimes too many closed-ended questions asked one after another may make clients feel like subjects of an interrogation. Therefore, it is usually more productive to mix closed-ended with open-ended questions and active listening responses.

Open-ended questions are phrased in a way that encourages clients to elaborate and express themselves more fully. Often they are phrased as "what" questions such as: "What is the nature of your concern?" and "What happened next?" "What" questions can be framed as closed or open-ended and can gather factual and feeling-related responses. "How" questions nearly always yield open responses from clients. Examples include: "How did that come to happen?"; "How did he react?"; and "Please tell me more, how do you manage those situations?" In addition, "Can you help me understand…" can be effective to begin an open-ended probe.

Seeking Clarification. During an interview clients may make statements that are vague, incomplete, or imprecise. Contradictory information may be communicated. The contradiction can be in the form of conflicting statements or other "mixed messages," such as clients saying they are comfortable when their tone of voice or body language appears to demonstrate a level of discomfort. Communication may not be clear because of cultural differences. In any case, it is critical to clarify what is being communicated. This attempt to gain understanding facilitates the development of a sound helping relationship. In addition, it may promote an opportunity for clients, who previously may not have had a clear understanding about their own person-issue-situation, to develop a more accurate understanding. When unclear about what a client has expressed, staff should attempt to elicit more complete expressions of the meanings of clients' words or gestures, asking clients to be more specific about something they have said. For example, staff could say, "I'm a little confused. You said _____, but you also said_____."

Reflecting Feeling and Meaning. A key element of the helping relationship is offering clients a mirror of themselves, which allows them to enhance their understanding of issues that are important to them and that they want to address. Reflecting feeling and meaning mirrors to the clients multiple aspects of themselves - their ideas, beliefs, and feelings - and helps link them together (Cournoyer, 2011). Until information or insights are reflected back to clients, they may not have been aware of the connection.

It is crucial to be disciplined in the reflection of meaning and feelings to clients and to precisely "give back" only what the clients communicated and not to make any changes in what the clients have conveyed. Suggested formats for reflecting feeling and meaning include:

You feel _____ because_____

You feel_____ and _____

You feel_____ but/yet/however _____

Partializing. Clients often have many complex issues along with many thoughts and feelings, each of which seem to require immediate attention to the client. To be effective, it is necessary to prioritize what needs to be addressed first. Partializing is a skill that staff can use to help clients break down several problems, issues, or concerns into more manageable pieces (Cournoyer, 2011). This skill may be applied throughout the FC intervention process. For example, it may be useful at the beginning of intervention to sort out issues and prioritize what must be addressed first. It may also be useful when a crisis arises or at other times when circumstances create overwhelming demands.

Going Beyond What is Said. Staff work with clients to facilitate understanding of the person-issue-situation and help to increase understanding by using skills that explore and clarify clients' thinking and feelings. Staff also help clients to organize their thoughts and emotions through skills of partializing and reflecting meaning and feeling. In going beyond what is stated, staff extend slightly what clients actually have said. Often there are clues in the general communication, both verbal and nonverbal, that suggest a theme that remains unspoken. Staff use their knowledge, experience, and intuition to add to the feelings or meanings actually communicated, however, what the staff says must be congruent with the clients' experiences to help continue the conversation (Cournoyer, 2011). This skill should only be used once a strong helping relationship has developed because it is essential to know clients well in order to effectively use this skill. An example follows:

Client: *I don't know what to do. My daughter left her children with me 6 years ago but she visits and disrupts things, makes promises to the children she never keeps. It upsets the whole house when she comes.*
Staff: *Your daughter left the children and you've had the sole responsibility to care for them. You don't know how to deal with her. You hope someday she'll be able to care for them but you also know this probably won't happen. You love her but you're also angry with her.*

Family Assessment as a Product

At the conclusion of the assessment process, the collected information and impressions are organized and summarized in a narrative. A tentative assessment is developed using information elicited by the family, by other contacts that the family gave us permission to speak with, our impressions, and our observations of behaviors and interactions among family members. In formulating a tentative assessment, informed judgments of observations and information are based on our theoretical knowledge base to develop intervention goals and a related plan. The tentative assessment should be built on the families' strengths to address the needs that have been jointly identified.

The family assessment has seven parts:

1. Reason for referral
2. Sources of information
3. Identifying information
4. Presenting problems, needs, strengths
5. Present status and social history, including strengths and concerns based on the FAF
6. Tentative Assessment

7. Planning and recommendations

Reasons for Referral. The referral information includes the date and source of referral and the concerns identified by the referral source. Included are the type(s) of neglect risk and additional risk factors (caregiver and/or child) that were recorded on the intake form at the time of the referral.

Sources of Information. In this section, all of the sources of information that were used to develop this assessment are identified. Specific dates of contact with the family and other persons or systems that relate to assessment information are noted, as well.

Identifying Information. Descriptions of the family system, as defined by the family, are recorded. Included are members' names, ages, and relationships to the primary caregiver; sources of economic support and whether it is perceived as adequate; and current school or vocational training status. Also described is the current household situation, including sleeping arrangements, and each family member's perception of his/her neighborhood, especially as it pertains to safety.

Presenting Problems. Family members' perceptions of the presenting needs as they relate to each individual member, the family system, and its environment are described. A history of the problem development and previous attempts to address the problem are included as appropriate, as well as an explanation as to why the family is seeking help for the problem at this particular time.

Present Status and Social History. Using the FAF, this section includes a comprehensive description of the present life situation of the family. Staff describes information about the risks and strengths related to: (1) each child in the family; (2) each caregiver's functioning; (3) the family system; (4) the relevant social history; (5) parenting skills; and (6) the environment and community. The results of the FAF support the description of risks and strengths. Using the FAF enhances the identification of the family's strengths and needs, and the eventual understanding of progress that the family makes in strengthening their capacity in identified areas of functioning.

Standardized Assessment Measure. Family Connections uses the FAF as the standardized assessment measure. Using the FAF enhances awareness of the family's strengths and needs and assists in ongoing assessment of progress over time. The FAF is completed within the first 30 days of service and at the end of work together, and at least every 90 days, if intervention continues beyond 4 months. Numerous child welfare organizations nationwide use the FAF to guide and enhance the evaluation of families that have significant difficulty meeting their children's needs. FC staff will specifically use the FAF's *Family Functioning Factors Sections A through F,* the six areas for family functioning, to guide family service planning, inform outcome driven family plans with SMART goals, and to serve as a practice and evaluation instrument to assess change within families. See the below table.

Tentative Assessment: The tentative assessment provides the opportunity to analyze the information that has been collected and draw conclusions about the most important strengths and needs of individual family members and the family as a system. Using their knowledge of human development, personality theory, psychopathology, family systems and psychosocial theory, staff make informed judgments about the objective and observational information that they collected and recorded. Areas of strength as well as areas of need, as indicated, should be identified for each level of the system.

Regarding the person and system, staff consider identity and structure; mood and emotion; life cycle development; competence; and risk. Family functioning and problem-solving capacity for each family member is addressed. When considering caregiver functioning, staff addresses any particular risks identified with respect to caregivers' abilities to demonstrate self-sufficiency, cope with daily stresses, manage emotions, and control impulses. In the discussion of areas of caregiver competence, the problem-solving capacity of the caregiver should be discussed. For all children, the degree to which they demonstrate developmental appropriateness in all areas of functioning should be included in the assessment. Regarding the environment, the degree to which the family has access to and effectively uses extended family, friends, and systems to meet social support functions is also addressed.

Planning and Recommendations. The key strengths and risks in the family are summarized, and the intervention outcomes are identified. The outcomes are those which the staff and families have agreed to address during the time that the family receives services. They are directly related to the needs or problems that were identified through the assessment process. Outcomes are directly related to the domains identified in the FAF standardized assessment measure. Many, if not most, families will want and need to work toward more than one outcome. Outcomes are reached through positive "Specific Measureable Achievable Relevant Time-limited" (SMART) goals that are developed with the family (See Chapter 10).

FAF Dimensions (See Appendix 9.1 for the complete Family Assessment Form)

A. Living Conditions - The family demonstrates the ability to meet its basic needs for food, clothing, and housing. 1. Cleanliness/Orderliness–Outside Environmental Conditions 2. Cleanliness/Orderliness-Outside Home Maintenance 3. Cleanliness/Orderliness-Inside Home Maintenance 4. Safety-Outside Environmental Conditions 5. Safety-Outside Home Maintenance 6. Safety-Inside Home Maintenance
B. Financial Conditions - The degree to which household financial resources are available. The caregiver demonstrates stress related to household financial demands and the abilities to manage the household fiscal resources. 1. Financial Stress 2. Financial Management 3. Financial Problems Due to Welfare System/Child Support 4. Adequate Furniture 5. Availability of Transportation
C. Supports to Caregivers - The availability of support from friends, children, and community involvement, including the availability of health care. 1. Support from Friends and Neighbors and Community Involvement 2. Available Child Care 3. Chooses Appropriate Substitute Caregivers 4. Available Health Care - Children 5. Provides for Basic Medical/Physical Care 6. Ability to Maintain Long-Term Relationship(s)
D. Caregiver/Child Interactions - Caregiver demonstrates understanding of child development, a degree of bonding with the children, the function of the role of parent, the proper use of discipline, and the capacity to effectively communicate with the children. The children demonstrate bonding to the caregiver and the ability to follow family rules. 1. Understands Child Development 2. Daily Routine for Child(ren) 3. Use of Physical Discipline 4. Appropriateness of Disciplinary Methods 5. Consistency of Discipline 6. Bonding Style with Child(ren) 7. Attitude Expressed About Child(ren)/Caregiver Role 8. Takes Appropriate Authority Role 9. Quality and Effectiveness of Communication [Caregiver to Child(ren)] 10. Quality and Effectiveness of Communication [Child(ren) to Caregiver]

11. Cooperation/Follows Rules and Directions
12. Bonding to Caregiver

E. Developmental Stimulation - Caregiver provides an enriching/learning environment for the children, engages them in play, and promotes appropriate interaction of siblings.

1. Appropriate Play Area/Things-Inside Home
2. Provides Enriching/Learning Experiences for Child(ren)
3. Ability and Time for Child(ren)'s Play
4. Deals with Sibling Interactions

F. Interactions Between Caregivers - Caregivers demonstrate with each other the ability to effectively communicate, problem solve, be mutually supportive, and manage conflict.

1. Conjoint Problem Solving Ability
2. Manner of Dealing with Conflicts/Stress
3. Balance of Power
4. Supportive
5. Caregivers' Attitude Toward Each Other
6. Ability to Communicate (Verbal and Nonverbal)

G. Caregiver History – Caregiver's history impacts his/her ability to parent and function effectively on a daily basis.

1. Stability/Adequacy of Caregiver's Childhood
2. Childhood History of Physical Abuse/Corporal Punishment
3. Childhood History of Sexual Abuse
4. History of Substance Abuse
5. History of Aggressive Act as an Adult
6. History of Being an Adult Victim
7. Occupational History
8. Extended Family Support

H. Caregiver Personal Characteristics - Caregiver demonstrates capacity to function independently on a daily basis, including the capacity to problem solve, cope with stress, and care for his or her own needs.

1. Learning Ability/Style
2. Ability to Trust
3. Current Substance Use
4. Passivity/Helplessness/Dependence
5. Impulse Control
6. Cooperation
7. Emotional Stability (Mood Swings)
8. Depression
9. Aggression/Anger
10. Practical Judgment/Problem-Solving and Coping Skills
11. Meets Emotional Needs of Self/Child
12. Self-Esteem

I. Acting Out Behaviors - The degree to which children manifest behaviors expressed toward someone or something outside themselves.

1. Poor Sibling and Peer Relationship(s)
2. Aggressive/Assaultive/Destructive
3. Tantrums
4. Sexual Acting Out
5. Run Away

	6. Lying/Stealing 7. Stubborn/Oppositional/Disobedient
J.	Inner-Directed Behaviors - The degree to which children manifest behaviors, sometimes harder to detect, in which the children's symptoms are directed inward. 1. Sleep Disturbance 2. Somatic-Eating Problems 3. Self-Destructive/Accident Prone 4. Depressed/Withdrawn/Suicidal 5. Anxious/Fearful 6. Excessive Masturbation or Preoccupation with Sexual Parts 7. Indiscriminate Attaching/Overly Friendly 8. Encopresis/Enuresis 9. Lacks Spontaneity
K.	School Behavior Problems - The degree to which each children are able to participate in academic and social activities in school. 1. Learning Delays 2. Disruptive in Class 3. Attended Many Schools 4. Poor School Attendance/Phobia
L.	Health and Developmental Problems - The degree to which children manifest acute and chronic health care needs or appear to be functioning at a level not commensurate with their developmental age. 1. Health Problem(s)-Chronic 2. Health Problem(s)-Current 3. Dental Problems 4. Developmentally Delayed 5. Adopted 6. Premature Labor/Difficult Pregnancy or Delivery 7. Asthma
M.	Temperament - Style of thinking, behaving, and reacting. 1. Shy (Introverted) v. Outgoing (Extroverted) 2. Activity Level 3. Attention Span/Persistence 4. Demanding/Irritable/Difficult

Appendix 9.1 – Family Assessment Form (insert here).

Chapter
10

DEVELOPING SMART GOALS AND THE FAMILY PLAN

Family Connections is guided by tailored interventions based on time-limited, individualized service plans, known as the family plan in Florida FC. The family plan facilitates goal and outcome achievement to strengthen protective factors and reduce risk factors for child maltreatment. This chapter describes the steps and elements of creating meaningful family plans.

Why is tailored, outcome-driven service planning important?

Outcomes are achieved through the attainment of positive and desirable goals that are developed in the service planning process and based on the comprehensive family assessment. This is intended to help caregivers target broader outcomes and break them into manageable, achievable steps, which will in turn increase the likelihood of success. Realistic steps may also foster client motivation. The goals need to be realistic, given FC's 4.5-month service time frame (i.e., 3 months of change focused intervention following the development of the family plan). They also need to be squarely focused on the family's view of what must change. The family plan is then used as a mechanism to specify actions that will support the achievement of outcomes and goals.

Family Plan Process

When the family assessment process has been completed (30 day requirement) and the outcomes have been defined and agreed upon, the next step is to establish a family plan. The family plan shapes the prioritization of outcomes, specification of SMART goals, and selection of specific change focused interventions that will be provided. Family plans are developed within 2 weeks of completing the comprehensive family assessment. Goals—the expected results or accomplishments that will be reached—should be constructed clearly so that FC staff, supervisors, and caregivers will know when they have been achieved. Goals should be written in the SMART (Specific, Measurable, Achievable, Relevant and Timely) format. They should logically follow the priority concerns identified during assessment and address changes clients agree need to occur. The intervention goals are consistent with our mission: they address risks related to meeting the basic needs of the children and preventing maltreatment.

When developing the family plan, FC staff should consider the following:

1. What is the time frame for goal achievement and service provision? Shorter time frames allow clients to experience success at faster intervals and provide reinforcement more frequently for their successes. This, in turn, enables clients to feel a sense of control and optimism over their situation and encourages the continuation of work toward achieving longer-term goal(s).

2. What are the priorities for work? Clients might become overwhelmed if they work simultaneously toward achieving numerous goals.

3. What is the likelihood of success? Staff should support the selection of goals that are important to clients and have a *high* likelihood of attainment. This is especially important at the beginning of fostering the helping relationship with the family. Most clients need to believe in and experience success as well as see that FC staff will effectively support them.

The family plan should reflect input and agreement from the family and FC staff. The analysis completed during assessment will provide insight into the capacities of family members and how to pace the activities in the plan.

The plan is intended to be a dynamic document; meaning, just as families change, the assessment and planning process evolves, too. Arriving at the final family plan requires discussion and often negotiation or compromise. This is to be expected, particularly because FC stresses that families should be in the driver's seat. After negotiation and discussion, staff should provide the documented plan of service to the family to review and sign.

Developing SMART Goals that Match Selected FC Core Outcomes

Working with the family to develop goals in its language (remember, the best words are those used by the family) and that match the primary outcomes that were selected as a result of the assessment process is a skill that takes practice. The actual process of setting goals reflects the spirit of the FC intervention because it emphasizes family involvement, reflects the family's voice, and engages the family in deciding what it wants to achieve. In addition, like assessment, goal setting is ongoing: work toward goal achievement needs to be continually tracked with the family, reviewed to ensure it makes sense given ongoing assessment findings, and revisited or adjusted as needed. Supervisors should actively support staff in conceiving of goals and ensuring they meet the below SMART criteria. In brief, SMART goals are changes in behavior or condition that if accomplished by the family will bring the family closer to achieving a targeted outcome.

SMART Goal Criteria

Specific • What is the desired result? (who, what, when, why, how)
Measurable • How will you know the degree to which the goal is achieved? • Can you quantify (numerically or descriptively) completion? • How will you measure progress?
Achievable • What skills are needed? • What resources are necessary to support goal achievement? • How does the environment impact goal achievement? • Does the goal require the right amount of effort given the caregiver's/child's readiness to make this change in behavior or condition? • Bottom line, is it likely the client will achieve the goal in the time allotted?
Relevant • Is the goal in alignment with the selected outcome? • If the goal is achieved, will the overall purpose of the FC work be at least partially achieved? • Given available resources, is it likely the goal can be achieved in the short term? • Would a particular goal be more realistic if other goals were achieved first?
Time-limited • What is the deadline? • Is the deadline realistic? • Is it likely the goal can be achieved by or before 90 days?

A word about the "Relevance" criterion: SMART goals should match the FC core outcomes selected as the target of change in the comprehensive family assessment. FC supervisors and staff should consult to ensure that goals align with the core outcomes. In addition, the family must view each goal as relevant to what it needs and wants to accomplish.

Family Plan Components

The Florida Family Connections Collaborative uses a Family Plan to identify family strengths and areas of need in collaboration with the family. The plan (Appendix 10.1) consists of several sections that help focus the family on their individualized goals, and the methods that will be utilized to create change. The Family Plan consists of the components listed below.

1. Identifying information: The initial section of the Family Plan lists the name of the primary caregiver in the family, telephone number (if applicable), the name of the Family Connections Specialist working with the family, and the number associated with the revision of the plan.

2. Strengths: This section lists any noted strengths within the family. In addition to listing the strengths, this section also provides information as to how the strength(s) will be used to help the family achieve their SMART Goals.

3. Concerns (Outcomes): This section lists the identified needs, or areas of desired change, within the family. Associated with every outcome and concern are SMART Goals, the method for achieving the goal, and a target date for goal attainment.
    a. SMART Goals: SMART Goals are Specific, Measureable, Attainable, Realistic, and Timely. When developing SMART Goals, each of the five listed components must be included. The goals are what a family member or the family system will accomplish that will bring them closer to achieving a specific outcome. [NOTE: SMART GOALS ARE NOT SERVICES – THEY ARE BEHAVIORS OR CONDITIONS THAT WILL BE CHANGED/ACCOMPLISHED].
    b. Method: The Methods listed are what the staff will do to support the family to achieve SMART goals. Specific change focused interventions should be identified that will support the family to achieve goals. Staff may also identify “methods” or tasks that the family will accomplish toward achieving a goal but the primary method is what we will do.
    c. Goal Date: This is the date by which the corresponding SMART Goal will be accomplished. This date should be individualized for each SMART Goal listed.

4. Child Behavioral Concerns: This Section provides detail around identified child behavioral concerns. Child behavioral concerns are used to inform the comprehensive family assessment, but are not measured to assess change. Content is this section is not necessary with families. [NOTE: CHILD BEHAVIORAL CONCERNS ARE NOT RELATED TO FC OUTCOMES].

5. Demographic Information: This section lists all members of the family unit, and defines their relationship within the family, and their individual dates of birth.

6. Intervention Duration and Frequency: This section provides the date that the plan was created, the estimated duration of service (estimated time to accomplish all SMART Goals), and the estimated frequency for service intervention.

7. Signatures: The signature section is where each caregiver, Family Connections Specialist, and Family Connections Supervisor sign and date the plan, acknowledging that this agreed upon plan is owned by, and driven by, the caregivers within the family unit.

Appendix 10.1 – Sample Family Plan

Chapter

11

CHANGE FOCUSED INTERVENTION STRATEGIES AND SERVICES

An important part of Family Connections is the process in which staff work directly with families to reduce maltreatment risk factors and strengthen protective factors. This is done through face-to-face, purposeful change focused intervention that occurs at least one hour per week with the family in the home. In Family Connections, "intervention" encompasses activities, services, or tasks that are undertaken at the individual, family, and/or group level to facilitate the family's change process.

From the time we say "hello" to clients, a process of simultaneously assessing what is going on in clients' lives and intervening with them and on their behalf has begun. This process of assessment and intervention continues until the end of our work with them. As we develop the helping relationship and implement an outcomes-driven family plan, we sharpen the focus on work that will promote defined, desirable, and lasting change. A key strategy for "doing the work" is to have regular, planed, and face-to-face contact with the family to encourage and support their success.

Why is change focused intervention important?

Staff provide the necessary frequent and ongoing support to caregivers to promote SMART goal attainment and improved outcomes. Weekly change focused intervention aims to attend to the caregivers' readiness and motivation to facilitate meaningful change and goal achievement. This chapter provides an overview of the skills and techniques used in change focused intervention, as well as a description of various types of change focused intervention services.

Section 1: Skills for Change Focused Intervention

At this stage of our work with families, staff move from skills that are used primarily for collecting information, developing a helping relationship, formulating an assessment, and establishing a family plan to those skills that promote the change-oriented work that must be done to reduce maltreatment risk and strengthen family functioning. During this phase, staff should continue to use the empathic skills discussed earlier, but should rely more heavily on expressive skills. Therefore, it becomes crucial to have a sharp awareness of the difference between personal and professional responses. In general, choices at any point of the process should be guided by several questions: "Am I saying or doing this right now because it will be the most appropriate and effective intervention that I have available?"; "What is my purpose for saying this/using this skill?"; "In using this skill, will I convey respect?"; "Does this question I'm considering asking reflect how I personally think or feel about this client?"; and "Am I using this skill as a form of self-expression or self-gratification?"

The efforts of staff and families should be shaped by the agreed-upon SMART goals and core outcomes. All the work done by staff and clients should, in some way, directly relate to one or more of the outcomes and goals. If the family's situation significantly changes and new needs or risks surface, the family plan should be adjusted to reflect the new or revised focus for work.

An essential skill to support the change focused intervention process is Motivational Interviewing. This skill should be used during assessment and service planning as well but it is critically important to discussion and intervention related to the family's efforts to change. Other skills that are especially helpful in carrying out change focused work include: (1) sharing perceptions, ideas, reactions, and formulations, (2) rehearsing action steps, (3) reviewing action steps, (4) evaluating, (5) focusing, (6) educating, (7) advising, (8) representing, (9) responding with immediacy, (10) reframing, (11) confronting, and (12) pointing out endings (Cournoyer, 2011). These techniques can be practiced during supervisory and peer consultation.

Motivational Interviewing

Motivational interviewing is essentially a conversation about change, particularly behavior change (Miller & Rollnick, 2002). Its purpose is to evoke and strengthen personal commitment and motivation for change. At its core is the helping relationship since motivational interviewing relies on collaboration, engagement, and trust between the staff and family. Additionally, motivational interviewing affirms the client's rights to self-determination and to make choices in both deciding to change and in selecting the specific behaviors that will be the focus of change.

Motivational interviewing involves the use of specific skills in particular prescribed ways that are matched differentially to each client and situation. In other words, although motivational interviewing is grounded in a set of principles and values, it is not a "one-size-fits-all" approach. To be effective, staff must consider the client's individual readiness for change (stage of change) and the specific behaviors or conditions that are targeted for change. Staff must then provide intervention related strategies that will best support the client at his/her particular stage of change. Some of these strategies have been described earlier in this manual. Supervisors should consult with staff to consider the strategies that will most effectively support the client's change process.

There are four essential principles of motivational interviewing (Miller & Rollnick, 2002):

- **Express empathy** – acceptance of the client facilitates change; skillful reflective listening is fundamental to expressing empathy; recognition that ambivalence is normal.

- **Develop discrepancy** – accomplished by thorough goal and value exploration; helps the client identify his/her own goals and values; identifies small steps toward goals; focuses on what is feasible and healthy; allows clients to make own argument for change.

- **Roll with resistance** – avoids argumentation; affirms the client's right to make own decisions.

- **Support self-efficacy** – expresses optimism that change is possible; reviews past success in making change; uses reflective listening, summaries, and affirmations to reinforce positive statements; validates frustrations while remaining optimistic about the prospect of change.

These principles build on the fundamental processes in motivational interviewing: (1) **engaging** – fostering the relational foundation that began with the first client contact; (2) **guiding** – using the strategic focus that began during the family assessment process; (3) **evoking** – drawing forth the client's own motivation and commitment to change using the techniques described earlier and the principles above; and (4) **planning** – making the bridge to change: arriving at core outcomes and SMART goals in the assessment and service planning stages.

Motivational interviewing during change focused intervention incorporates *change talk* (Miller & Rollnick, 2002), which is a statement(s) by the client revealing consideration of, motivation for, or commitment to change. In motivational interviewing, staff guides the client to expressions of change talk as the pathway to change. The more someone talks about change, the more likely they are to change. Different types of change talk can be described using the phrase, DARN-CAT (Miller & Rollnick, 2002):

Preparatory Change Talk: DARN

- Desire (I want to change)
- Ability (I can change)
- Reason (It's important to change)
- Need (I should change)

Implementing Change Talk: CAT

- Commitment (I will make changes)
- Activation (I am ready, prepared, willing to change)

- Taking steps (I am taking specific actions to change)

Other Skills for Carrying Out Change Focused Intervention

Providing Feedback: Sharing Perceptions, Ideas, Reactions, and Formulations

An important role of staff in the change oriented phase is provision of candid feedback concerning clients' needs or challenges. Hepworth, et al., (2009) suggest that this feedback is to facilitate the change process in one or more of the following ways:

1. Heighten clients' awareness of dynamics that may play an important part in problems.
2. Offer a different perspective regarding issues and events.
3. Help clients conceptualize the purposes of their behavior and feelings.
4. Enlighten clients on how they affect others (including staff).
5. Bring clients' attention to cognitive and behavioral patterns (both functional and dysfunctional) that either operate at an individual or group level.
6. Share here-and-now affective and physical reactions of staff to clients' behavior or to processes that occur in the helping relationship.
7. Share positive feedback concerning clients' strengths and growth.

This feedback process should begin with staff's first contact with the client. Communicating upfront that feedback will be offered informs the client about what to expect. It is likewise important to provide feedback that is strengths-based and constructive. Positive feedback increases the likelihood that it will be heard and fosters the client's sense of optimism and self-efficacy. For example, when a client feels overwhelmed with their financial situation, staff might say, "How have you managed so well until now? You must feel proud that you have been able to provide for your family with little money to go around."

Rehearsing Action Steps

There are many barriers that may impede a client's implementation of planned actions to change behaviors or conditions. Proper preparation and practice can enhance the potential for successful or partial completion of action steps. Careful rehearsal of all the action steps helps clients stay abreast of and attend to their own intentions and reactions. This can facilitate planning and modifying the action steps when necessary. This in turn increases the likelihood that clients will translate an expressed intention into desirable behavior. Staff may opt to model or role- play rehearsing action steps with clients to help them identify different ways of acting/reacting (Cournoyer, 2011).

Reviewing Action Steps

Whether clients have successfully completed, partially completed, or *not* completed action steps, it is always important to review results with them. This sends the message that what has happened is important. It also holds clients and staff accountable to the agreements they made and increases the likelihood that future action steps will be attempted. In addition, it provides information related to goal attainment and helps guide the process of identifying future action steps (Cournoyer, 2011).

If clients have partially or successfully completed action steps, verbal praise should be offered. In addition, the factors that may have contributed to the accomplishments should be explored so that clients may develop

insight into their desirable behavior. Also, clients should be encouraged to express satisfying thoughts and feelings that accompany actions toward goal achievement. For some clients that are unaccustomed to success or its acknowledgment, this may be a threatening or otherwise uncomfortable request that is at least as difficult as taking the targeted action. It may require its own action plan to increase the client's comfort level.

When action steps have been partially completed, reviews of what occurred may also reveal challenging factors that need additional attention and a revised plan. Clients may decide that partial completion is acceptable and that further action is not desirable. If this occurs, staff should reassess the situation—keeping child maltreatment risk factors at the forefront of their consideration—and decide if they need to encourage clients to reconsider or support the changed decision.

When action steps have not been attempted, staff should not express disapproval or criticism. Rather, they should convey concern and ask clients to help them understand what may have gotten in the way. Staff should try to help clients express the thinking and feeling that contributed to the change in plans and how they are thinking and feeling about it now. Then, staff should continue a process similar to that conducted for partially completed action steps.

Evaluating

Evaluating involves staff and clients exploring and reviewing progress toward clients' goals and objectives (Cournoyer, 2011). Informal evaluation occurs during weekly visits. Staff should continually assess progress toward SMART goals and core outcomes and discuss this with clients. A formal evaluation occurs 90 days after finalization of the family plan. Two weeks prior to the 90 days, staff should complete the FAF ratings to assess the degree to which family has made changes in the most concerning behaviors and conditions previously identified during the Family Assessment. (See Chapter 12 for details).

Focusing

Focusing is a crucial skill that is not always easy to consistently implement. Many families face multiple challenges and needs, and their lives are often chaotic and unpredictable. Families may have learned that "the best laid plans" always seem to go astray. In trying to support and empathize with families, staff may become overwhelmed by their needs and disorganized in efforts to help families implement service plans. In addition, diversions—attempts to dismiss, avoid, or change the subject—may occur because of external demands, psychological processes, or familial dynamics. In focusing, staff, together with the family, sustains attention on a particular topic. There are times that patterns become apparent and this can be reflected to clients to help them monitor their own processes and how they cope with challenges, distractions, avoidances, or other factors that can throw them off course. Focusing can likewise benefit staff and families by renewing shared understanding of the key priorities that are the target for change.

> Example of focusing to address a client's tendency toward diversion:
>
> Staff: "It seems as though when I ask about Johnny's father, you change the subject."

Sometimes, diversions are productive. They may lead staff and families to an enhanced understanding of what is really going on; in turn, this can facilitate development of more realistic plans. On the other hand, diversions can be unproductive and lead staff and clients astray. Through focusing, staff and clients can increase insight and consider how to redirect shared energies to what is relevant.

Example of focusing a client's thinking:

Staff: *Would you please hold that thought so we can finish talking about what happened at school today? It seems that needs our attention right now.*

In addition, focusing can draw a client's attention to something that they might otherwise not be aware or appreciative of. By directing attention to it, staff may heighten client awareness (Cournoyer, 2011).

Example of focusing to increase client awareness:

Staff: *I don't know if you realize it, but often when I compliment you about something you have done, you change the subject. I'm wondering if it's hard for you to hear nice things about yourself.*

Educating

It sometimes becomes clear that clients lack information or competency that is helpful or necessary for completing an action step. To assist clients, staff assumes the role of educator, but in doing so, it is essential to give careful consideration to the role of teacher and the reciprocal role of learner (Cournoyer, 2011). To be effective, both roles require being open and receptive. In addition, the educator should understand basic principles of teaching and learning.

First, staff are often in a position to share knowledge or informed opinion. This should be expressed in such a manner that clients feel free to ask questions, dispute, or discard a suggestion (Cournoyer, 2011). For example, many parents have unrealistic expectations of their young children. Staff may see the need to help parents better understand the developmental capacity of their children, as well as share suggestions on how to respond appropriately to particular developmental stages.

Second, people have different learning styles. Some are deductive thinkers – they do well taking the theoretical and applying it to a particular situation. Others are inductive thinkers – they do best with specific examples that can be applied to their situations. They may then have the skill to generalize what they have learned to other situations, or may need help doing so. Some clients learn best through telling a story that can be applied to their situation; bibliotherapy is an example of this technique. In addition, some people learn best by seeing, hearing, or doing, or through a combination of these approaches (multisensory learning). As staff help clients learn new information, it is important to understand their learning styles and adapt teaching techniques accordingly (Cournoyer, 2011).

Advising

It is sometimes appropriate and effective to give advice. In general, staff should not offer advice based on personal feelings, attitudes, and preferences. Instead, they should offer suggestions and encouragement based on professional knowledge and experience. It is preferable that staff provide advice in a way that makes it clear that clients may accept or reject it (Cournoyer, 2011). Staff could simply say, "May I offer you some advice to consider?" or "Can I give you advice on that? You don't have to agree with me but it might be helpful to hear me out." Advice should be given so families are empowered. It should be avoided if it engenders dependency. The exception is when there is a life-threatening situation or a significant risk to safety or well-being.

Representing

Representing includes actions that staff take on behalf of clients with their knowledge and permission to assist them in obtaining their goals. These actions are intended to facilitate clients' effective and successful interactions with members of formal and informal helping systems (Cournoyer, 2011). Representing incorporates the social work roles of brokering, advocating, and mediating (Compton, Galaway, & Cournoyer, 2004).

Representing clients can be extremely satisfying when interactions with other providers are easy and successful. However, interactions can sometimes be frustrating, even infuriating at times. It is crucial for staff to remember that they are acting in a professional capacity on the client's behalf and must keep the client's best interests in mind. Staff are encouraged to consult with their supervisor on ways to navigate challenging interactions and effectively represent clients.

Responding with Immediacy

The client/staff relationship can enable the client to experience new ways of relating and expand their skills of engaging others in meaningful relationships. To facilitate this it may be helpful to reflect on the relationship development process that occurs between client and staff. In responding with immediacy, staff focuses on the client's experiences in the here and now, including their reactions to the staff and the work in which they are engaged (Cournoyer, 2011).

> Example:
>
> Staff: *It seems to me that right now, you seem to be (thinking/feeling/doing/experiencing)…*

When responding with immediacy, staff may be modeling an open and attentive communication style with which clients are unfamiliar. The interaction may prompt a similar response, such as greater openness from clients. Clients' past and present problematic relationship patterns may also exist in the client-staff interaction patterns. Staff's ability to respond with immediacy during the present time may increase the clients's self-awareness and create healthier interaction styles (Cournoyer, 2011). That said, responding with immediacy is not appropriate for use with all clients. It depends on the family plan, the theoretical approach, and the client's capacity for insight. In general, staff would use immediacy when clients' reactions are clearly relevant to the goals for work.

Reframing

Sometimes, clients rigidly embrace a point of view that is, in itself, an obstacle to goal achievement. Reframing is applicable when fixed attitudes impede or sabotage work on the family plan. The overall goal is to liberate clients from negative perspectives that get in the way of their best interests (Cournoyer, 2011). One type of reframing is turning a negative into a positive, such as describing a client's negatively-labeled attribute as a positive one. For example, a client who is "overprotective" of her children could be described as careful and caring about their safety. A second type of reframing is personalizing meaning (Cournoyer, 2011). This skill is used to encourage clients to change from externalizing responsibility to internalizing it and hopefully build their sense of self-empowerment.

> Example of reframing to personalize meaning:
>
> Client: *My mother is always on my case. She's so controlling – I can't do anything I want to do.*

Staff: *You experience your mother as controlling and that's frustrating for you because you think you should be assuming more responsibility for your own decisions.*

A third type of reframing is situational meaning (Cournoyer, 2011). Here, staff reflects an understanding of the client's feelings or behaviors, but then suggests that they may also be viewed as a result of external, situational, or other factors beyond the client's control or responsibility. For example, a client may be losing sleep because she has to talk to a co-worker about always coming in late and making it difficult for their work team to get their work done on time. The client is worried that she will lose her job because of the co-worker's poor performance.

Example of reframing around situational meaning:

Client: *I can't sleep, all I do is think about talking to her and how hard it's going to be.*

Staff: *I know this is really bugging you and you can't get it off your mind. This is a big deal and I'd think it would keep anyone up just trying to figure out how to do it.*

Confronting

In confronting staff help clients understand how their words, feelings, and actions may be contradictory, inconsistent, or otherwise illogical. This is done directly and without condemnation or judgment. Staff challenge clients' behaviors but do not discount their personhood (Cournoyer, 2011). One format for confronting is:

"On the one hand, you (say/feel/think/do) _____, but on the other hand, you (say/feel/think/do) ____" (Cournoyer, 2011).

Confrontation is powerful and may have significant negative effects on some clients. Some might feel attacked, accused, judged, or defensive. Therefore, before using this skill, staff should be certain that clients have the capacity and support to tolerate and grow from being confronted. Also, staff should feel confident that the helping relationship is well-established.

Pointing Out Endings

In pointing out endings, staff maintains the focus on the goal-oriented family plan by periodically reminding clients that the working relationship will end at a predetermined time (Cournoyer, 2011). Service is provided for a time-limited duration that is determined at the beginning of work. This defined timeframe may help motivate clients to stay focused on action steps and strive to achieve the mutually agreed-upon goals.

Section 2: Change Focused Intervention Services

To help families meet the basic needs of their children, change focused intervention needs to provide an individualized mix and intensity of services. Interventions are geared to increase the ability of families to successfully nurture their children by enabling them to use resources and opportunities in the community that will help them alleviate stress, overcome knowledge and skill deficits, and build and maintain caregiving protective competencies. Since the contributors to maltreatment are varied, interventions may be directed to

developing and/or providing: (1) concrete resources; (2) social support; (3) individually oriented interventions; (4) family focused interventions; (5) group interventions; and/or (6) service facilitation. These are explained below.

Provision of Concrete Resources. A crucial component of intervention is responding to the complex basic needs of families often associated with living in poverty. As noted earlier in this manual, emergency and concrete services are provided at any point when families need them. Examples of concrete services can include: emergency food or clothing; financial assistance to prevent eviction or other family disruption; and household furniture and supplies. It is important to note that these interventions may be provided at any time and do not have to match a change focused SMART goal.

Social Support Interventions. Social support serves as a protective factor and can serve to off-set specific risk factors. For example, if a family is socially isolated, knowing that they have at least one person they can call on through thick and thin may help to reduce stress and social isolation (DePanfilis, 1996). For example, FC Staff may help families establish or mobilize a personal social to serve one or more social support functions, i.e., emotional, instrumental, or tangible support; cognitive aid; appraisal support; and companionship. Studies on the stress-buffering role of social support and from intervention programs involving mobilization of social support suggest that having both a confidant and a network help buffer and defend families against a range of stressors (DePanfilis, 1996).

Opportunities to help families build or reconstitute previously existing social supports are varied and multiple and can offer hope that someone will be there for the family, long after formal interventions have ended. These services are crucial to an empowerment philosophy. Extended family, neighbors and friends; faith based groups and community group members; children's school groups; parent and home health aides; and self-help groups are some ways to build new, supportive relationships.

Interventions Focused on the Individual. Since maltreatment risk is due to multiple factors, individually-oriented intervention is sometimes needed to address problems that interfere with caregiving, e.g., mental health challenges, destructive stress-related coping skills, or substance use/abuse problems.

Staff determine which individual interventions are best suited for each family member based on their unique situations and capabilities and select these when they will support the achievement of specific outcomes and SMART goals. Potential interventions that may be applicable to families and their individual needs include: substance abuse intervention, developmental remediation, cognitive-behavioral techniques, parent education, client-centered therapy, problem-solving therapy, crisis intervention, grief and loss work, narrative therapy, play therapy, and/or art therapy. Details on several of these interventions follow.

Substance Abuse Intervention. A collaborative treatment approach to help caregivers recover from an alcohol or other drug problem will also improve their capacity to provide adequate care. Olsen and colleagues (1996) suggest that risk of child maltreatment among families whose caregivers have a substance abuse problem is affected by eight dimensions: (1) commitment to recovery; (2) patterns of use; (3) effect on child caring; (4) effect on life-style; (5) supports for recovery; (6) parent's self-efficacy; (7) parent's self-care; and (8) quality of neighborhood. It is likely that no single provider could address all eight dimensions, so a collaborative approach would be needed.

Developmental Remediation. This perspective views human behavior and social functioning within an environmental context. It goes beyond ecology by bringing in other aspects such as the stages and tasks of the family's life cycle; the bio-psychosocial principles of individual growth and development; and goals and needs that are common to all human beings and families. It considers the particular aspirations, needs, and qualities of each person and each family in light of diversity in such areas as culture, ethnicity, race, class, and sexual orientation.

Developmental remediation intervention should be guided by an optimistic view of the capacity of children and adults to overcome deprivation through nurturing experiences throughout the life cycle. This optimistic view should be balanced by a realistic appraisal of the capacity of caregivers to meet the developmental needs of themselves and their children.

Children whose basic needs have not been met consistently may require individual attention to help them overcome deficits in cognitive, academic, social, and emotional skills. Special education programs; school or community-based tutorial programs; individual therapy and medication; and personal or social skills development groups may be considered.

For children, pre-school programs like Head Start and pre-kindergarten programs enhance self-esteem and skills. Many therapeutic day care programs also recognize that their intervention will be more successful if they target intervention to the whole family. They may provide both child-oriented services and involve caregivers in parent education and support experiences.

Cognitive Behavioral Interventions. These techniques are especially useful with vulnerable families when they target both the environment and the individual. Staff selects specific techniques after the completion of the assessment process, which may include:

1. Verbal Instruction (e.g., about basic child care tasks)
2. Social Skills Training, such as modeling, role play, and behavior rehearsal skills
3. Cognitive Restructuring, a process to assist clients to gain awareness of dysfunctional and self-defeating thoughts and misconceptions that impair functioning and to replace them with beliefs and behaviors that lead to enhanced functioning
4. Communication Skill Building
5. Employment Counseling/Training
6. Financial Management Counseling
7. Behavior Modification Techniques

Therapeutic Relationship. Carl Rogers, in his Client-Centered Theory (1957, 1959), believed that individuals seek therapeutic assistance because of inadequate functioning due to perceptual distortions. He described six conditions that needed to be present in the therapeutic relationship to result in constructive personality change:

1. A relationship in which there is a perception " that this makes a difference"
2. Vulnerability, that motivates the client
3. Genuineness articulated by the therapist
4. Unconditional positive regard demonstrated by the therapist
5. Accurate empathy displayed by the therapist
6. Client's perception of genuineness

Problem-solving Therapy. Problem-solving therapy involves helping clients define their problems and needs and then mutually develop goals, resources, and plans to implement strategies to address them.

Crisis Intervention. As previously discussed, when crises occur, it is important that staff apply nine principles of crisis intervention (Ell, 1996, pp. 179-180):

1. Aid is provided as quickly as possible, often through outreach to families
2. Crisis interventions are time-limited and brief
3. The staff's role is active
4. Symptom reduction is a primary goal
5. Practical information and tangible support are provided
6. Social support is mobilized
7. Expression of feelings, symptoms, and worries is encouraged

8. Effective coping is supported to restore a sense of competency as early as possible
9. Cognitive issues about reality testing and confronting the experience are addressed

Grief and Loss Work. Loss may be an enduring theme among families involved in FC. There are many forms and manifestations of grief and loss that individuals can experience. For example, children may have been abandoned by their parents or lost a family member through murder, illness, or drug overdose. As another example, grandparents with a primary caretaking role may grieve the loss of their adult child as well as experiencing loss of the life they had envisioned for themselves once their children were raised. The purpose of grief and loss counseling is to find adaptive mechanisms for alleviating distress (Sharp & Cowie, 1998) and to assist clients with coping with feelings of sadness, anger, and anxiety and with recovering from loss.

Service Facilitation and Advocacy. Each family presents with a unique set of strengths and needs. Staff understanding of the family's dynamic picture, including who they are and what they need, is developed during the assessment process. The implementation of the family plan for enhancing their strengths and addressing their needs occurs throughout the FC work with families. However, because families' needs are usually complex, few families are able to meet their goals with support from only one provider, professional, or agency.

When families begin FC services, they might already have connections to a variety of community systems, such as human service, health, education, legal, and mental health resources. It is possible that the FC staff's work with families will surface the need to expand those connections. Because few families can be assisted by one system and because families with multiple needs can overwhelm a single provider, it is crucial for FC staff to understand the clinical dynamics of service facilitation and to become familiar with the resources that may be available to families in their community. When staff and family members develop SMART goals, there may be times when families need to be connected to additional services to support goal achievement. Use of other service providers should be selectively determined in consultation with supervisors.

Clinical Perspective on Service Facilitation and Advocacy. Simply handing clients slips of paper with names and numbers of referral sources and expecting them to make effective connections with them is usually not effective. Staff can maximize the likelihood of a successful referral by keeping in mind the complex interplay among clients, agencies, and systems. Making appropriate referrals on behalf of clients requires strong verbal and written language skills, an assertive nature, patience, and a willingness to tackle new situations.

Client Perspective on Receipt of Services. There may be many difficulties, both real and perceived, that challenge clients' ability and willingness to connect to providers or services. These include, but are not necessarily limited to, the following:

1. Clients do not want someone else managing their lives or telling them what to do.
2. Clients may not want to directly acknowledge their inabilities to meet their individual or family needs.
3. Clients do not want to make personal issues into public ones by sharing them with "still another helper."
4. Clients may not have the cognitive and/or emotional resources to reach out and ask for help.
5. Clients may be afraid that entering a new system will result in them being labeled.
6. Clients may be afraid of the unknown (providers or systems).
7. Clients may be afraid of the proposed interventions.
8. Clients may be afraid of the results of the proposed interventions.

In addition, there are client feelings and/or behaviors that may be accurately or inaccurately labeled as *resistance*. These include, but are not necessarily limited to, the following:

1. Clients do not agree with the problem identification that is precipitating the referral.
2. Clients do not see the identified problem as a priority for work at this time.
3. Clients do not want to commit personal resources (time, emotion, energy, finances) to FC.
4. The identified community resource is difficult or inconvenient to access.
5. Clients do not "like" the helper who is making the recommendation.
6. Clients do not understand the service that is being recommended or appreciate the impact that receiving the service would likely have for them or their families.

7. Clients know, through experiences or hearsay, someone who has had a bad experience with the community provider or agency.

SO WHAT DOES STAFF DO TO HELP CLIENTS BECOME MORE RECEPTIVE TO SERVICES?

Acknowledge that reaching out for and connecting with services is not an easy process and:

1. Encourage clients to identify barriers, both functional and emotional, which can be addressed through mutual problem solving.

2. Help clients to identify similar feelings that have been successfully overcome, and can be generalized to this situation.

3. Self disclose – the staff can share an experience that they have had entering a new system, describing both the challenges and opportunities that the experience provided.

4. Encourage clients to discuss feelings with friends or family who will be understanding and supportive, and who may have had a similar experience.

5. Utilize role rehearsal and role reversal exercises to help clients reduce their anticipatory anxiety and increase their skills.

6. Provide "in-vivo" support – In other words, offer to accompany clients to their first (or first few) appointment(s).

7. Encourage new providers to reach out to clients.

Agency Perspective on Service Facilitation and Advocacy: A crucial piece of the service facilitation process is the actual agencies to which staff would like to refer clients. In this process, staff hope that clients receive timely, effective services. Understanding system dynamics within organizations is crucial knowledge for staff and supervisors to have. The following characteristics may describe some of the community agencies with which the FC program is working:

1. At any one time, too many people may need the services of a particular agency.
2. In some service areas, budget cutbacks have resulted in limited service availability.
3. The providers may be poorly trained and/or have inadequate supervisory support.
4. Burn out among the workforce may be a significant problem.
5. The agency system may be dysfunctional and prevent good workers from doing good work.
6. Waiting lists may be long.
7. Fees may be increasing and/or rigid, with little or no available financial assistance.
8. Caseloads may be too high.
9. Hours of operation may be limited.

SO WHAT DOES STAFF DO TO ADDRESS SYSTEMIC CHALLENGES EXPERIENCED BY COMMUNITY AGENCIES?

1. Expect the process of referral and connection to be challenging *yet* manageable.

2. Call ahead to obtain a detailed and realistic expectation of what it will take to facilitate the client's connection to the service. Determine what paperwork the client should bring, how long they may expect to wait, and anything else that will prepare the client for the first contact(s).

3. Keep the client's goals and best interests in mind in all transactions with an agency. Staff should be guided by professional standards and behaviors and the desired outcomes for the client.

4. Be the squeaky wheel. Most providers have quite a "to do" list. Gentle inquiries regarding the status of clients within the other agency system may help.

5. Whenever possible, identify multiple or alternate resources to meet the clients' needs. Simultaneously engage in the process of trying to secure the needed resource(s).

6. Develop relationships with key people in agencies with which you will most often work. Try to identify a contact person at the agency and develop a working relationship. Appreciate the role that s/he is assuming and support rather than antagonize.

7. Expand knowledge of available resources. If one provider is unavailable, ask if s/he knows other resources that could be helpful. Talk with peers and colleagues. Ask clients themselves.

8. When all else fails, staff should be sure that they have carefully and accurately documented all efforts. If staff believe that a client has not been well served, a supervisor should be consulted. If the FC program cannot locate a resource because it does not exist, careful documentation of need may support future efforts to develop the resource.

The Staff's Perspective on Service Facilitation and Advocacy: It is always important that staff remain aware of their own thoughts and feelings that may be contributing to the behaviors they display and the ways in which they engage clients. The following feelings and realities may become especially significant as staff engage clients in the service facilitation process:

1. Staff may have difficulty letting go or sharing the professional control.

2. Staff may have concerns about the quality of the new service or provider.

3. Staff may feel frustrated by clients' behaviors, in general, or by their responses to the referral process, in particular.

4. Staff may feel overwhelmed by the paperwork that is required to facilitate the referral.

5. There may be a lack of needed resources, which results in a detrimental delay, a poorly matched service, or no service at all.

6. For service referral that occurs at the end of the FC case, staff may have many feelings about saying "good-bye" to clients, from sadness to ambivalence.

SO WHAT DOES STAFF DO TO MANAGE THEIR OWN FEELINGS AND THOUGHTS?

1. Staff need to stay in touch with their own feelings and thoughts! These are neither right nor wrong – it's how staff handle them and what they do with them that can be more or less desirable in your professional capacity.

2. Self disclose, as appropriate. If unsure about whether or how to self disclose, staff should consult with their supervisor.

3. Staff must be honest with themselves and their clients. For example, if a client's behaviors are confusing or frustrating, staff must use their clinical skills to effectively approach him/her.

4. Advocate for the development of services to meet identified needs, such as affordable housing, utilities, special education, health care, etc. For instance, staff can join a professional or community group that supports meeting the needs of families, or they can participate on local and state committees to advocate for systemic change.

Chapter
12

EVALUATING CHANGE & PROGRESS ASSESSMENT

A key element of Family Connections is the ongoing evaluation of change over time. During all interactions with the family, staff should review progress on SMART goals, discuss the progress with caregivers, and target change focused interventions strategies to support goal attainment. While ongoing assessment of progress is important, a formal reassessment based on standardized measures supports an objective determination of progress. FC requires that 90 days post-family plan development, staff conduct a reassessment using the FAF and evaluate both changes in behaviors and conditions as well as the degree to which SMART goals and outcomes have been achieved.

Reassessment Process

Staff prepare the family by reviewing the components of the reassessment process and how information will be collected from multiple sources to assess progress. Typically, staff completes the standardized assessment measure approximately two weeks prior to the end of the service period (90 days post-family plan). Information can be gathered from the following sources:

1. Verbal reports from the family. The reassessment protocol calls for meeting with the family as a group and individually with family members. FC staff is interested in what family members say about their progress toward SMART goals and an outcome, including their perspective about their feelings, views, and thoughts about what they achieved during the time assistance was provided by staff.

2. Direct observation of nonverbal behavior for cues of emotional states and reactions. Observations may be within the family or with others outside it, if available and appropriate.

3. Direct observation of the interaction between adult caregivers, between caregivers and children, and between the family and other household members who may not have a direct caregiving role.

4. Collateral information from relatives, friends, physicians, teachers, employers, and other professionals who may have information about the family's progress on SMART goals and outcomes. Collaterals are involved with the family's knowledge and consent.

5. Psychological tests, mental health assessments, and/or substance abuse assessments. When mental health or substance abuse problems of a caregiver or child increase maltreatment risk, it may be necessary for staff to enlist other professionals to help in the reassessment process.

6. Physical health evaluations of chronic/acute illness. To gather an overall picture of the needs of the family, staff needs an understanding of the physical health status of its members. When physical health issues have affected the day to day care of children, and when health providers have been involved in providing change focused intervention related to a specific SMART goal, contact with health provider at the point of reassessment is appropriate.

7. The Family Assessment Form (FAF) is used to assist in the measurement of family functioning and the relative changes in behaviors and conditions that prompted the need for FC intervention in the first place. Ninety-days past the development of the Family Plan, the FAF is completed again to measure change in behaviors and conditions since the original Family Assessment and to support

decision-making related to appropriateness of case closure. If the decision is made to extend FC intervention beyond four months, the FAF is done again 90 days following the development of a second SMART case plan.

Planning and Protocol for the Comprehensive Family Reassessment

FC staff should begin to prepare families for reassessment at least two weeks before the 3-month intervention period comes to a close. Staff should discuss what the reassessment process will entail and how the information will be used. The number of family meetings needed to complete the reassessment will vary in each situation. The method generally includes explaining the process, holding reassessment meetings with the family as a unit and with individual family members, collection of information from other sources (if relevant), and discussion between staff and the family regarding progress toward changing behaviors and conditions that have been the target of intervention and in relation to the achievement of SMART goals and selected outcomes. Since a focus of each weekly change focused intervention visit is also on assessing progress toward achieving SMART goals, the process of reassessment serves to formalize a process that should naturally evolve.

Following the formulation of the formal progress assessment, staff should meet with the family to discuss areas of success and challenge. It is at this time that the staff and family decide if there is sufficient progress toward changing behaviors and conditions and achieving goals and whether case closure is appropriate. If certain ratings in the FAF are still a 3 or higher, staff should consult with the supervisor to determine whether this targeted area of functioning can be addressed by the family alone or by another community agency. When insufficient change has been made but continued work with the FC program is likely, the supervisor and staff and staff will consult with the appropriate CBC to make the final decisoin.

It is important to review and celebrate what led to goal achievement and support the family's expressions of satisfaction about accomplishments. When there is no progress or movement toward the family's identified outcomes and goals, the family should be encouraged to explore what did or did not occur that interfered with taking the action that was planned. Then, staff and the family should consider whether a major change in the family plan is needed or whether relatively minor adjustments are made.

Comprehensive Family Reassessment as a Product

At the conclusion of the reassessment process, including completing the FAF reassessment, the collected information and impressions are organized and summarized in a narrative in the Outcomes and Closure section of FAF Web culminating in the Reassessment/Closing Summary report (Appendix 12.1). A progress assessment is developed using information elicited from the family, other contacts that the family gave staff permission to speak with, staff impressions, and staff observations of verbal and non-verbal behaviors and interactions among the family members. In formulating a progress assessment, informed judgments of observations and information are based on the FC theoretical knowledge base to develop a formal evaluation of change and progress. The written progress assessment should be built on the family's strengths and identify the observed change that has helped address the family's needs.

In FAF Web, information is entered into the Outcomes and Closure tab to create the Reassessment/Closing Summary report. The Reassessment/Closing Summary has four parts:

1. Outcome on Goals
2. Referrals
3. Progress Summary
4. Additional Comments

Outcome on Goals (Goal Outcomes section in Outcomes & Closure tab in FAF Web). Each outcome and SMART goal created in collaboration with the family is listed. Using observations and the information gathered

pertaining to each goal, staff describe actions and evidence that justify if a family has made progress, or not, in regards to each outcome and SMART goal. Explanations of the methods used, what was achieved, and what was not achieved with each outcome and SMART goal are outlined in this section. Activities by the family and staff as they relate to each SMART goal are discussed. For each SMART goal, staff also selects a rating of progress from the following options: Achieved SMART goal, Substantial change has occurred, Some Change has occurred, Minimal or no change has occurred, or Problem/Concern worsening. The documentation regarding the goal outcome should justify the aforementioned progress rating.

For each SMART goal, this section also shows the FAF rating for the associated Concern (FC/FAF Outcome and Item (e.g. Living Conditions/A.3 Cleanliness/Orderliness – Inside Home Maintenance) from the initial FAF Evaluation completed as part of the Comprehensive Family Assessment as well as the rating from the FAF Reassessment. The degree of improvement or change in rating from the initial FAF Evaluation to the Final FAF Evaluation for the Concern is displayed.

Referrals (Referral Outcomes section in Outcomes & Closure tab in FAF Web). This section includes a list of referrals made on behalf of the family to show the coordination of interventions provided by others. Additional interventions or referrals to others should only be selected if they support change as defined in the SMART goals. Staff also notes which services provided by outside organizations the family received during the Family Connections service period or is receiving at case closure.

Progress Summary (Closing section in Outcomes & Closure tab in FAF Web). A summary and analysis of the changes within the family and a description of current family functioning are provided. The degree of sufficiency of the observed change in addressing the needs and risks of the family is described in this section. The results of the FAF ratings should enhance awareness of the family's strengths and needs and assist in assessment of progress over time. FC staff provides descriptions of key observations based on the FAF reassessment as well as changes and progress made since completion of the first FAF. A description of the family's perception of progress is included in this section.

Additional Comments (Additional Comments section in Outcomes & Closure tab in FAF Web). At the conclusion, a recommendation is made as to the appropriateness to close services with the family. If a family's maltreatment risk has not been sufficiently lessened, a description is provided of the steps that must be taken, goals that must be met for closure to occur, and a projected timeframe to reach closure. This section should also include a description of the process of closure with the family. Any additional comments may also be included in this section.

Of note, there is also an additional part to the Reassessment/Closing Summary report, Children Placed, which need not be completed as Family Connections provides services to intact families.

Chapter
13

CLOSURE AND ENDINGS

In Family Connections, families receive intervention for specific time durations. FC staff reinforce this timeframe and seek families' commitment to participate in services for the assigned duration. Staff might use naturally occurring markers, such as holidays, to talk with families about the time that has passed in the professional relationship and how much time remains to work together. It is also important to use the timeframe as a reality check to identify what has occurred to meet goals and outcomes and to sharpen the focus of work and, as necessary, renegotiate the family plan given the time that remains. This chapter discusses how to make appropriate case closure decisions, implement a positive process of ending with families, develop an Aftercare Plan[1], and document case closure.

The Process of Ending with Families

Cournoyer notes that ending a relationship can be difficult and painful. For clients and staff alike, the end of the professional relationship can trigger intense thoughts, feelings, reactions, and behaviors. It is a time of transition with "many manifestations of the psychological and social processes associated with ending" (Cournoyer, 2013). Exploring feelings and thoughts around ending is an important part of concluding the FC relationship and, like all the other components of FC practice, is intended as a collaborative process between the family and staff. That said, in most instances families and staff can anticipate the end will occur and prepare for it.

"Termination" is the process of ending the professional relationship between the family and FC staff. As noted, it is a time that may generate a range of feelings for both parties. Those feelings may, in part, be determined by the kind of ending that clients and staff choose together or that clients unilaterally select. It is a process that remembers the relationship that was established, the work that was done, what was accomplished, and what remains to be addressed. It also explores the meaning that the relationship has had for everyone involved and how it feels to say "goodbye." Finally, it may be a time of choice for families if they are deciding to discontinue services or to connect to or continue non-FC services. Often, the termination process reflects parallel relationships or provokes memories of relationships, previous endings, grief and loss, or other individual and family dynamics related to separation. Termination can be a time of both stress and opportunity, including the chance to address unresolved issues from the past and create productive patterns of interaction and reflection.

As FC staff anticipate their planned ending with clients, they should evaluate progress toward identified core outcomes and SMART goals. If all the outcomes were sufficiently achieved, the progress is recognized and celebrated. It is important to identify in the final evaluation the strengths, accomplishments, and ways for the family to sustain the goals that were reached and to independently complete goals that were not met. If families are still experiencing substantial challenges and need further intervention (more on this below), staff should consider, with supervisory input, various options, such as making appropriate referrals to other community services, developing a new family plan based on reassessment results, and/or identifying informal supports, such as relatives or friends.

With all cases, FC staff report case closure to the initial referring entity and other service providers that have collaborated in serving the family. In addition, staff and the family together create an Aftercare Plan with the intent of affirming the family's strengths and accomplishments during the service period and addressing strategies for any unmet needs at the time of closure. The Aftercare Plan should address each outcome in the

[1] It should be noted that developing a formal After Care Plan is a feature of FL Family Connections and is not part of the original Family Connections intervention.

family plan, including reiteration of referrals provided, helpful strategies and techniques, and services planned after case closure. The Aftercare Plan should include names and information for individuals the family can contact for informal support after case closure.

Sometimes families may discontinue services while the FC work is still underway and incomplete. When possible, staff should explore with the family the reason(s) for its decision. Keeping an open mind is important. Often with good reason, clients decide to discontinue services (Cournoyer, 2013).

The Personal to Professional Continuum

In reality, termination begins when staff first meet the family and continues throughout their work together until the final "goodbye." Staff and families need to be equally aware that the FC relationship is time-limited. The genuineness that staff present to families is one of the most powerful dynamics of building and maintaining a successful relationship. At the same time, it is crucial that staff continually examine their own personal feelings, thoughts, and reactions during every interaction with the family and throughout the working relationship as a whole. Termination may be especially difficult for some staff due to losses or endings that have occurred during one's own life. Staff need to be aware of their own experiences of loss and endings, particularly if they suggest unresolved issues or conflicts, so they do not project their personal feelings onto families. Staff should consider working through any unresolved concerns with their supervisor or other trusted party.

It is a myth and mistake to believe that professionals can consistently separate personal emotions from professional ones. Instead, it is crucial that staff consciously stay in touch with the personal feelings that FC work may elicit. Continued self-awareness will usually enable staff to identify their feelings, ensure they do not interfere with the professional relationship, and use effective coping strategies. Sometimes, colleagues or supervisors may need to help identify and acknowledge these personal feelings before FC staff can appropriately recognize or address them.

The Skills of Ending

Although there are different "types" of termination, there is shared content across all of them. Lawrence Schulman (2008) identifies a set of skills that are central to the process, four of which are discussed here: 1) reviewing the process; 2) final evaluating; 3) sharing ending feelings and saying goodbye; and 4) marking the end. These skills do not signify distinct stages of the ending process; rather, they can be used, often concurrently, to effectively carry out the process.

Reviewing the process refers to the mutual recollection of the beginning, middle, and end of the staff/family relationship. All family members are encouraged to share their memories, sometimes individually and, whenever possible and appropriate, together. Often, different family members will recall different dimensions of the process. It is important that FC staff do not discount anyone's impressions. Rather, staff may acknowledge the differences and perhaps encourage the family members to hypothesize what may be contributing to them. It is also important that staff share his/her own memories of the work that has been done together, including acknowledging the ups and downs. Being honest about successes and challenges normalizes the FC relationship and experience as well as role models for the family effective communication skills and the value of open expression.

In *final evaluating* FC staff encourage individual family members and the family as a whole to identify accomplishments and strengths as well as any remaining unmet needs. Staff should encourage clients to "own" the successes and celebrate them. Whenever possible, staff should also help clients identify and appreciate the problem-solving skills that they have used and support them in exploring how they may apply those skills to address remaining problems or challenges.

Sharing ending feelings and saying goodbye may be the most challenging dimension of the ending process for both clients and staff. Clients and staff may experience a wide variety of feelings such as sadness, loss, anger, betrayal, powerlessness, fear, rejection, confusion, ambivalence, and denial along with happier feelings

such as pride, relief, gratitude, and joy. These feelings are influenced by the duration and quality of the professional helping relationship and by personal characteristics.

For many people endings are a type of loss. Depending on one's own life experiences, ending the FC relationship may trigger unexpected or strong feelings. It is helpful to encourage families to recall past endings and explore the feelings, coping strategies, and supports that came into play. It is equally important that staff talk with their supervisor about their own losses and explore how their own experiences may affect work with families at this time in the FC process. In addition, it is important that staff deliberately determine which, if any, of their personal feelings should be shared with clients.

It is crucial to remember that all clients will experience the ending of the FC relationship in a unique way. In addition, his/her *behavior* will be unique. It is a mistake for staff to assume that all clients will want to discuss their feelings and thoughts. In some instances, clients may have learned that such feelings or thoughts will be discounted, ignored, punished, or ridiculed. In others, it may not be part of the family's culture. In still others, clients may experience denial, such as if they do not acknowledge that the relationship is ending, then it cannot really end. However, it is still important that staff encourage openness and sharing while acknowledging the difficulty and discomfort it may precipitate.

Marking the end is often desirable to finish the termination process before the last formal meeting/visit with staff, and to end the relationship in a way that is different in setting, content, and tone. Rituals are often important in cultures and families. They can help normalize, manage, and understand experiences, as well as create a context in which life events or experiences are framed. Formal ending markers might include staff giving an appropriate, small gift, such as a certificate or family photo celebrating the family's participation in FC. Any plans to give a gift should be discussed with the supervisor to ensure it is ethically appropriate under the values and norms of the agency and social work profession. Whenever possible, the final meeting should be with the entire family. This can reinforce a sense of mutuality of the family members. In addition, staff may consider encouraging families to plan a special activity to mark the end of their FC participation, such as a family outing.

When working with children, it may be helpful to complete a small project together that the children—and the family as a whole—can keep as a concrete remembrance of the relationship and its accomplishments. Examples include writing a story based on a mutual story-telling process, drawing a picture together, making a recording of successes or lessons learned, or creating a memory book.

Arriving at Case Closure Decisions

Staff and supervisors should consider several factors or guiding questions in making case closure decisions. These are likewise considered when evaluating the family's progress (see Chapter 12):

- Change demonstrated by the family and reflected by the FAF and Evaluating Change process
- Current child maltreatment safety and risk:
  - If the family were referred to FC today, would it be an appropriate referral?
  - Is change focused intervention with FC staff still needed?
  - If any factors are still rated a 3 or higher on the FAF, is it realistic that the family has readiness or capacity to make changes in this area if FC services were continued?
- Core outcomes and SMART goal achievement:
  - If all goals were adequately achieved, what would justify continued FC services?

In addition, when sufficient change has occurred and maltreatment risk adequately reduced for the FC case to conclude, staff should consider the following:

- Does the family need continued services to sustain its changes? Do other service providers believe continued services are appropriate?
- Is the family requesting assistance in being linked to other services or supports?

- Does the family need continued support or treatment for other issues outside of those that affect child protective and risk factors?

FC staff is responsible for identifying any potential needs and helping families make relevant connections before case closure.

Documenting Case Closure

Staff completes the Outcomes and Closure section of FAF Web resulting in the Reassessment/Closing Summary report (See Appendix 13.1) when a decision to close the case has been made due to sufficient change in behaviors and conditions and progress on goals and outcomes. Case closure may also occur when the family withdraws from or otherwise does not complete the FC program. In such instances, the Reassessment/Closing Summary should be completed to document the reasons for non-completion. In all instances, staff should note the completion/non-completion type (closure code) in FAF Web. Specifically, staff completes the Date Closed and Reason for Closing in the Outcomes and Closure section of FAF Web. In addition, staff should document the primary outcomes achieved and summarize the progress of achievement on outcomes and SMART goals; the status of important events (e.g., a new maltreatment report), as well as the services provided by FC staff and others. If a referral(s) was initiated at the time of case closure, it should be documented as well. This process is detailed in Chapter 11 Evaluating Change.

Follow-Up after Case Closure

FC staff should make a follow-up contact[2] with each family that successfully completes the program to ensure gains are maintained, reinforce accomplishments, and provide additional referrals and support when necessary. Follow-ups are completed at or before 30 days from the case closure date. Staff should complete a Follow-Up Report (See appendix 13.2) documenting the family's strategies for maintenance of progress, any plans for ongoing support, and any referrals provided at the time of follow-up.

[2] It should be noted that making follow-up contact with families 30 days following case closure is a process required in Florida Family Connections. This is not a requirement of the original Family Connections intervention.

Chapter
14

FIDELITY, DOCUMENTATION, AND ADMINISTRATIVE EXPECTATIONS

About the Florida Family Connections Collaborative (FCC)

The Florida FCC is structured to support the ongoing implementation, improvement, and sustainability of FC in the geographical areas in Florida served by Kids Central and Partnership for Strong Families. The Florida FCC Implementation Team exists to support the consistent use of FC across areas and agencies. Each agency has representation on the Implementation Team with team members having a role in communicating Implementation Team decisions as well as leading implementation at their agency.

Each agency is responsible for ensuring that weekly individual clinical and group supervision is implemented with FC staff to support their continuous learning and improvement. Each agency has developed and will maintain an implementation plan that details relevant activities to ensure FC's ongoing implementation and improvement. The plans are coordinated across the FL FCC to promote efficiency and shared resources. Additionally, the FCC Implementation Team work collaboratively to identify implementation support needs across the agencies based on implementation, intervention, and fidelity data. This chapter highlights the FC fidelity process as well as overarching documentation and administrative standards.

FCC Fidelity Criteria

Family Connections fidelity is the extent to which the FC model is implemented as it is described; in other words, the degree to which actual FC practice with families reflects the model's principles, activities, components, and other standards. Increased fidelity has been linked with better outcomes. Determination of fidelity can help measure the quality of FC as it is actually being practiced in order to identify strengths and areas needing additional learning, development, or capacity building. To ensure that FC is implemented and practiced consistently and as expected in Florida, specific fidelity criteria should be assessed. These appear in Table 14.1. The FL FCC works with the FCC Training and TA Team implement methods for assessing these criteria.

Table 14.1 Florida Family Connections Collaborative Fidelity Criteria
Family Connections Philosophical Principles
Uses and supports Family Connections philosophical principles in the delivery of services: 1. community outreach 2. comprehensive family assessment and individualized, tailored intervention 3. development of a helping alliance 4. empowerment approaches 5. strengths perspective 6. cultural competence 7. developmental appropriateness 8. outcome driven family plans with SMART goals

Table 14.1 Florida Family Connections Collaborative Fidelity Criteria
9. focus on the practitioner 10. critical thinking[1]
Administrative Activities
Contributes to modifications of FC intervention manual to respond to families receiving prevention services throu the Florida FCC.
Establishes safety policies for staff related to their work in the community.
Affirms that the program has developed and implemented risk management procedures (e.g., child abuse/neglect reporting, self-injurious behavior, etc.).
Develops and implements marketing and recruitment procedures targeted toward potential clients (e.g., CPI & families).
Establishes and manages referral procedures for actively reaching out to eligible families with offers of service.
Forms and uses a community advisory committee that incorporates consumer input.
Professional Development Activities
Recruits and supports a professional workforce (social work education or equivalent).
Ensures that all staff and supervisors complete the learning/coaching program developed in collaboration with the FL FCC and FL FCC Training and Technical Assistance Team prior to being assigned families for FC practice.
Provides at least one hour of weekly face-to-face individual clinical supervision/coaching to FC case staff.
Fosters an organizational culture that reinforces FC philosophical principles, intervention methods, and procedures via providing at least one hour of weekly group clinical supervision, seminars, or team meetings, and interpersonal interactions.
Provides opportunities for staff to participate in seminars, conferences, and/or other training to support their continuous professional development in FC related social work practice methods.
Fidelity Assessment & Outcome Evaluation Activities
Uses a logic model to specify the connections between outputs and outcomes.
Develops, implements, and manages continuous methods for assessing the quality of services through a continuous quality improvement system.
Implements a self-assessment of fidelity at least every six months and participates in on-site fidelity assessments by the model developer at least every six months.
Measures change over time in risk factors, protective factors, and child safety outcomes at the client family level and aggregates agency data for all families served.
Implements strategies that document the implementation and service delivery processes.
Tracks time units of service by type of services delivered.
Tracks costs of all service units and develops periodic reports on the costs of services.
Implements All FC Practice Components
ELIGIBILITY & INTAKE Uses the FC Intake screening criteria adapted for the Florida FCC to identify families eligible for FC. Enrolls families deemed eligible using the criteria and screens out families that do not meet eligibility criteria. Documents the process of screening for eligibility including the basis for decision-making and the supervisor's involvement in decisions.
OUTREACH & BEGINNING THE FAMILY PARTNERSHIP After clients are assigned to the FC intervention, the FC case staff initiates the therapeutic alliance through face-to-face contact with the family within one business day of screening a family as eligible.

[1] NOTE: Critical thinking was added as a philosophical practice principle by the FL FCC. It is not part of the original Family Connections intervention.

Table 14.1 Florida Family Connections Collaborative Fidelity Criteria
Provides most services in the family home, meeting families where they live.
RESPONDING TO EMERGENCY & CONCRETE NEEDS Provides emergency services to address initial concrete needs and on an ongoing basis as needed.
CONDUCTING THE COMPREHENSIVE FAMILY ASSESSMENT Conducts comprehensive family assessments to guide the service planning and delivery process within 30 days of the first contact with families. Uses standardized clinical assessment instruments to guide the identification of risk and protective factors associated with child maltreatment as part of the comprehensive family assessment. Selects at least one outcome from a standard set of FCC outcomes to drive development of the family plan.
DEVELOPING SMART GOALS AND THE FAMILY PLAN Engages the family in a goal setting and planning process. Develops outcome driven family plans with SMART goals geared to decrease child maltreatment risk factors and increase protective factors within 2 weeks following completion of the comprehensive family assessment.
CHANGE FOCUSED INTERVENTION STRATEGIES & SERVICES Delivers tailored, direct change focused services to help families reduce risk, maximize protective factors, and achieve FCC outcomes and SMART goals. Provides a minimum of one hour of face-to-face change focused intervention to each family at least once per week. Advocates on behalf of family clients in the community and facilitates services provision by other organizations/individuals as appropriate to support achievement of outcomes and SMART goals.
EVALUATING CHANGE/PROGRESS ASSESSMENT Implements a process for evaluation of client change over time by using standardized client assessment instruments 90 days post family plan. Implements a process to evaluate family progress to achieve case outcomes and SMART goals 90 days post family plan. If insufficient change has occurred to sufficiently decrease risk factors and increase protective factors at the 90-day evaluation/progress assessment, negotiates a new family plan. Plans and implements a new family plan evaluation/progress assessment including the use of standardized assessment instruments within 90 days post a 2nd family plan (if applicable).
CLOSURE AND ENDINGS Implements a planned and purposeful review of change and progress with the family prior to closing, including using the family plan evaluation/progress assessment to document basis for case closure. Documents the case closure decision with supervisory approval.

Documentation

Quality case record documentation is integral to professional practice. A tool to guide intervention and provide accountability, it serves the functions of: (1) providing a detailed chronological description of activities with respect to a specific client; (2) organizing planning and activities with and on behalf of clients; and (3) integrating an approach to measure the results of intervention with families.

Purposes of Record Keeping

1. Case records provide an ongoing "picture" of the nature of our involvement with families, the progress toward achieving outcomes, and the basis of recommendations for supportive services at time of case closure. Case records support accountability for staff. Records describe the family served, the quality and quantity of services rendered, and the basis for all decisions.

2. Case record documentation is a therapeutic tool for staff and families. This is particularly true if they work together to define the purpose of the work, identify outcomes and goals that will help families meet the needs of their children and reduce the risk of maltreatment, and evaluate progress toward achievement of outcomes and goals.

3. The case record is a means to organize the staff's thinking about practice. Structured presentation of factual information leads to in-depth assessment and intervention planning; whereas, disorderly recording and disorganized thinking often go hand and hand and will likely lead to inadequate and ineffective service delivery to families.

4. The case record is a means for training and supervisory review, statistical reporting, and program management.

Principles of Record Keeping

The case record is a professional document that should be completed in a concise, professional manner with confidentiality respected at all times. Principles of record keeping include the following:

1. All information maintained in case files should be relevant and essential to our mission. Document and record facts and distinguish the facts from opinions. When opinions are offered, the basis for them should be clearly established (e.g., Ms. Jones appeared intoxicated: her eyes were red, she had difficulty standing without losing her balance, and her breath smelled of alcohol).

2. Collect and record as much information as possible based on direct communication with clients.

3. Omit details of client's intimate lives or their political, religious, or other personal views from the case record if this information is irrelevant to the program purpose.

4. Do not include process recordings in case files. (A process recording is a training tool to build practitioner skills. As such, it is inappropriate for an agency case record).

5. Maintain and update records to assure accuracy, relevance, timeliness, and completeness. Errors should be marked as such, but should not be erased or deleted.

6. Inform clients about the agency's authority to gather information, their rights to participate (or not) in the process, the principal purpose for the use of the information that they provide, the nature and extent of the confidentiality of the information, and under what circumstances information in records may be shared with others.

7. Obtain the client's written authorization prior to disclosure (verbal or written) of any information (medical, psychological, educational, legal, etc.) to other service providers. State laws and policies should guide these actions.

8. All case records should be kept in locked files with keys issued only to those who require frequent access to them.

9. Case records should not be left on desks or in other open areas where janitorial or other unauthorized persons might have access to them.

10. Case records should only leave the agency in extraordinary circumstances with special authorization (e.g., if subpoenaed for court).

Electronic Client Management System

Florida Safe Families Network (FSFN)

Case records factually document both *what* staff and families do (assessment and intervention activities) and the *results* of what is done (intervention outcomes and goals). All case records and pertinent information are stored in the Florida Safe Families Network. The FSFN helps document and record the results of assessment instruments. It is a tracking system that mirrors the clinical case record and maintains case-specific information related to the following content areas: demographic information obtained during the intake process; client contacts, measurements and scales; clinical activities; case notes; distribution of monies; goal attainment; and administrative activities. FSFN data represent a snapshot of the client and her/his collaborative work with the program in addition to other case specific documentation. The FSFN is also used to generate reports for quality assurance purposes, supervision review, and administrative purposes.

The FSFN enhances clinical and administrative decision-making and supports training and research objectives. It addresses and integrates outcome-driven practice, records information related to outcome driven items, and is an electronic record of intervention. It serves as the case record and it is a centralized location to view household and family member information. The FSFN, however, is only as good as the quality of the information being entered. It is routinely cross-referenced with FAF Web and other case records to ensure accuracy and consistency. The FSFN tracks all activities and information related to:

1. Personnel
2. Household Information
3. Referrals to Family Connections
4. Contacts
5. Outcomes/Items
6. Clinical Activities
7. Information from the Family Assessment Form
8. Comprehensive Family Assessment
9. Family Plans
10. Client Resources
11. DCF Reports
12. Case Closing
13. Data Quality Assurance
14. Reporting/Analysis

FAF Web

FAF Web integrates the research-validated Family Assessment Form with case management functions. FAF Web enables staff, supervisors, and all authorized stakeholders to access essential data remotely from any internet-enabled device. With it, staff can track information from intake through contacts, family/service planning, and case closure. Its service planning feature is an efficient tool for incorporating strengths and outcomes into goals developed by staff and families for the family plan. FAF Web tracks and reports data related to family functioning, family plans, contact notes, closing summaries, caseload reports, demographic reports, and a host of other evaluation functions. While FSFN is the electronic case record, FAF Web serves as an internet-based application to support staff in completing the observational assessment tool, family plan, progress notes, progress assessment, and case closure.

Paper Case Records

The FSFN functions as the case record. However, in addition to an electronic file, a paper file will be maintained to contain signed documents, received documents, family plans, comprehensive family assessment, reassessment and closing summaries, and supporting information. Case records will be organized by case name and include the following specific documents:

Intake and Screening: The purpose of the Intake and Screening form is to collect pertinent information on all clients referred to the program and to document information gathered from the referral source as well as the decision-making process to determine the appropriateness of the referral for FC. The Intake and Screening Form collects information about the nature and extent of the referral; contact information for the family; identifying data on the child(ren), family, and significant others; eligibility criteria (i.e. risk factors); and identifying data on the referral source or agency. Designated CBC staff interview the referral source to determine eligibility for FC and document the referral decision on the Intake and Screening Form. The form is provided to the FC provider and provides basic information to the person assigned to work with the family. The form is entered into the FSFN (See Appendix 14.1).

Authorization for Service and Releases of Information: The Authorization/Consent for Service, Informed Consent, Authorization for Release of Information, Notice of Privacy Practice forms and related documentation are proof that the family has voluntarily requested program services and has been informed as to the respective agency's policy on the release of information. These forms are specific and may vary based on the respective Florida provider agency providing FC services. These forms must be reviewed and completed with the family in accordance with the respective agency's guidelines, polices, and procedures before services may be rendered (Appendix 14.2).

Family Assessment Form (FAF): The program uses the FAF as the standardized assessment measure during the family assessment, the reassessment which occurs at least every 90 days, and approximately two weeks prior to case closure. The FAF is completed in the web-based application, FAF Web. All assessment information must be loaded into the FSFN upon completion and at the time of case closure (See appendix 14.3).

Comprehensive Family Assessment: This narrative documents the process of conducting the family assessment, the sources of information, and summarizes findings from the Family Assessment Form. Core intervention outcomes that drive the family plan and change focused intervention are identified. The family assessment narrative partially based on the FAF includes a comprehensive review of the family system's past and present history; identification of the concerns and strengths of the family; a theoretically sound evaluation of that information; and an explicit plan for working with the client to address identified needs. The assessment is designed to include data provided by observational assessment measures. Staff should complete the assessment within 30 days of beginning work with the client, and the completed assessment must be co-signed and dated by the supervisor. The Comprehensive Family Assessment is loaded into the FSFN (See Appendix 14.4).

Family Plan: The purpose of the family plan is to develop a mutually negotiated contract that defines the outcomes, goals and plan for intervention. The family plan should clearly define the Outcome(s), Goal(s), and Service Method(s) that guide the work done by the staff and the family system. The goals must be directly related to the identified intervention outcomes. The initial family plan is finalized within 2 weeks after the conclusion of the comprehensive family assessment, which occurs by 30 days of service. The family plan is completed in FAF Web and is printed upon completion. It is a working contract, and both staff and primary caregivers sign it. The Family Plan is loaded into the FSFN (See Appendix 14.5).

Progress Note: A Progress Note succinctly summarizes contact with and on behalf of the client, and with other community resources that are serving the family. It tracks the intervention process between staff and clients. All notes must reference the outcome and goals that are being addressed in the contact. The progress note also

includes newly elicited information, specifically referencing goal attainment (progress or lack of progress), any significant changes in client/family functioning, and a summary of contact activity. All notes must conclude with a "plan" section that includes the methods to be completed by staff and family. A Progress Note must be written in narrative format and entered into FAF Web within 48 hours of any client contact. Progress Notes are also loaded into the FSFN.

In FAF Web, the Contact Details section of the note includes the date of contact, the length of contact (time spent), the location (where it occurred), the type of activity, person seen (who was involved in the activity), and the SMART goals addressed. The Services Provided section of the note indicates the types of services provided. The Progress section of the note should include a description of the skills being used (e.g. engagement, assessment, change-focused intervention), techniques used (e.g. active listening, probing, reflection, summarizing, motivational interviewing), progress or lack thereof regarding SMART goal achievement, current stage of change, and any changes to SMART goals if deemed necessary. The Homework/Tasks for next session should include steps to accomplish the SMART goals, types of methods of activities to be completed by staff or the family, any planned follow-up, and the next visit (See Appendix 14.6).

Reassessment/Closing Summary: The evaluation of change and progress is an ongoing process but must occur at least every 90 days based on the date of the family plan and at case closure. Information gathered during this process is entered into FAF Web in the Outcomes and Closure section and results in the Reassessment/Closing Summary report. The Reassessment/Closing Summary should include: the outcomes and goals established with the family; the nature of the services that were provided and the activities that the staff and the client undertook; a rating and description about the level of progress that was accomplished with respect to the outcomes and goals; any referrals/new connections established; information from the FAF reassessment; an overall progress summary; an overall summary of perception of progress by the family; an identification of goals unattained; recommendations for further services; closure date; and closure reason.

The Reassessment/Closing Summary should clearly define all the Outcome(s), Goal(s), and Method(s) that guide the work done by FC staff and the family system. In addition, staff document outcome and related goal attainment in partnership with the families. Goal attainment represents the degree to which the desired change has been accomplished. Staff and families also collaborate to identify new, modify, or continue goals (if/when services will continue). The purpose of the review is to not only assess progress related to the outcomes and goals defined in the initial Family Plan, but also to review accomplishments that have been made and activities that have transpired since the initial or last formal review. This narrative documents findings from the Family Assessment Form reassessment as well as includes an overall analysis of progress and readiness for case closure. When goals are not achieved, obstacles are specified and modifications may be made to the goals and methods that define the activities to be accomplished by staff and families. This process precedes any family plan update and is repeated when the case is closed (See Appendix 14.7).

A closing summary is completed at the termination of services with the client/family and is included in FAF Web in the Outcomes and Closure section when a family is ready for case closure. It should include a description of the process of closure with the family, closure date, and the reason a family ended services.

Below are the closing codes that will be used when documenting case closure in FAF Web:

- Judicial/non-judicial in-home or out-of-home services case
- Closed successful (Goals Met)
- Closed partially successful (Some Goals Met)
- Closed Unsuccessful (Goals not met)
- Family Refused Services
- Unable to contact family
- Referral inappropriate for services
- Family relocated out of service area

Closed cases must be submitted for approval to the supervisor within two (2) weeks of the closing date. All FSFN data entry must be completed at the time of submission. The Reassessment/Closure Summary must be signed and dated by the staff and co-signed by the supervisor. The signed Reassessment/Closure Summary must be loaded into FSFN (See Appendix 14.8).

Outcomes

The Outcomes that are mutually defined by FC staff and families as the target of their mutual activities are continually assessed during the course of service. They are used to develop the Family Plan, Reassessment/Closing Summary, and Case Closure. This ongoing review facilitates defining a focus for the activities, a means for review for staff, a means for review in supervision, and data to evaluate program effectiveness. The outcomes are defined based on the instrumentation that is used by staff to assess family functioning (the FAF outcomes).

Administrative Expectations

Our professional identity is developed in many ways. As staff members, we follow professional and organizational expectations. This section outlines key administrative expectations expected across the FCC including CBCs and Florida provider agencies implementing Family Connections. Individual agencies comprising the FCC will have their own internal policies and procedures that their respective staff follow (e.g. reimbursement for mileage, dress code, supplies, and computers).

Overall Expectations

- Establish and maintain a professional relationship with clients and colleagues at all times.
- Maintain a high level of commitment and responsibility to the program.
- Conduct self in manner consistent with the NASW Code of Ethics and/or the CBC (Community Based Care) Code of Ethics.
- Conduct all work in accordance with CBC policies and procedures, COA standards, and the FC Intervention Manual.

Hours of Operation

Office hours may vary to be responsive to client needs (e.g., clients may work during routine business hours). Routine office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday with the exception of closings for holidays or other standard office closings by staff's respective employer of the CBC or provider agency contracted to provide FC services. As needed and reasonable, staff is expected to work flexible hours to meet client or community needs. With regards to receiving intakes, FC provider agencies are expected to receive intakes during routine office hours from 8:00 a.m. to 5:00 p.m.

Attendance

Regular and consistent attendance is required for successful fulfillment of the job duties. Staff is expected to notify their supervisor of any changes in their schedule. This serves a secondary purpose to support safety practices in knowing where staff are in case there is an emergency. Paid time off, holiday time, and/or other leave benefits are determined by the policies and procedures set forth by staff's respective employer of the CBC or provider agency. In case of any unanticipated absence, staff must provide all information to allow the supervisor or other staff to notify families and make other arrangements to fulfill obligations the staff had scheduled for the day. Staff follows their respective employer of the CBC or provider agency closure policy or determination for inclement weather. The determination of closing is made by the appropriate staff within the agency's organization.

Phones

Staff should provide their office number to clients and colleagues as set forth by the policies and procedures of the CBC or provider agency. Everyone shares the responsibility to answer his/her phone and to check his/her phone for messages. Although there may be voice mail, every effort should be made to answer the phone by the fourth ring. Personal calls should be kept to a minimum, except in the case of an emergency or if it is the only time to reach someone. An emergency is the only time a call should be received while in a training, at a meeting, visiting a client, or in a conversation. This includes texting and reviewing incoming messages.

Mail

Mail should be addressed to the respective agency office, with the designation of C/O, and the recipient's name.

Punctuality

Time management is a key professional responsibility. All staff must be on time for scheduled appointments and meetings. In the event of a delay, it is necessary to inform those with whom you have scheduled to meet.

Alcohol and Drug Use

No alcohol or illegal substances are allowed in the offices or are to be used during time in the field.

Confidentiality

At the end of every day, staff are responsible for replacing case files in the designated storage area. Files or other identifiable client information should never be left out on desks overnight. Files are not to be removed from the office. Staff should consider confidentiality at all times. For example, a staff member would not use identifiable information when speaking to another person in the office or on the phone. All discarded papers should be shredded if they contain confidential information.

Self-Care

Part of professional development is to learn effective and appropriate ways to release stress. Staff are encouraged to talk with their supervisors and colleagues to explore stress management and coping strategies. If a staff member is concerned about a colleague, they should consult with a supervisor.

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