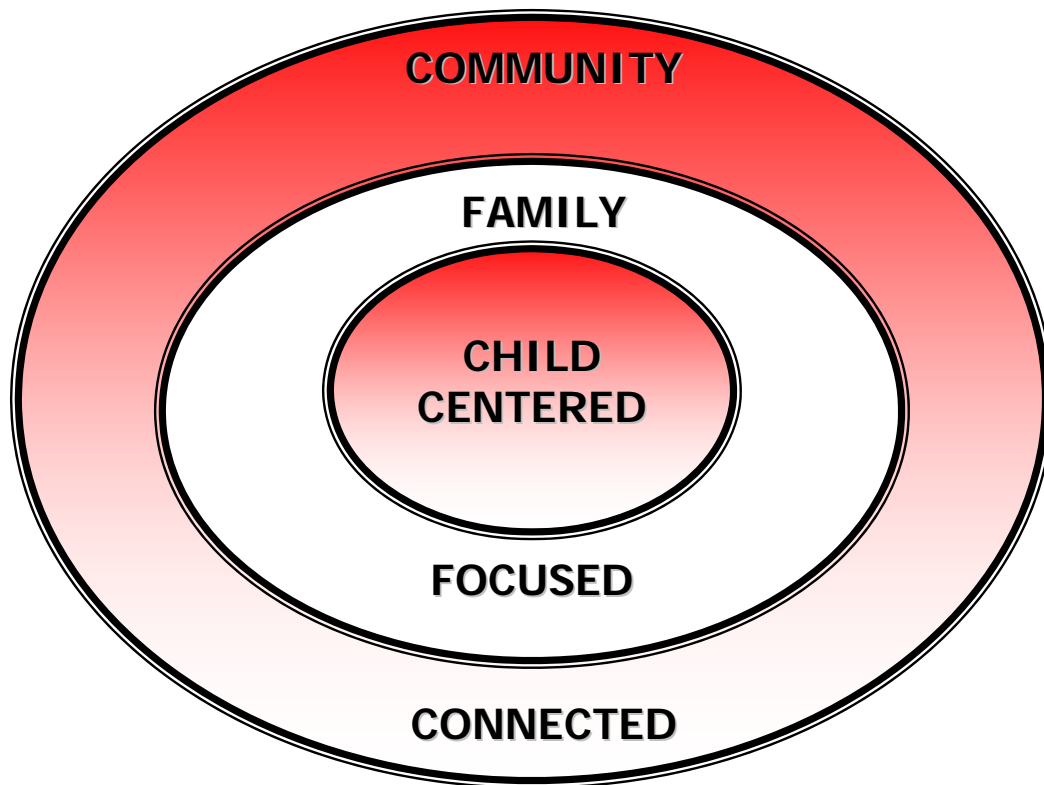




District of Columbia  
Child and Family Services Agency  
and the  
Healthy Families Thriving Communities Collaboratives

## Partnership for Community-Based Services

### *Practice Protocol*



*"A Community Partnership for Protecting Children and Strengthening Families"*

December 2007

# CONTENTS

<b>INTRODUCTION AND OVERVIEW</b> .....	<b>2</b>
<b>A NEW MODEL FOR SERVICES</b> .....	<b>2</b>
<b>CONCEPTUAL FRAMEWORK</b> .....	<b>4</b>
Philosophy .....	<b>4</b>
Core Practice Values .....	<b>4</b>
Core Activities and Helping Behaviors .....	<b>7</b>
<b>PRACTICE PROTOCOL</b> .....	<b>9</b>
Engaging Families .....	<b>9</b>
Assessing Families.....	<b>12</b>
Case Planning .....	<b>15</b>
Quality Home Visitation .....	<b>19</b>
Safe Case Closure .....	<b>25</b>
Supervision.....	<b>29</b>
Training .....	<b>32</b>
<b>MANDATED REPORTING</b> .....	<b>34</b>
<b>DEFINITIONS</b> .....	<b>36</b>
<b>LOGIC MODEL</b> .....	<b>37</b>

## **INTRODUCTION AND OVERVIEW**

Families that come into contact with the child welfare system often face numerous complex challenges. Their needs cut across the service array, frequently requiring services for substance abuse, mental health issues, domestic violence, economic support, child care, and housing. Although the District's Child and Family Services Agency (CFSA) retains the responsibility for ensuring child safety, permanency, and well-being, this is not a charge that can be accomplished alone. To succeed in our mission we must build strong partnerships with families, communities and other agencies. We need the entire community to help protect children and strengthen families.

For children and families at risk of entering the child welfare system, an array of services is available through the seven neighborhood Healthy Families Thriving Community (HFTC) Collaboratives located throughout the District. The HFTC Collaboratives work to build strong families and supportive communities in which children, youth and adults can safely and productively reside and thrive. CFSA is strengthening its partnership with the HFTC Collaboratives through the **Partnership for Community-Based Services**.

There is a growing movement across the country to link public child welfare systems with the communities where the children live in efforts to achieve the goal of safety for children<sup>1</sup>. Through the Partnership for Community-Based Services, CFSA joins in this movement. CFSA is partnering with the HFTC Collaboratives and families within their communities to promote the shared mission, "*To improve the long-term safety, permanence, and well-being of children and to strengthen their families.*" This practice protocol guides our work with children and their families.

## **A NEW MODEL FOR SERVICES**

*Vision of the Partnership for Community-based Services:*

*Every child in the District of Columbia shall live in a safe, stable, permanent home, nurtured and supported by healthy families, strong communities, and a coordinated cohesive child welfare system of care.*

This Partnership will serve as a national model guiding the work of public, private and community based organizations to build an effective system of care for children and families in the community. The Partnership compels:

- Government systems to integrate principles, values and evidence-based practices that empower families to lead the service delivery process;
- The community to advocate for needed services and participate in supporting families; and,

---

<sup>1</sup> Harrigan, Shelia. (2006). A policy framework for ensuring child safety. *New York Public Welfare Association*.

- Stakeholders to hold the District’s child welfare system accountable for family progress.<sup>2</sup>

Recognizing that a more coordinated and comprehensive approach is needed to address the complexity of family issues, CFSA and the HFTC Collaboratives have created a practice model for in-home services. To ensure that children are safe from abuse and neglect and that families are strengthened to better care for their children, this new community-based model seeks to improve outcomes for children and families. Strategically placing public child welfare staff with staff from other agencies enables cross-agency and cross-system coordination on behalf of families and children<sup>3</sup>.

The goal sought by CFSA and the Collaboratives when working with these families is to keep them safe, provide avenues, resources and supports for strengthening and stability, and to keep them together. Specifically, CFSA and the Collaboratives are seeking to achieve the following family and system level outcomes:

- Children remain safe;
- Caregivers demonstrate adequate and effective parenting skills to promote child safety;
- Families have financial and housing stability;
- Families have strengthened social connections with formal and informal supports;
- Families access concrete services and supports independently;
- Caregiver functioning is adequate to promote family and child well-being;
- Family and child well-being is improved;
- Abuse and neglect rates are reduced;
- Community and public resources are used more efficiently; and,
- Family engagement and outcomes are improved.

To effectively implement this model, all 10 CFSA in-home units (supervisors and social workers) will co-locate with the HFTC Collaboratives.

---

<sup>2</sup> “Stakeholders” are defined as children, families, advocates, community members, and other public, private or community-based organizations with an interest in the District’s child welfare system.

<sup>3</sup> Center for the Study of Social Policy. (2005). Community partnerships offer a means for changing frontline child welfare practice. *Safekeeping*.p.6.

## **CONCEPTUAL FRAMEWORK**

### **PHILOSOPHY**

The safety, stability, and well-being of children, as well as that of the people connected to them, is at the center of the work of CFSA and the Collaboratives. When a child protective services investigation determines that the children can safely remain at home with services, the family is referred to the Collaboratives or to an on-going unit within CFSA for services. Keeping families safe, stable and intact is the goal sought by CFSA and the Collaboratives when working with these families. This model does not suggest that workers should do away with the main objective—child safety—but rather it introduces a different approach to working with families in crisis when it is deemed safe for the children to remain at home.

### **CORE PRACTICE VALUES**

#### ***CHILD CENTERED:***

*All children have the right to be safe from abuse and neglect*

- Children's physical and emotional safety is paramount.
- Children have the right to be part of a safe family.
- Children have the right to a fair chance in life and opportunities for healthy development.
- Children have the right to community protection.
- Children's experiences and perspectives are heard and understood.

#### ***FAMILY FOCUSED:***

*Families will experience being understood and valued. Parents will always have a voice, will be listened to, encouraged and empowered.*

- Families are the primary source for the nurturing and protection of children.
- Mothers, fathers and other significant caregivers should be supported and respected in their efforts to nurture their children.
- Family is defined broadly by its members and includes mothers, fathers, and other significant caregivers who may not be currently involved in the child's life.
- Family is significant to all aspects of the child's development.
- Families are partners in decision-making and goal-setting.
- Families are capable of change.
- Families deserve to be engaged respectfully.
- Families are partners in meeting children's needs for permanency, safety and well-being.

## **COMMUNITY CONNECTED:**

*Community partnerships are essential to ensure the safety of children.*

- Families are resources to one another and to communities.
- Every community has assets as well as needs.
- Identifying and strengthening informal and formal supports strengthens children and families.
- Service providers and community resources must be accountable and responsive to the communities they serve.
- Work with families is focused on identifying and strengthening community resources.
- Child safety, well-being, and permanency are a community responsibility.
- Families deserve coordinated services in which all the agencies they work with hold similar values.
- Agency and community leaders must cultivate an environment that promotes information sharing, team-building and family-centered practice.
- Most successful families maintain a healthy interdependence with extended family, friends, spiritual organizations, cultural and community groups, schools and agencies, and the natural environment, and are not dependent on long-term public support.

## **STRENGTH-BASED, SOLUTION-FOCUSED:**

*Our shared vision will be strength-based and outcome-driven.*

- Engaging families respectfully promotes involvement that focuses on and supports strengths.
- Children and families have strengths that need to be recognized and supported.
- Families have the ability, with support, to overcome adverse life circumstances.
- Families can grow and change through identifying and building upon assets and strengths.
- Identifying family strengths will inspire hope.
- Strength emerges from building partnerships between the family, community, and the public child welfare system.
- Empowering families to use their own strengths independently requires a paradigm shift from the top down throughout the organizations involved with the child welfare system.

**COMMITMENT TO CULTURAL RESPONSIVENESS AND CULTURAL COMPETENCE:**

*The uniqueness of every family will be supported and respected. Families will be understood and served within the context of their own traditions, history and culture.*

- Families are diverse and have the right to be respected for their economic, ethnic, racial, cultural and religious experiences and traditions as well as for the genders, sexual orientations and ages of family members.
- Understanding cultural diversity assists in working successfully with families from all cultures.
- Practice and services are delivered in a manner that respects, supports and strengthens the child's and family's identities.
- Every culture is recognized for its positive attributes and challenges for families, professionals and communities.

**COMMITMENT TO QUALITY PRACTICE:**

*We will adhere to best practices and engage in continuous quality improvement in service delivery to children and families.*

- Self-reflection, by individuals and systems, fosters growth.
- Data should be used to promote learning and skill-building.
- Opportunities for continuous learning must be widely afforded to professionals, families and community providers.
- Child, family and community input are essential in the learning process.
- Positive growth and change must build on identified strengths.
- Families have a right to participate in services with highly skilled and trained professionals.
- Evaluating the quality of services and family and system level outcomes is a continuous activity.

## **CORE ACTIVITIES AND HELPING BEHAVIORS**

In addition to the core practice values, with a focus on improved outcomes for children and families, CFSA and the HFTC Collaborative staff shall:

- Share responsibility for engaging a child's entire family, including fathers and paternal family members.
- Develop a partnership with the family.
- Respect family members as individuals with inherent dignity, worth and value, and recognize that all family members have the capacity to participate as equal members in a collaborative change process.
- Recognize the values of fathers to their children.
- Understand the issues unique to working with fathers.
- Help each family assess their needs and strengths and decide on a goal and steps towards reaching that goal.
- Help the family recognize its own strengths that they can draw on to reach the goals set by the family.
- Provide guidance, support, encouragement, and reinforcement for efforts toward positive change, and give developmental feedback, guiding family members in trying new strategies and solutions.
- Empower family members to generate their own solutions through active participation in the development and implementation of the activities in the case plan.
- Help the family make a written plan for pursuing these goals—assisting the family with deciding what service(s) is needed to meet the goals and arranging for the services.
- Appreciate the importance of fathers to the case planning and service provision process.
- Work successfully with fathers in the wide range of family situations and structures, including those fathers that may be incarcerated.
- Communicate desirable outcomes, requirements for safe case closure, time frames, and rights and responsibilities clearly and directly.
- Reassess the family's strengths, needs and progress toward outcomes continually with the family, adapting the goal, case plan, services and safe case closure requirements accordingly.
- Help the family coordinate services so they do not overlap and important services are not missed. Focused efforts to help the family identify the underlying causes of challenges and services to help them overcome those challenges will be paramount.
- Visit the family regularly to ensure child safety, child-family engagement in services, and effectiveness of services in promoting positive change.
- Advocate for and with a family with other agencies, schools and businesses, and review services with the family to make sure that the services still fit as the family's needs and strengths change.
- Offer a compassionate presence to help families sort out their goals and take steps toward healthy self-reliance.

- Initiate and facilitate a family meeting, where decisions and the plan for the child (ren) is (are) left in the hands of the family, when appropriate.

Effectively implementing these activities and engraining these behaviors in practice requires a delicate balance between maintaining child safety and facilitating and building upon family development.

# ***Practice Protocol***

## **ENGAGING FAMILIES**

### **PHILOSOPHY**

Engagement is an essential part of strength-based case management. For In-home staff to assist families in developing and reaching their own goals, and to assure the safety, stability, and well-being of children, In-home staff must actively be responsible for developing a positive rapport and an effective working relationship with families. In-home staff must embrace and convey certain attitudes to successfully engage families. These include:

1. Respecting and supporting mothers, fathers and other significant caregivers in their efforts to nurture their children;
2. Respecting families for their diversity; and,
3. Believing families want the best for their children.

### **DEFINITION**

Engagement is the process of building a collaborative working relationship between the family and the In-home worker for the purpose of meeting the identified and individualized service plan goals of the family. Engagement is based on honesty, empathy, mutual respect, unconditional positive regard, respect for diversity, a collaborative service planning process, and an ability to understand and work through a family's resistance to receive services.

### **KEY PRACTICE OUTCOMES**

1. Families feel supported.
2. Improved communication by and amongst family members and service providers.
3. Trusting relationships amongst family members and with service providers.
4. Linkages with formal and informal supports (individuals and organizations).
5. Families are empowered.

### **ACTIVITIES**

1. In-home staff shall develop positive rapport with the family beginning with the initial contact, and work to maintain that positive rapport until safe case closure. Positive rapport is developed through:
  - a. A recognition and use of the families' values and beliefs as the foundation of the partnership;
  - b. Treating families and children with respect;
  - c. Assisting families to recognize their own resilience and using this knowledge to meet current needs and solve current problems;
  - d. Demonstrating empathy;
  - e. Acknowledging the families' accomplishments and achievements;
  - f. Communicating respectfully in a language that is familiar to the family;
  - g. Cultural awareness;

- h. Active listening—soliciting input from the family and valuing their opinion;
  - i. Modeling behavior to help family members express their feelings—that is, using strength-based, solution-focused language; and,
  - j. A compassionate presence.
2. In-home staff shall treat all families with respect, recognizing the individual dignity of all clients. Respect is demonstrated by:
    - a. Interviewing families and children with a focus on potential solutions;
    - b. Being culturally aware;
    - c. Scheduling arrival and departure times with the family; and,
    - d. Recognizing that families can make good decisions for their children.
  3. In-home staff shall encourage families to express their feelings, personal goals, and self-identified needs and strengths. The following techniques may encourage the families to express their feelings:
    - a. Involving the family in the planning process;
    - b. Asking open-ended questions;
    - c. Modeling empathy, respect and genuineness;
    - d. Making supportive statements;
    - e. Promoting leadership opportunities to build on family strengths; and,
    - f. Allowing the family to identify their unique needs and goals.
  4. In-home staff shall demonstrate honest communication with the family, clarifying expectations and roles and responsibilities. This includes:
    - a. Clearly explaining expectations to achieve safe case closure;
    - b. Clarifying time frames for working with the family;
    - c. Informing the family of their rights and responsibilities; and,
    - d. Clearly explaining possible legal ramifications.
  5. In-home staff shall help families create linkages with formal and informal supports, including individuals and organizations. Helping families create linkages can occur by:
    - a. Coaching families to advocate for themselves by modeling self-advocacy, patience, and problem-solving;
    - b. Assisting the family to identify its service needs; and,
    - c. Exploring how families have solved problems in the past and identifying what formal or informal supports may have been helpful in the past.
    - d. Encouraging mothers to identify fathers early in the case, explaining the benefits to children of the involvement of father's and paternal family.

## TEAMING

The teaming aspect of the engagement process shall include the family, CFSA In-home staff, and Collaborative staff working together to build a strong, trusting, productive, and lasting therapeutic relationship. This will be accomplished by:

1. The family, CFSA In-home staff, and the Collaborative staff holding each other accountable for their role in making the relationship work. This may include a written document with duties/tasks and time frames for completion.
2. Defining the professional helping relationship at the beginning. The In-home staff will produce and share with the family a written document with clear roles for each member of the team, including the family and, as appropriate, CFSA and Collaborative staff.
3. CFSA and Collaborative staff initially engaging/contacting families jointly for a specific amount of time (possibly first four weeks of the case).
4. All In-home staff working with a family will present the same message.

## SHARED DECISION-MAKING

Shared decision-making will include all parties at the table making choices that are consistent with the mission of safety, permanence and well-being for each child and their caregiver. Families shall be made aware of their power to choose to participate in services.

When families choose not to engage in services:

1. In-home staff shall discuss alternative methods of engaging the family in group supervision or team conferences.
2. In-home staff shall propose to the family that a family group conference or family team meeting be held.

## EVALUATION/FEEDBACK

1. In-home staff will engage families within 7 days of case assignment, including attempts to engage fathers. If the location of the father is unknown, efforts to initiate a diligent search for the non-resident fathers shall occur within 30 days of case assignment.
2. Supervisor coaching during individual supervision.
3. Feedback from family during family group conferences.
4. Peer supervision.
5. Client satisfaction surveys.

## **ASSESSING FAMILIES**

### **PHILOSOPHY**

The family assessment is an integral part of empowering families and minimizing dependence on formal social services systems. We recognize that families and children possess strengths that provide the foundation for change. When assessing families, we identify and build upon these assets, while recognizing that families are partners in decision-making. We also recognize that families are diverse and must be approached in a manner respectful of this diversity.

### **DEFINITION**

A family assessment evaluates and identifies the current level of family functioning, the current risk to the child (ren) of abuse and/or neglect, and the family's strengths and service needs. A combination of several tools may be needed to complete a successful assessment. Assessments continue throughout the duration of services to the family. A risk assessment looks at the likelihood of future maltreatment of a child and a safety assessment evaluates a child's present danger and any intervention needed to protect the child. An assessment is necessary for the In-home worker to have a deeper understanding of a family's current and past situation, family dynamics, underlying issues, and strengths and concerns from both the worker's and family's point of view. Ultimately, the family strengths and needs assessment is used to identify the most appropriate services to help families overcome the challenges that they are experiencing. The family is at the center and must be involved in the assessment process.

### **KEY PRACTICE OUTCOMES**

1. Determination of children's degree of safety.
2. Assessment of all areas of risk to children and family, particularly those risks that make maltreatment likely to occur, continue or reoccur.
3. Awareness of especially serious safety factors.
4. Identification of family strengths, needs and resources, including the strengths and needs of mothers, fathers, and children as individuals.
5. Collection of only the needed information; treatment of needed information with great care.
6. Continuous information gathering.
7. Determination of the case level and frequency of contact between the In-home worker and family.
8. Determination of the community's impact on the family and the family's ability to access formal and informal community resources.

### **ACTIVITIES**

1. In-home staff shall recognize and assess the family strengths and accomplishments during the initial contact with the family and ongoing during each contact until case closure.
  - a. In-home staff shall recognize the family's strengths and accomplishments.

- b. In-home staff shall assist families in recognizing their own strengths and accomplishments.
  - c. In-home staff shall integrate their observations of the family's strengths and needs with the family's own perspective of its strengths and needs.
  - d. In-home staff shall assist families in mobilizing the strengths and accomplishments to raise the level of family functioning.
2. In-home staff base their assessment on significant family history and knowledge of the individual family system, including information relevant to the family's needs.
- a. In-home staff should assist the family in identifying its own natural family supports, including maternal and paternal relatives, fictive and non-fictive kin, and community resources.
  - b. In-home staff should use case records, school reports, substance abuse evaluations, medical reports, mental health assessments, and any other pertinent information gathered to inform the assessment of the family.
  - c. In-home staff should use engagement tools such as open-ended questions and active listening skills to gather information for assessing the family.
  - d. Assessment should focus on identifying the underlying issues that families may be experiencing, rather than just identifying immediate, concrete needs.
  - e. Continuous assessments should inform the case planning process.
3. In-home staff shall assess for safety and risk factors from initial contact to case closure.
- a. In-home staff should use approved evaluation tools such as the SDM (CFSA tool), genograms, family group decision conferences, etc.
  - b. The results of the risk and safety assessments should be used to determine the case level and resulting frequency of contact between the In-home staff and the family.
  - c. In-home staff should address concrete needs of families as soon as possible.
  - d. In-home staff must address imminent safety issues immediately in a manner that is germane to the situation, including counseling, coaching, and teaching. Removal is the last resort.

## TEAMING

Assessment is a joint process involving the entire family, including non-resident parents, and In-home staff. The process shall evaluate and identify the family's level of functioning, the current risk of abuse or neglect to the child (ren) and the family's strengths and service needs. The assessment process continues throughout the duration of services to the family.

1. The family, CFSA social worker, and Collaborative family support worker shall have an open discussion about the family's needs, strengths, concerns, accomplishments, and perspective on the situation.

2. The family support worker shall seek additional information or contacts to inform the assessment, including but not limited to school records and personnel, mental health professionals, medical professionals, and other community-based programs.
3. The CFSA social worker shall seek family and case history information available within CFSA.
4. The CFSA social worker is responsible for completing the SDM assessments (risk assessment every 90 days; needs and strengths initially and every 6 months) with supporting information provided by the family support work or family members.
5. The completed assessments shall be reviewed by the CFSA and Collaborative supervisors for approval.
6. Results of the assessments shall be shared with families during case planning discussions.

## SHARED DECISION-MAKING

1. Families shall be informed that information is being gathered for the purpose of the identifying their needs and strengths and guiding the case planning process.
2. Families shall be informed that the tools will not be completed in their presence, but the results will be shared with them during discussions for creating the case plan.
3. In-home staff shall discuss the results of the assessments in group supervision or team conferences allowing for discussion of different perspectives or alternative ideas.
4. When families disagree with the results of the assessments or the needs and services that have been identified, a review shall take place with the family and the CFSA and Collaborative staff and supervisors.
5. All disagreements or differing opinions between family and In-home staff shall be routed through the CFSA and Collaborative supervisors.

## EVALUATION/FEEDBACK

1. All assessments must be in the case record.
2. Case reviews of the record and file.
3. In-home staff will review completed assessments with families.
4. Supervisors will discuss the assessments in case reviews.
5. Supervisors will provide coaching on the quality of the completed assessment tools.

## **CASE PLANNING**

### **PHILOSOPHY**

Case planning is a cooperative effort between the family, the In-home staff at CFSA, and the community service providers. The strength-based, empowerment-focused strategy allows the family to define and monitor goals for themselves. Case planning is a dynamic process built upon professional rapport and takes into account a family's unique strengths, needs, psychological stressors, support networks, and coping skills.

### **DEFINITION**

Effective case management relies on the belief that families and children possess strengths, which provide the foundation for positive change and the tools to reach their goals. Productive case planning relies on recognizing and affirming these strengths. Social workers will assess the details of the case and in partnership with the family and family support worker develop a sufficient program of services to protect the child and remedy parental behavior. The case plan will consist of:

1. The family's identified strengths and challenges;
2. An outline of the services that will eliminate child abuse and neglect;
3. The dates of contact between the family and the In-home worker(s);
4. The purpose of contacts;
5. Progress made toward the achievement of service goals; and,
6. Timelines for future contacts and developmental events.

### **KEY PRACTICE OUTCOMES**

1. Individualized plans, written in the family's terms/language, that emphasize everyday life events and skill development aimed at increasing safety of children and stability of families.
2. Clear objectives that allow the family to channel energy towards specific changes that lead to long term goal achievement.
3. A strong collaborative working relationship between the family, the In-home staff, and community providers.
4. Clearly defined roles, tasks, and responsibilities for all team members.
5. Improved accountability amongst service providers through the evaluation of outcome data.

### **ACTIVITIES**

1. In-home staff will create a partnership with the family to find solutions by:
  - a. Trusting that families have strengths and are experts on themselves.
  - b. Recognizing and verbalizing that families have experienced historical success and can implement strategies towards success again.
  - c. Communicating with the family using positive, everyday language.
  - d. Understanding the stages of change (i.e. contemplation, determination, action, and maintenance) and assisting clients through the change process during the life of the case.

2. In-home staff will create a detailed evaluation of the family's strengths for inclusion in the case plan strategy. As part of identifying the family's strengths, the In-home staff will:
  - a. Normalize the challenges and stressors that families encounter.
  - b. Assist the family in recognizing patterns that contribute to stress/crises.
  - c. Guide the family to identify exceptions to patterns that serve to insulate the family from harm.
  - d. Emphasize those exceptions in an effort to increase cooperation from family.
  - e. Identify specific individual, family and community protective capacities that ensure safety of children and family stability.
  - f. Reinforce and develop protective factors.
  
3. In-home staff will collaborate with the family to assess problem(s) and develop prevention skills. As part of developing prevention plan, the In-home staff will:
  - a. Discuss high-risk behaviors and the triggers associated with these behaviors.
  - b. Focus on specific events and the family's ability to control despite circumstances.
  - c. Create strategies that will interrupt negative behavior patterns.
  - d. Practice and reinforce small steps towards positive behavioral change.
  - e. Build a long-term plan for family stability and relapse prevention.
  
4. In-home staff will join with the family to develop, implement and monitor comprehensive case plan. To effectuate the case planning process, the In-home staff will:
  - a. Determine relevant and appropriate case goals with the family. (Goals must be realistic, obtainable, and measurable.)
  - b. Determine how the family would like to achieve the case goals.
  - c. Set priorities so that the focus is clear.
  - d. Identify individual, family, In-home staff, and service provider responsibilities.
  - e. Determine realistic time frames for achievement of objectives and tasks.
  - f. Determine how the team will measure accomplishment of objectives and goals.
  - g. Monitor the effectiveness of the plan and the family's progress towards goal achievement during home visitation and quarterly as a team.

## TEAMING

Effective community-based practice results from fostering healthy and productive partnerships. Because the families served may have multiple, complex needs that cut across a variety of programs, establishing teams is critical to the success of In-home based work. Teaming must occur between CFSA and the Collaboratives, between CFSA and other District and federal agencies, between helping professionals and community/faith-based organizations, and between In-home Staff and their immediate clients.

1. To coordinate the case management responsibilities of CFSA and Collaborative agencies, a number of procedures must be implemented:
  - a. CFSA and the Collaboratives should jointly develop one comprehensive case plan to ensure that families are receiving consistent services.
    - i. This case plan should be developed through a teaming conference attended by the CFSA social worker, the family support worker, the appropriate supervisory staff from both CFSA and Collaborative, and family representatives, including the child(ren)'s mother and father.
    - ii. The collaborative staff will be responsible for monitoring the agreed upon services through Efforts to Outcomes (ETO).
  - b. Each case will consist of co-Team Leaders who will be the primary representatives for the family and the Partnership. In all cases, at least one team leader will be a member of the family and the second team leader will be a CFSA social worker.
  - c. Team meetings for case review will occur on a quarterly basis, or more frequently in the case of an emergency as determined by the team leaders, and shall involve a core of multidisciplinary team members in devising and reviewing case plans, assessing progress every quarter.
2. The family's natural supports will be identified and engaged in the case planning and treatment processes.
  - a. Identify support networks that will provide attention, support and after care services after formal case closure.
  - b. Engage the family in a Family Team Meeting and/or Family Group Conference in an effort to establish a plan that utilizes the family's voice.
  - c. Monitor safety and case plan effectiveness.
  - d. Engage maternal and paternal kin in the case planning process to ascertain the degree of responsibility they may share in ensuring safety and well-being needs of children.

## SHARED DECISION-MAKING

On all active CFSA cases, it is the CFSA Social Worker's responsibility to ensure that assessment information and interventions/services are included in the case plan and that the plan is effective in meeting the needs of the family. Consequently, other agencies must clearly understand the family's strengths/challenges and tailor interventions to encourage active family participation and an effective use of resources. Ongoing communication is necessary to provide updated information to team members and to discuss progress and impediments toward goal achievement and safe case closure.

1. The In-home staff, the family support worker, and the *family representative(s)* will meet at least quarterly to review the current state and progress of the case.
  - a. Conduct a Family Group Conference during the first 30-60 days of the case to develop a single case file for both CFSA and the Collaborative. Assign roles and responsibilities accordingly.

- b. Together, the team will evaluate the resources available to the family (e.g., community supports, extended family members, etc.) and ways to use them to meet the family's goals.

## EVALUATION AND FEEDBACK

1. Case plans must be documented in FACES and a signed copy kept in a hard record file. Case plans should be signed by mothers and fathers, and services for all family members should be identified in case plans. CFSA and Collaborative case records will be reconciled every 30 days until the case is closed.
2. Supervisory review of case progress to ensure that goals and objectives are linked to positive outcomes for families and safe case closure.
3. Regular case record reviews to determine appropriateness, effectiveness, comprehensiveness, responsiveness and timeliness of interventions.
4. Review of case plans as part of Quality Services Reviews, Child Fatality Meetings and federal audits.
5. Family Team Meeting Staff to follow up in 30-45 days after FTM to monitor progress towards short-term goals and incorporation of FTM plan into long-term case planning.
6. Supervisory coaching in clinical supervision aimed at continual quality improvement.
7. Group supervision to encourage information sharing on techniques for engagement and creating individualized case plans.
8. Communication with other states and jurisdictions to stay abreast of the best child welfare practices across the nation.

## **QUALITY HOME VISITATION**

### **PHILOSOPHY**

Home visitation is face to face contact with an individual or family within their residence and provides In-home staff with an opportunity to assess the family. A successful home visit incorporates effective communication, partnership building with families, and understanding and embracing cultural differences. In-home staff shall demonstrate the following characteristics for home visitation to be optimal:

1. Flexibility;
2. Respect for others;
3. Realistic expectations;
4. An ability to address resistance;
5. Authenticity;
6. Directness; and,
7. An awareness of both personal and environmental safety.

To achieve the goals of visitation, all visits should gather useful information that is relevant to the families social history, generate an exhaustive family assessment, create an effective case plan, and foster a strong partnership between the family and the In-home worker.

### **DEFINITION**

In-home staff are in a position to make informed recommendations about the safety, permanence, and well-being of children; therefore, quality visitations will consist of thorough assessments of children's needs, the extent to which their needs are being met, and the family's progress toward meeting service goals. Furthermore, quality visitation should engage the family to advance their case plan with appropriate expectations for improved stability.

### **KEY PRACTICE OUTCOMES**

1. Creation and maintenance of a strong, working partnership between the family and In-home staff.
2. Children remain safely in their homes.
3. Reduction of the reoccurrence of maltreatment.
4. Reduction of the risk factors that contribute to future maltreatment.
5. Families have age-appropriate expectations for their children and interact with them accordingly.
6. Families ensure the health and well-being needs of their children are met on a consistent basis.
7. Families are empowered, self-sufficient, and capable of meeting the goals they have set for themselves.

## ACTIVITIES

1. Conducting quality home visits are an important method for developing a positive relationship and strong partnership with the family. During each home visit, the In-home staff shall build a relationship with the family through the following activities:
  - a. Demonstrating a genuine interest in the development of the family (appropriate eye contact, body posture, and verbal messages).
  - b. Addressing the family in ways that are congruent with their cultural expectations.
  - c. Providing feedback to encourage mutual understanding of thoughts expressed.
  - d. Complimenting the family on past and present success.
  - e. Utilizing open-ended questions and solution-focused interviewing techniques.
  
2. During every visitation, the In-home staff will assess safety and risk. In-home staff shall assess the safety of the family, household, and community.
  - a. Assess family dynamics (i.e., parent-child interaction) and parent responsiveness to child's basic needs.
  - b. Observe physical environment of home for hazards, provision of food, and operable utilities.
  - c. Identify with the family the risk factors that make the child unsafe.
  - d. Identify with the family strengths and protective factors that reduce risk.
  - e. Engage family in discussions about the safety, stability and well-being of children remaining in the home.
  - f. Formulate safety plan with family in an effort to ameliorate immediate danger and risk in future.
  - g. Determine accessibility and availability of services needed to reduce risk to child.
  - h. Assist the family with concrete services such as food, housing, and medical care in an effort to minimize crises.
  - i. Determine the least intrusive intervention necessary to assure child safety and family stability.
  - j. Document visits in electronic and hard record within 48 hours of contact with family.
  - k. Complete *Structured Decision Making* tools, as appropriate.
  - l. Refer family to neighborhood agencies, such as the local Collaborative, once risk level has been reduced.
  
3. During the visitation, the In-home staff will encourage and facilitate the family's active participation in identifying other family resources. For example, the In-home staff will:
  - a. Encourage the identification of maternal and paternal relatives and fictive kin who may support the children and the safety plan.
  - b. Identify and acknowledge other kin who can assist in parenting and model a nurturing relationship.

- c. Engage family in Family Team Meeting or a Family Group Conference to establish a plan that utilizes the family's voice.
  - d. Encourage the use of informal support networks such as family, faith-based organizations and community resources that will be sustainable after formal case closure.
4. During home visitation, the In-home staff shall encourage positive parenting skills and healthy parent-child interaction.
- a. Observe parent-child interaction and provide feedback and positive reinforcement.
  - b. Discuss the importance of bonding and attachment between caregiver and child.
  - c. Model healthy interaction and communication between adult and child.
  - d. Join with the parent to offer the child opportunities to build skills and abilities.
  - e. Provide examples of developmentally appropriate and non-physical options for discipline.
  - f. Educate parents on laws pertaining to compulsory education and curfew.
  - g. Discuss the importance of supervision of children and assist parent with making child care arrangements.
  - h. Be alert to signs of stress in parents, normalize parental stress when appropriate and provide a forum for expression of stress.
  - i. Facilitate discussion regarding the parenting the caregiver received as a child and its connection to his/her own parenting style.
  - j. Coach parent towards the development of structure, family rituals and routines (e.g., morning and bedtime time schedules and eating meals together).
5. During regular home visitation, the In-home staff shall assist caregivers with an understanding of child development stages and activities that promote healthy development. The following techniques may encourage understanding of child development stages and promote child development:
- a. Assess caregivers' awareness of child development and whether they have realistic age-appropriate expectations for their children.
  - b. Provide basic parenting education and/or determine whether parents are able to generalize skills learned from parenting education.
  - c. Model how to meet children's needs through praise, positive reinforcement, corrective instruction and attention.
  - d. Assist parents to ensure that children are enrolled and attending educational or vocational programs consistent with age and ability.
  - e. Encourage child participation in social, recreational activities necessary for gaining positive social skills and positive peer group.
  - f. Join with parent to ensure child is benefiting from a positive, consistent adult connection.

6. During visitation to the home, the In-home staff shall ensure prenatal care and child health and development. Healthy child development requires that In-home staff ensure:
  - a. Basic physical needs for nutrition, clothing, shelter and hygiene are met on a daily basis.
  - b. Proper medical and dental care (preventive, acute, chronic) are secured and timely for maintaining good health.
  - c. Pregnant mothers have access to appropriate and consistent pre-natal care.
  - d. Education and referrals for early intervention services and postpartum and infant care are provided.
  - e. Cultural and ethnic influences related to co-sleeping and SIDS are recognized.
  
7. During visitation to the home, In-home staff shall promote parental self sufficiency, independence, empowerment and stability by:
  - a. Approaching the family with respect and expecting cooperation.
  - b. Focusing on family strengths and articulating them in oral and written communication.
  - c. Assisting the parents to set and achieve important life goals (e.g., education, employment, and sobriety).
  - d. Working jointly with the family to increase protective factors and reducing risk of future maltreatment.
  - e. Modeling advocacy and negotiation skills with parents so they may in turn advocate for themselves, refer themselves to resources, and navigate systems effectively.
  - f. Encouraging the use of key life skills to avoid and resolve problems related to parenting.

## TRAINING

1. In-home staff must understand and incorporate strength-based and family-centered beliefs into case practice with families.
2. In-home staff will be given parenting training class and curriculum.
3. In-home staff will be well versed in child development so as to appropriately assess normal childhood development and intervene appropriately when child is not meeting developmental milestones.
4. All in-home staff must be clear on CFSA's policies regarding corporal punishment, detecting child abuse and understanding mandated reporting of suspected abuse.
5. In-home staff must have a clear understanding of cultural influences and its impact upon parenting.
6. In-home staff must be trained on maintaining professional boundaries and personal safety.

## TEAMING

Members of the family's team must have a shared vision of the family's situation and what must be done to reach good outcomes and safe case closure. An effective team is characterized by the following behaviors:

1. Engaging the family as partners in the change process by practicing in a family-centered manner.
2. Developing a joint, suitable strategy to alleviate safety concerns in the event that four or more calls are made to the CFSA hotline regarding a single household.
3. Establishing a team leader who is responsible for planning and mobilizing team members in the service process.
4. Designing, reviewing and monitoring case plan goals and objectives jointly with the family.
5. Clearly distinguishing roles and responsibilities of each team member.
6. Ensuring that mothers and fathers understand, sign, and possess a copy of the case plan.
7. Coordinating services across providers without duplication.
8. Arranging schedules to conduct joint home visits on a monthly basis.
9. Reviewing the case plan during home visitation and identifying and reporting implementation successes and problems.
10. Convening team meetings every quarter to assess the effectiveness of the plan, interventions and progress towards safe case closure.

## SHARED DECISION-MAKING

When children remain at home with their caregivers, it is the caregivers' primary responsibility to ensure that the children's physical, emotional, medical and educational needs are met. CFSA social workers and Collaborative family support workers are charged with partnering with the family to increase the likelihood that the needs are being met.

By utilizing family-centered principles, the In-home staff recognizes the resiliency within families and their natural capacities to solve problems for themselves. The In-home staff shall support the family through their decision-making process. When children are at greater risk for harm, it is CFSA's ultimate responsibility to exercise protective authority to ensure safety of children. When team members determine that the risk to children has increased, the CFSA social worker will initiate a Family Team Meeting in an effort to gather team members to formulate a plan to ameliorate crisis and prevent a possible placement into foster care.

## FEEDBACK/EVALUATION

A quality home visit can be evaluated by:

1. Observing In-home staff during home visits and providing feedback.
2. Utilizing clinical supervision to ascertain the nature of home visitation and coach towards quality improvement.
3. Reviewing documentation of contact notes.

4. Reviewing cases to assess progress and timeliness towards goal attainment and safe case closure.
5. Drawing on peer supervision and skill building buddies that conduct joint home visitation to share skills and techniques for engagement and effective communication.
6. Conducting client satisfaction surveys to assess for quality indicators.

## **SAFE CASE CLOSURE**

### **PHILOSOPHY**

It is expected that cases will be closed within six to twelve months of receipt of the case. Termination of casework services is a planned and natural component of the casework process. Like others, the family should be actively involved in this casework stage. Moreover, due to its importance to the child and family, In-home staff must prepare carefully. In-home staff should be prepared to assist the family in building independent support systems. Because the casework relationship should/will be a rewarding one for the family, In-home staff should be prepared to help the family cope with case closure and termination.

### **DEFINITION**

After the family has demonstrated the appropriate competencies (as defined in the case plan drafted by the In-home workers and family) and can solve problems related to daily living and parenting using their own skills or external supports, the In-home workers can begin the safe case closure process.

### **KEY JUSTIFICATIONS FOR SAFE CASE CLOSURE**

Note: At a minimum, the first three measures must be met to justify case closure.

1. The family has achieved the treatment goals and indicators of risk have been sufficiently reduced or eliminated.
2. There has not been a substantiated report of abuse or neglect within the past three months, and the risk of future abuse or neglect has been appropriately lowered.
3. The family consistently demonstrates the ability to function at an acceptable level as defined by the risk assessment tool.
4. The family has moved out-of-jurisdiction; the social worker will call the appropriate community-based agency and/or family services agency in the new jurisdiction. The social worker will make a record of the details of case management and the appropriate contact information. If applicable, these cases will be referred to the Collaborative for Information and Referral services after CFSA case closure.
5. Cases that are open because of substance abuse by the parent may be closed if the parent shows improvement in their parenting skills and is without an observed instance of drug use. There must be clear documentation in the record of how the parent(s) has improved.
6. Families have completed their own defined goals.

### **ACTIVITIES FOR ENGAGED FAMILIES**

The lead In-home staff member at CFSA will be primarily responsible for these case closure activities.

1. Visit the family within 30-days of case closure
2. Interview each child of appropriate age and complete a risk assessment instrument documenting low-risk.

3. Discuss with the family the progress of their treatment plan and the most recent case review to identify specific gains.
4. Assist the family with locating appropriate support services.
5. Complete a safe case closure summary, including:
  - a. How the case came to CFSA attention
  - b. History of case including service provision
  - c. Description of current state of family and reason for closing case
  - d. Documentation of the family's goals
  - e. Documentation of the family's strengths and the family needs
  - f. Documentation of decreased risk as determined by SDM tools
    - i. Problems/issues/concerns within the last three months
  - g. Documentation of support systems and resources for the family
  - h. Follow-up plan regarding service recommendations
  - i. Closing letter to family and service providers
  - j. Signature of social worker, supervisor, and family representative
6. Participate in a case transition staffing prior to case closure if being referred to the Collaborative for on-going services.

## ACTIVITIES FOR UNENGAGED FAMILIES

### ***Unsubstantiated Cases:***

For families that choose to make themselves unavailable for In-home services, the Agency must demonstrate diligent efforts to contact and serve the family before it can justifiably pursue case closure. In the event that an allegation of child maltreatment is *not* substantiated, but case transfer to a CFSA In-home unit is still necessary because of the high or intensive risk, the following will be required of CPS before the case is transferred to an In-home unit:

1. Completed investigation;
2. Investigation findings are unfounded or inconclusive;
3. A child is in the home;
4. No abuse or neglect legal proceedings regarding the current investigation;
5. Initial risk assessment scores the family as high or intensive risk (See Investigations Policy, Attachment B, Assessment Criteria); and
6. Parent/guardian must agree to services and have signed the Authorization to Refer and Disclose Information to Child and Family Services Agency.

Within the first 30-day period that the case has been open with an In-home unit, In-home staff will be responsible for attempting between 3 to 4 home visits to engage the family and sending a certified letter to the family's home informing them of CFSA's offer to provide services. If this 30-day period ends without contact from the family, the case may be closed.

### ***Substantiated Cases:***

For families with a substantiated allegation of abuse/neglect whose case has been opened within a CFSA In-home unit, the following will be required of In-home staff BEFORE case closure within the first 90 days.

If no one is home or family cannot be located:

1. Leave notification letter (neglect only);
2. Conduct school visit (if school is unknown, contact DCPS Attendance Office);
3. Interview neighbors, resident managers, or landlords to confirm family address;
4. Conduct at least 2 additional home visits after or before normal work hours;
5. Send a certified letter to family requesting their cooperation;
6. Diligent search; and,
7. Complete a Pre-Petition Custody Order, if required.

If family refuses to cooperate:

1. Contact supervisor for consultation;
2. Attempt contact with victim at another location (e.g. school, daycare);
3. Contact MPD for safety assistance;
4. Contact the Office of the Attorney General for legal advice; and,
5. Complete a Pre-Petition Custody Order, if required.

## TEAMING

1. Involve a core of multidisciplinary team members in devising and reviewing safe case closure summary.
2. Identify support networks that will provide attention, support and after care services after formal case closure.
3. Participate in final case review cycle prior to case closure.
4. Refer low or moderate risk cases to Collaboratives prior to case closure based on the following criteria:

### **CASES FROM CPS**

- a. Completed investigation;
- b. All children remain in the home;
- c. No court involvement;
- d. Initial risk assessment scores the family as low or moderate risk; and,
- e. Family/parent must agree to services and have signed an Authorization to Refer and Disclose Information to Healthy Families Thriving Community Collaborative form.

### **CASES FROM IN-HOME**

- a. All children remain in the home;
  - b. No court involvement;
  - c. Case has been open at least 90 days;
  - d. Risk reassessment scores the family as low or moderate risk at the time of referral; and
  - e. Family/parent must agree to services and have signed an Authorization to Refer and Disclose Information to Healthy Families Thriving Community Collaborative form.
5. The designated family support worker (FSW) will assume primary responsibility for the following case closure activities for low or moderate risk level cases referred by CFSA to the Collaboratives:
    - a. For engaged families that have achieved their identified goals, the case will be closed upon completion of the following procedures:

- i. FSW reviews case file with their supervisor to ensure that family goals have been completed and case closure is appropriate.
  - ii. FSW begins the termination/case closure process with family, which consists of home visits, letter correspondence, and telephone calls.
  - iii. FSW reviews the family's case for a final time in the case review cycle.
  - iv. Supervisor reviews closing summary and case file.
- b. For families that are unable to be engaged, the case will be closed upon completion of the following procedures:
  - i. Conduct a staffing/conference with the supervisor to discuss the family.
  - ii. Attempt at least three home visits (scheduled and unscheduled).
  - iii. Send either regular or certified letters to family informing them of their service options and to request the family's response.
  - iv. Notify the referring CFSA worker through telephone and/or email of the difficulty in engaging the family.
  - v. FSW and CFSA worker will attempt a joint home visit to engage family.
  - vi. If the family refuses services or is not responsive within the first 30 days of Collaborative case responsibility, the case will be closed.

Note: These steps and strategies are not intended to be exhaustive, and are subject to varying approaches based on the family.

## SHARED DECISION-MAKING

1. CFSA social worker and Collaborative family support worker should meet with the family to discuss case closure.
2. High or intensive cases: CFSA social worker will take the lead in the case closure process. Low-to-moderate cases: Collaborative family support worker will take the lead in the case closure process.
3. Safe case closure cannot occur until the supervisor has provided formal consultation and approval to the In-home staff.

## EVALUATION/FEEDBACK

1. Does the case closure summary document the child (ren)'s safety and well-being?
2. Were specific family stabilization goals/objectives met within established timeframes?
3. Does the safe case closure summary contain all required signatures?
4. The family should be asked to complete a survey that evaluates their satisfaction with CFSA/ Collaborative services and the family's ability to meet their own goals and the stated goals of the case plan.
5. Supervisors will provide a review and evaluation of the case's management and closure.

# **SUPERVISION**

## **PHILOSOPHY**

Supervisors and managers have a pivotal role in ensuring that the needs of children and families are appropriately addressed through the support and development of front-line staff. All workers--direct-line social workers and family support workers--should receive quality clinical supervision and guidance on the service provision to families and children on their caseload. Staff best learn how to engage families in a strength-based way through modeling of helping strategies used by supervisors, including treating In-home staff with respect and praising their strengths and efforts. Using coaching and clinical feedback in case discussions and supervision of staff, supervisors focus on staff development and reinforcing skills learned in training.

## **DEFINITION**

Supervision is a rational, effective, and interactive process focused on giving staff the coaching, training, support and feedback they need to ensure that they are providing effective and appropriate services to children and families. It is also a primary means of communicating expectations for the well-being of children and families and requirements to achieve the vision and objectives of the Partnership. In the implementation of this community-based family development partnership, supervision supports the approach to strength-based family practice, guides staff interaction with the community, and builds staff abilities to help families achieve their goals.

## **KEY PRACTICE OUTCOMES**

1. Staff feel supported.
2. Staff are competent in the areas of engagement, assessment, and implementing a strength-based, family-centered approach.
3. Staff grow as professionals.
4. Staff feel comfortable accessing/approaching supervisors and managers for help and guidance.
5. Staff understand their role and responsibilities.
6. Staff assess families for risk and safety.
7. Staff utilize SDM and FTM/FGC to make informed case closure decisions.

## **ACTIVITIES**

Supervision is a one-to-one or group conference between a worker and supervisor that is structured and meaningful. Supervisors coach staff to develop skills and effectuate growth. Supervision is provided through scheduled appointments or emergency walk-in as needed. The conference is initiated by a supervisor and includes the social worker, family support worker, and CFSA and Collaborative supervisors. Each individual worker's caseload is discussed in depth to ensure that 1) FACES/ETO is updated, 2) case plan is appropriate, 3) family needs are being met, and 4) appropriate management support and resources are provided to support family's goal. This exchange between supervisor and worker is purposeful and clinical, whereby the enhancement of the worker's skills is the expectation.

1. Supervisor displays schedule for weekly supervision of each individual worker in unit (at least 1 hour per session).
2. Supervisors prepare an agenda or require staff to bring an agenda that includes the number of cases to review.
3. Supervisors utilize the FACES/ETO system to review case plan expirations, visitation contact summaries, and court calendar when applicable.
4. Supervisors provide clinical feedback, both positive and constructive, using solution-focused/strength-based/FDC approaches on each case to assist workers with identifying appropriate family strengths.
5. Supervisors help social workers and FSWs to identify families for case peer reviews/clinical staffings/grand rounds to assist with problem-solving when momentum or engagement is problematic.
6. Supervisors offer suggestions to engage family in team approach towards goal settings.
7. Supervisors review safety and risk assessments and inquire about current family situation for up-to-date service provision at least once per month for each family.
8. Supervisors will attend key trainings that the social workers and FSW attend to support the learning objectives.
9. Supervisors shall attend quarterly in-service compilation training to support staff learning.
10. Supervisors shall reinforce training during supervision (Transfer of Learning).
11. The supervisory structure, activities and goals are paralleled by the program manager when supervising the supervisor.

## TEAMING

Teaming is an integral part of the supervisory process. Supervisors will ensure workers are teaming with families and whomever the family deems an integral part of the team. Supervisors will advance collaborative processes such as case peer reviews/clinical staffings and FTMs/FGCs in clinical supervision with each worker. CFSA and Collaborative supervisors will identify families where there are significant areas of concern or lack of clear direction for joint case peer reviews. Supervisors will assure that workers are acting as facilitators with multiple community providers and the family's support network.

1. Supervisors shall ensure that In-home staff and all community providers work closely with all members of the family to identify the family resources for purposes of goal setting.
2. The CFSA and Collaborative supervisors, CFSA social worker, and the FSW shall have a joint staffing within 7 days of case assignment.
3. Supervisors shall ensure that the In-home staff meet to identify roles.
4. Supervisors shall ensure that the In-home staff convene a team meeting with family members within 30 days of case assignment.
5. During supervision, the social worker, FSW, and CFSA and Collaborative supervisors shall strategize to achieve safe case closure.

## SHARED DECISION-MAKING

Joint decisions will be made by the CFSA social worker, the FSW and their respective supervisors as a team. When a conflict cannot be resolved within the team, the following will apply:

The CFSA supervisor/program manager has final decision-making authority with regard to team recommendations for families active with CFSA. When the family is not active with CFSA, the Collaborative supervisor/director has final decision-making authority. Whenever a child is alleged to have been abused or neglected, all staff as mandated reporters will make a report to the hotline.

1. The FSW and the social worker will meet at least monthly with their supervisors to review the family's progress and avoid splitting.
2. FSWs and social workers will communicate to families that information will be shared equally and planning will be joint.
3. Supervisors will ensure that the monthly joint supervisory sessions are scheduled and that everyone is available to participate.
4. As the risk level decreases, shared families may be transferred to the FSW based on the risk level.
5. When the family's progress resolves the concerns about risk or the family refuses services and there is no justification to mandate compliance, the team may decide to end services with the family.

## EVALUATION

Evaluation of quality of supervision ensures that families are served by competent staff with a passion for the work. Supervisors can be evaluated through various methods.

1. A 360 evaluation of supervisors by staff should be completed annually.
2. Human Resources exit interview data will be reviewed at least biannually to examine trends and ensure that staff is supported by supervisors.
3. Case reading of supervisor reviews using SDM tools by program managers ensures workers and supervisors are adequately assessing and intervening with families.
4. When employees are evaluated, recommendations will be made for training to address knowledge gaps, per the performance plan.

# **TRAINING**

## **PHILOSOPHY**

Training is one strategy to achieve practice change. Training supports the practice change and is one approach to supporting In-home work with families. Training should be viewed as not just an activity that occurs in the classroom, but as an activity that is supported by a transfer of knowledge and skills from supervisor to worker. Training is part of a continuum of staff development. Training ensures that knowledge and skills needed to provide effective services in support of children and families are shared with staff. Training assists with the professional growth of each employee. All staff will have access to and participate in training relevant to their duties and goals.

## **DEFINITION**

Training is a learning process whereby an expert or experienced person provides relevant information to staff to teach new skills, philosophies, and/or protocols. Training is used to develop the abilities and further growth of employees.

## **KEY PRACTICE OUTCOMES**

1. Staff demonstrate an understanding of Family Development.
2. Staff understand child development and share their knowledge with families.
3. Staff model and teach positive parenting skills in their work with families.
4. Staff are empathetic and skillful in helping families with choices.
5. Staff are respectful toward and team with families, including non-resident parents.
6. Staff use concrete skills and resources to assist families.

## **OUTCOMES FOR WORKERS**

1. Job Satisfaction.
2. Worker retention.
3. Increased opportunities for advancement.
4. Coaching or mentoring for front line workers.
5. Strengthen core values to families.

## **OUTCOMES FOR FAMILIES**

1. Families' regain their sense of responsibility and hope.
2. Families become self reliant and less dependent on government programs.
3. Families develop a healthier interdependence with the rest of their community.
4. Families learn to set and reach their own goals for self-reliance.
5. Families learn to serve as their own "self manager."

## **OUTCOME FOR COMMUNITIES**

1. Communities identify means to and become more supportive to local families.

## TEAMING

CFSA and Collaborative staff implementing this practice model will share training, i.e., Collaborative staff will have access to CFSA training and CFSA staff will have access to Collaborative training. These trainings include:

- FDC Training for supervisors, social workers, and family support workers.
- Solution-focused Interviewing - supervisors, social workers, and family support workers.
- Facilitating and Leadership- Collaborative and CFSA supervisors.
- Household management, budgeting, meal planning, accessing community resources
- Conflict management/crisis intervention
- Empathetic work with clients/active listening and providing choices and support

## SHARED DECISION-MAKING

Decisions about training for CFSA and Collaborative staff implementing this practice model will be made jointly by CFSA and the Collaboratives.

- Managers from CFSA and the Collaboratives will discuss and recommend training at the quarterly program managers and program directors management meetings. Training will be a standing agenda item and progress and next steps will be discussed.
- At the meetings, patterns and concerns for employees will be discussed and a plan of action will be made jointly to support training.
- Line staff will contribute suggestions for needed training.

## EVALUATION

Transfer of learning objectives from training will be evaluated individually by supervisors as well as the outcomes achieved by the staff as a whole.

1. During group supervision, training goals can be reinforced and barriers can be identified for resolution.
2. Each training session will be individually evaluated by attendees.

When designing training to meet a specific need, the benefits that should result from a change in practice or further development of practice will be quantified and a means of measuring those outcomes will be developed by the joint CFSA/Collaborative team.

# **MANDATED REPORTING**

In the District of Columbia, mandated reporters are those professionals obligated by law to report known or suspected incidents of child abuse or neglect. As part of this safety net that protects children **ALL CFSA and HFTC staff members are mandated reporters**. Families should be informed at the very first contact that social workers and family support workers are mandated reporters.

## **Standard for Reporting:**

Know or have reasonable cause to suspect that a child has been abused or neglected.

## **Person's required to Report:**

Physicians, psychologists, medical examiners, dentists, chiropractors, registered nurses, persons involved in the care and treatment of patients, law-enforcement officers, school officials, teachers, **social service workers**, day care workers, mental health professionals

## **When to Report:**

By law, you must report when, in your professional capacity or within the scope of your employment, you know or reasonably suspect that an infant, child, or teen has been abused or is in immediate danger of being abused. You must report immediately.

Each HFTC Collaborative may have its own policy about reporting, such as notifying a designated person in the organization who is responsible for calling CFSA. However, by law, it is the individual's responsibility to ensure that a report is made to CFSA. If you find no one has called CFSA, *you must do so yourself*.

## **How to Report:**

1. If abuse or neglect is suspected, the immediate supervisor or on-call staff should be contacted first (unless the child is in imminent danger) regarding the suspicion.
2. Call the hotline. Informing a supervisor or team members is not reporting; a call to the hotline is reporting.
3. Inform the other team members about the suspicion and the report.

The hotline is staffed by trained professionals around the clock. Be prepared to provide as much of the following information as possible:

- Name, gender, age, and address of (1) the child who is the subject of the report, (2) the child's siblings (if any), and (3) the child's parent(s) or caretaker(s).
- The nature and extent of the abuse and any previous abuse, if known.
- Anything that may shed light on the cause and circumstances of the abuse and the identity of the perpetrator.

By law, you must identify yourself, your occupation and how CFSA can contact you. You must also describe any actions you have taken concerning the child.

**Call CFSA  
24-hour child abuse reporting hotline at:**

**(202) 671-SAFE (7233)**

**Failure to report:**

Any person required to make a report who willfully fails to make such a report shall be fined not more than \$100 or imprisoned for not more than 30 days or both.

## **DEFINITIONS**

**In-Home Worker/Staff:** Social Workers and Family Support Workers who work with children and families in their homes to reduce risk and strengthen families; includes both CFSA and Collaborative staff members.

**The Partnership:** A joint effort between CFSA and the 7 HFTC Collaboratives designed to protect children and strengthen families.

**CFSA Staff:** Employees of the District of Columbia Child & Family Services Agency.

**CFSA Social Worker:** CFSA staff members who provide professional social work services to children and families.

**HFTC Collaborative Staff:** Employees of one of the 7 HFTC Collaboratives.

**Family Support Worker:** Collaborative staff members who provide direct support to families through information, referrals and case management.

**Community-based services:** Service array delivered to families from helping professionals located directly within their community.

**Teaming:** CFSA and Collaborative staff working together to build a professional helping relationship with families to prevent the placement of children into foster care.

**Caregiver:** Parent or other person legally responsible for the care of a child.

			<b>IN-HOME LOGIC MODEL</b>			
<b>Resources</b>	<b>Activities</b>	<b>Outputs (key practice outputs)</b>	<b>Short-Term</b>	<b>Medium-Term</b>	<b>Long-Term</b>	<b>Goal</b>
			Family level outcomes			Families remain stable and intact.
Strengths-based, family-centered practice model	Shared responsibility for engaging the family	# and % of families receiving services jointly from CFSA and Collaborative staff	Caregivers recognize the safety needs of their children.	Caregivers demonstrate improved coping mechanisms and developmentally appropriate nurturance.	Children remain safe.	
Families	Help the family assess (and reassess) its needs and strengths	% of families participating in completion of assessment tools			Caregivers demonstrate adequate and effective parenting skills to promote child safety.	
Credentialed CFSA and Collaborative staff	Help the family decide on a goal and steps toward reaching that goal	# and % of case plans co-written and signed by family members	Families recognize the components of a stable, healthy and secure living environment.	Families demonstrate the ability to maintain a stable, healthy and secure living environment without consistently relying upon emergency intervention.	Families have financial and housing stability.	
Training and education on strengths-based family engagement	Empower family members to generate their own solutions through their active participation in the development and implementation of the activities in the case plan	# and % of case plans meeting the quality standards established in the practice protocol	Families report increased contact with and an understanding of the importance of informal and formal support networks.	Families demonstrate the ability to effectively identify and access necessary formal and informal supports for themselves and their children.	Families have strengthened social connections with formal and informal supports.	
Assessment tools	Help the family make a written plan for pursuing these goals	# of hours engaged in face-to-face contact with families	Families can identify their own strengths and understand the importance of using those strengths to achieve case plan goals.	Families effectively advocate for their own needs.	Families access concrete services and supports independently.	
Neighborhood-based service delivery system	Communicate desirable outcomes, requirements for safe case closure, time frames, and rights and responsibilities clearly and directly	% of home visits meeting the quality standards established in the practice protocol	Families recognize their developmental and well-being needs.	Families address their physical, emotional, behavioral, and academic needs.	Caregiver functioning is adequate to promote child well-being.	
Federal and local funds	Visit the family regularly to ensure child safety, child-family engagement in services, and effectiveness of services in stimulating positive change	% of home visits linked to case plan goals			Family and child well-being is improved.	

Multi-system partners	Advocate for and with a family with other agencies, schools and businesses	% of referrals made that successfully link families to needed resources			
	Coordinate family meetings, when appropriate	# and % of family meetings held for all families served			
			<b>System level outcomes</b>		
	Facilitate multi-system planning and service provision	% of cases safely closed within 12 months	Multi-system partners identify the processes and supports to function in partnership with families as a multi-system team addressing families' immediate needs and risk factors.	Multi-system partners continue to team to meet the underlying service needs of families.	Abuse and neglect rates are reduced.
	Increase service collaboration and access	% of family meetings with multiple service providers attending			Community and public resources are used more efficiently.
		% growth in service array available	Multi-system partners understand strengths-based, family-centered practices.	Multi-system partners continue building strengths-based, family-centered practices.	Family engagement and outcomes are improved.