

SAFEKEEPING

Community Partnerships for Protecting Children

An Initiative OF THE EDNA MCCONNELL CLARK FOUNDATION

VOLUME 4 – No.1 – FALL 1999

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INDIVIDUALIZED COURSES OF ACTION

Enhancing the Way We Work

Every family has times when it needs help with a change or a crisis: changes in employment, relocation, child birth, separation and divorce, death of a family member, a sudden life-threatening illness, an aging parent, the aftermath of domestic violence, or the roller-coaster of substance abuse. Many families call on friends, relatives, and professionals for support at these times. With this support, they craft a “plan” that meets their particular needs.

The young widow with two children can get through the week filled with school activities, but she needs help keeping herself and her children busy on the weekends so as not to sink into depression. She calls on friends to come help with her daughter’s science project or to provide some male companionship to her son.

The young couple bring their infant home from the hospital and give each other looks that seem to say, “now what?” Baby’s room is all prepared with a crib and rocker, but the parents are not prepared for colicky cries and baby’s unpredictable feeding schedule. They swallow their pride and call their parents for help—“come for a visit,” they say; they make a doctor’s appointment for baby; they call the nurse who taught their birth classes looking for advice; and they get together with other couples from their birth class to share experiences and find support.

These are “individualized courses of action.” Nothing particularly extraordinary for families with a strong network of support or the knowledge of available resources and how to access them.

However, for families with limited support networks, problems such as the ones described often escalate and can be overwhelming. Because child safety often presents itself as an issue, many of these families are brought to the attention of a Child Protective Services (CPS) agency. In the four Community Partnership sites, the CPS agency, other human service providers, and private citizens are linking together to blend formal and informal supports and services that are tailored to families' specific needs. This assessment and planning process is the individualized course of action (ICA) strategy—one of the cornerstones of community child protection.

WHAT IS AN “INDIVIDUALIZED COURSE OF ACTION?”

An individualized course of action (ICA) is a family-centered service delivery process that stresses partnership among families and their supports, formal and informal. The ICA process is being implemented in the Community Partnership sites as part of the continuing effort to achieve the initiative's outcomes, three are:

- Children targeted by the initiative will be less likely to be abused or neglected.
- Children who come to the attention of CPS will be less likely to be re-abused or neglected.
- The rate of serious injury to children due to abuse or neglect will decline.

In practice, the ICA process is targeted for use with families where there are significant concerns about child safety and well-being. At a team meeting multiple partners (including, and most importantly, the family) identify strengths, assess the issues concerning the family, and tailor the activities and solutions to meet specific needs. To many, an ICA sounds simply like good casework practice, but those who participate in the ICA process know that it goes much deeper.

The three scenarios describe families who might benefit from the ICA process. In every case, parenting classes are provided because they are available and may be helpful, but are these the most useful plans for these families? Will these children ultimately be safer over the long term, or are these families likely to return to the CPS system separately? In serving a family through an ICA process, the family's strengths and underlying needs are considered, not just how to resolve the immediate problem or crisis. The ICA process does not confuse needs with services that are available (that is, an ICA identifies what the family's needs really are, rather than just those that can be met by “what's available”). For example, in all three scenarios, the primary “need” was met by a service—parenting classes while some other very real needs, such as respite care, employment referrals, connections to neighborhood supports, or anger management, were not addressed. The ICA process recognizes the substantial contributions that can be obtained from a team of people—agencies' staff, as well as the family and its own network of supports. Friends, extended family members, and community organizations, as well as formal service providers, are enlisted so that immediate concerns, as well as longer term issues, are identified and addressed.

The following scenarios are typical examples of families that become involved with the Child Protective Services (CPS) system:

Scenario 1. Andrea, a young single mother, leaves her children home alone for several hours when she goes to a food pantry across town, having “used-up” her “turns” for the month at a pantry closer to home. A concerned neighbor calls CPS, and a worker is sent out. The worker strongly cautions Andrea and refers her to parenting classes.

Scenario 2. Jose and his family have just moved to the city. Their house has no electricity or heat. A concerned mother on their street calls CPS after three small children knock on her door asking to borrow blankets. A CPS worker visits the home, determines that Jose needs some support, and offers parenting classes that Jose promises to attend. The worker also takes Jose to the Salvation Army to get some blankets and uses flexible funds for emergency assistance for utility connection.

Scenario 3. Delia’s aunt calls CPS after she notices a wide bruise across her niece’s back. When asked, Delia says, “mommy hit me.” A worker meets with Delia’s mom, who admits to having hit Delia just that once because she was “at her wit’s end.” The worker offers her parenting classes, and the mother accepts.

WHICH CHILDREN AND FAMILIES WOULD BENEFIT FROM AN “INDIVIDUALIZED COURSE OF ACTION”?

The goal of the ICA strategy is to ensure that every child and family identified as at substantial risk of abuse and/or neglect has the benefit of a specially developed course of action to ensure the child’s safety and to support the family. The Community Partnerships sites are not yet able to initiate ICAs with every family, so their current focus must be on those families where the children are at greatest risk of abuse or neglect. But how do we identify these families? Ask frontline workers from a variety of different agencies and they can readily identify the families on their caseloads that are at highest risk. Ask involved residents of neighborhoods and they can describe the families nearby whose children are at risk for abuse and/or neglect. Research and practical experience show the following characteristics to be associated with the likelihood of substantial risk:

- A pattern of abusive or neglectful behavior by caretakers toward children.
- Problems with parental substance abuse.
- Untreated depression or other forms of debilitating mental health problems.
- Problems with family violence.
- Caretakers with poor impulse control and inability to manage anger and frustration.
- Families where parents are highly critical of their children and show little warmth.
- Families where there are long-standing patterns of isolation and lack of social supports.

One of the basic values of the Community Partnerships initiative is that child protection involves more than just the public CPS agency—other service providers and informal supports stand together with the CPS agency to help keep children safe from abuse and/or neglect. This value is clearly demonstrated by the ICA strategy. While the frontline CPS staff are obvious leaders in developing and implementing ICAs, other partners can and do initiate this process for families they serve. Also, many partners within the network of services and supports participate in the development of the ICA, assuming specific responsibilities to strengthen and safeguard a child and his or her family.

Participating team members of the ICA includes those agencies and supports that already know the family. Others asked to take part in the ICA process may be persons who, while not known to the family, could offer specific supports or resources that the family may need. For example, a

representative from the site's domestic violence program may participate in an ICA for a family identified as having problems with family violence—even though the family has never used the services of the domestic violence agency in the past. Getting the “right” participants in ICA planning emphasizes why sites must expand their networks of services and supports so that the needed resources are available to families where children are at substantial risk. Individuals asked to participate in the ICA process will be called upon to fulfill a number of tasks, including:

- Attending and participating in child and family team meetings;
- Sharing observations and adding to the assessment of the situation;
- Identifying the strengths of the family;
- Offering suggestions about how to keep the children; in the family safe;
- Identifying the needs of the family;
- Brainstorming for short-term and long-term solutions; that address child safety and family functioning; and
- Offering services, supports, and resources to the family as a result of plans established through the ICA process.

Through these efforts the questions constantly posed are: Is there a real partnership with the family and service providers to tailor the services to what the family needs? Have the family's true strengths and needs been assessed? Keeping in mind what has been learned about the family, what plans should be made with them?

PUTTING FAMILIES BACK INTO THE CHILD PROTECTION PARTNERSHIP

Family group decision making (FGDM) offers another new approach to working with families involved with the child welfare system. Families are engaged and empowered by child welfare agencies to make decisions and develop plans that nurture their children and protects them from further abuse and/or neglect. The FGDM process inherently fosters cooperation, collaboration and communication between families and professionals.

Since 1989, two primary models of FGDM have been practiced worldwide in child welfare; (1) Family Group Conferences (FGC); and (2) Family Unity Meetings (FUM). The FGC model which New Zealand developed and legislated in 1989 has been adapted by communities in Canada, United States, Australia, Sweden and England. The Family Unity Model began in Oregon in 1990.

In communities where FGDM has been implemented, the cornerstone philosophies tend to be similar. These beliefs are that families, communities, and the government must partner together to ensure child safety and well-being, and that families must be regularly involved in making decisions about protecting and ensuring the safety of their children. FGDM is a nonadversarial process which provides families with the opportunity to make these important decisions, while being assisted by their own support systems and formal service providers.

FGDM is characterized as family-centered, family strengths-oriented, culturally and community-based practice. It recognizes that families have the most information about themselves to make

well-informed decisions. It values the security and sense of belonging children find within their own families.

The FGDM models have four main phases:

1. Referral to hold a FGDM meeting.
2. Preparation and planning for a FGDM meeting.
3. The Family Meeting, where a plan of action is made.
4. Subsequent events and planning after the FGDM meeting.

FGDM offers a nontraditional response to families in crisis that may result in greater permanency, stability, long-term safety, and well-being for children within their families and communities

CREATING AND USING AN ICA:

The use of individualized courses of action to serve children and their families is based on a philosophy and practice strategy that is a very effective approach for reducing the risk of child abuse and neglect. Effective implementation of this strategy embodies the values, skills, and practices that are fundamental to truly helping families— valuing child safety and well-being while engaging families with genuineness, warmth, and empathy; building on the family’s strengths; assessing their underlying needs; involving the family in decision-making; and enlisting the family’s natural helping systems in implementing lasting solutions.

The development of individualized courses of action involves five basic components. These components, from engaging the family to implementing the course of action, will call upon an array of skills and techniques that support the family in the process of change and offer opportunities for lasting gains.

The components of an individualized course of action are:

- Engaging the family, Assessing strengths and needs;
- Developing and implementing the course of action (or plan);
- Tracking progress and responding to new concerns and
- Sustaining the change.

These components do not stand alone and are not entirely sequential. In other words, while a helper must engage the family effectively in order to move onto the other components of the ICA, engagement must continue throughout the entire process. Similarly, the assessment of the family begins at the very first encounter and continues throughout the ICA process as the plan is developed, implemented, reviewed, and updated.

ENGAGING THE FAMILY

If families are to change their lives, and if we are to be successful in helping them make those changes, we must form caring relationships with families that enable them to trust us. There is an adage among the helping professions that “families don’t care how much you know until they know how much you care.” The use of the engagement process is an essential first step in offering caring support to a family.

If we can communicate respect for the family and empathy for its struggles in a genuine way, real partnerships with families are possible. A variety of interpersonal helping skills are used to engage families in ways that demonstrate genuineness, respect, and empathy. Because these skills seem so basic (and obviously needed), their importance is often overlooked and under-used. However, they are the foundation in building effective relationships.

There are three core skills for successfully engaging families

Genuineness—communicating with the family honestly in ways that are consistent with what we say and do

Respect—demonstrating and acknowledging the value and potential in every member of the family

Empathy—expressing an understanding of and compassion for the other person’s experience

These skills are:

Active listening—Helpers demonstrate this skill by paying close attention to the family’s description of its situation. It is seen in the helpers behaviors, words, posture, expressions, eye messages, and gestures which communicate intense listening in order to fully understand is being said,

Clarification—Helpers use this skill to develop a greater understanding of the feelings, thoughts, and behaviors communicated to them. Clarification also permits helpers to test the accuracy of what they hear.

Reframing —Reframing allows the family (and its helpers) to approach an identified problem in a more positive way.

Questions—Questions are the most common method for gathering information. They help elicit facts and feelings and serve to focus the conversation.

Reflection—Reflections are restatements in your own words of what the family is saying or the emotions they are revealing.

Summarization—Summarizations are used to blend a wide range of facts and feelings that have been communicated.

ASSESSING STRENGTHS AND NEEDS

Unless we are aware of the underlying needs and conditions of families in crisis, our efforts to help may be focused on using social controls to address only the symptoms. Focusing only on symptoms is ineffective because the basic needs have not been addressed. Symptoms generally reappear, which is one reason the reoccurrence of abuse and neglect in the same families is so common. The critical areas to be assessed as part of the ICA process include:

- Determining safety and identifying risks,
- Identifying strengths,
- Identifying underlying causes, and
- Identifying needs.

First, safety should be determined and risks evaluated. There are many factors to be considered in the assessment process, particularly those that are relevant to child. Among those that are most critical are: a family's skills, and motivation; its values and behaviors; the family's concrete and immediate needs, including economic and environmental needs and the availability of support systems and resources; and an assessment of family members' mental and physical health, cognitive and social skills, maturity, substance abuse or domestic violence problems, coping skills and strategies, and the nature and quality of the parents' interpersonal relationships; and parenting skills.

DEVELOPING AND IMPLEMENTING THE INDIVIDUALIZED COURSE OF ACTION

It is very important that the family be actively involved in all areas of decision-making. The family should be present and involved when decisions are reached about it. Families usually feel more comfortable if their participation occurs on safe and familiar ground, such as in their own home or neighborhood. If families have some control over the planning for assistance to them, they are much more likely to feel invested in an individualized course of action and work toward its achievement.

Based on experience, an individualized course of action will be most suited to the needs of the family and children if it is developed in conjunction with a team meeting. Team members will include individuals from the family's own support systems as well as representatives of the more formal systems involved, such as schools, counselors, and family support organizations. To help the family identify its own support resources, it's useful to ask, "Whom do you call on when there's a problem or crisis?"

The helper who is initiating the development of an ICA should ensure that all current and potential members of the family's team are identified. Attention should be given to identifying a caring adult who may be an extended/family member or even someone yet unknown to the family who is able to take responsibility for a long-term commitment to the child and the family's needs.

In the team meetings, both the family and other team members should be encouraged to identify strengths. The use of strengths is particularly effective when they are openly affirmed by the team and listed on a flip chart. Like strengths, needs can also be listed on the chart. Having the strengths and needs displayed makes the matching of activities to needs easier as the plan is developed.

Following the identification of strengths and needs, the family and team members should reach agreement about the desired overall outcomes or goals that will respond to the needs of the child and family. For example, in the case of a father who has resorted to excessive corporal punishment, the goal may be to prevent the father from using excessive corporal punishment as a means of discipline. Other goals should also be identified and prioritized.

After these steps have been completed, responsibility for accomplishing tasks and time-frames for their completion should be established and recorded. All team members should be given a copy of the course of action. It is important to build in early successes that are achievable for the family, so the family will experience critical reinforcement of its new undertaking. The family

will need consistent support as the course of action is implemented. Regular contact with the family by team members can provide encouragement as the first steps are taken.

TRACKING PROGRESS AND RESPONDING TO NEW CONCERNS

Ongoing attention is needed to ensure that the ICA is being followed. Follow-through should not be taken for granted by any members of the team. The facilitator should contact providers and individuals who offered informal supports to verify that the course of action is being followed. Many plans fail, not because they are poorly designed, but because they were not followed. Are services being delivered, supports being provided, and is progress being made? One of the team members, often the person initiating the ICA (often the facilitator), should be given the responsibility for tracking progress. If progress is not occurring, or if other problems arise, any team member, including the family, may reconvene the team. It may be necessary to revisit the needs identified to confirm that they were the right ones or to assess if the goals need to change—or services and supports may not be appropriately matched to needs. If the family is experiencing difficulty in adhering to the plan, the expanded use of the family’s informal supports is often most effective in helping renew commitment to the plan.

Once the course of action has been completed and the family’s goals achieved, the case will be closed to formal agency involvement. In cases where child safety has been an issue, it is important to assess the extent to which the family’s circumstances, behavior, and ongoing support systems can maintain the progress that has been made. The simple question to ask is, “What will be different tomorrow (after closure) that will keep the child safe?” If there is uncertainty about whether things will be different, the case should remain open.

With families who are the most challenged by their life experiences and stresses, some will again need the intervention and support of formal helping systems. Where there is substance abuse, domestic violence, and other long standing patterns of harmful behavior, relapse can be an expected part of the recovery process. To the extent that the natural helping systems and supports have been linked to the family through the individualized courses of action, families will have their own supports to sustain them through the temptations to return to old patterns of coping.

SUSTAINING THE CHANGE

When the case is closed, there should be clarity among team members regarding “what could go wrong” with the individualized course of action and the process by which team should be reconvened. The development of crisis plans at the time a case is closed will help a family (and the informal supports remaining) to know how to respond quickly to new risks and problems.

We know that the likelihood of success with families is heightened when we engage the family, address underlying needs in the assessment process, and involve the family and its team in planning, decision-making, and implementing courses of action. Where this process occurs, safety issues are less likely to reoccur. There are some families, however, for whom the creation of long-term, specialized supports are necessary for the family to function in a manner that keeps children safe and developing normally.

Research from the child development field has told us that children develop best when there is at least one adult in their life who cares passionately about them and is committed to them unconditionally. Some parents with long-standing, multiple, and complex needs may have difficulty providing that consistent nurturing. The challenge for the community of helpers is to contribute to the identification and development of such resources when they are not naturally available in the family's life.

SUMMARY

The families we serve have enormous strengths, many of which help them survive the multiple challenges they face. Through the process of recognizing and affirming those strengths in the development of individual courses of action, we have the opportunity to help families tap their own resources to affect changes in their lives.

In addition to helping families recognize and use their own capacities, through the creation of individualized courses of action we can employ the helping systems of their own networks and communities to support and sustain the changes they desire. Where their own support systems are incomplete, we can help them build more responsive networks of support. By addressing the underlying conditions that produce the challenges in their lives, we can support change that will be fundamental.

While the process of developing individualized courses of action may include more steps than the practice to which we are accustomed, it offers the promise of lasting change for families. Effectively designed individualized courses of action will help families lessen their dependence on external helping systems. As a result, families become more independent and less likely to require our continuous help and support. For helpers, this independence means that rather than devoting all our time to serial interactions with the same families, we will have more time to extend to help others.

THE FAMILY’S EXPERIENCE WITH AN INDIVIDUALIZED COURSE OF ACTION

USING FAMILY TEAM CONFERENCES TO START THE PROCESS

The emerging use of family team conferences in the Community Partnership sites has been so effective in contributing to the development of individualized courses of action (ICA) that the conference and ICA are often thought to be the same activity. Of course, the elements of an ICA, such as engaging the family, and assessing its strengths and needs, and sustaining the change, are broader than the family team conference alone and may include actions that occur before, during or after a conference. For that reason, it is useful to keep in mind the differences in the two processes, even though they are closely related.

Because the family team conference is so useful in initiating an ICA and Grafting a needs-based course of action, especially for those families already served within the system, it is helpful to provide “real life” examples of their use and power to help families. The following case stories illustrate the ways in which the family team conference can be effective in helping achieve safe and stable families.

ENGAGING THE FAMILY AND RECOGNIZING THE FAMILY’S STRENGTHS

Ms. May is a mother of two, pre-school age children, one of whom is less than a year old. Her boyfriend, who lives with her, works at two jobs and provides her with very little time or emotional support. She was described in the case summary as withdrawn, passive, limited, and unable to do anything for her family without help. CPS had been involved previously due to possible medical neglect and a home-based provider is currently assisting Ms. May. The family team conference was convened to try to find additional supports for her.

When asked what her goals were for the conference, Ms. May responded to those in the room, “I want you to believe that I’m a good mother.” And when asked to identify her own needs, she included: finishing school (she had attended college), becoming a child day care teacher, and finding time to do things for herself.

“Through the ICAs, I have seen some real success around engagement of the family. It seems that an ICA really helps providers work with the family from a strengths-based perspective and truly coordinate their efforts. In chronic neglect cases, you may be dealing with a family who has three or four people in its home in one week. In some cases, the different providers aren’t aware of each other—a “left hand not knowing what the right hand is doing” issue. The ICA process brings everyone together to make a plan that is behaviorally and time-specific. With open lines of communication and a family that recognizes there is a problem and really wants to change, the ICA process provides a wonderful way of developing a plan that is realistic and achievable.”

Meg Hufford, M.S.W. Chronic Neglect Specialist

By having the opportunity to tell her own story and, with support from the group, identify her own needs, Ms. May changed the team’s perception of her. Previously, they saw her as limited and helpless, with little interest in her children or changing her own life. By the conclusion of the

conference, the team recognized that she was an overwhelmed, young and isolated mother who had a vision of a better life for herself and her children and who was hurt by being considered inadequate. They also realized that she had many strengths that had been overlooked in the past, such as the capacity to nurture her children, a foundation of career interests on which to build, and the desire to be a good parent.

Later in Ms. May's conference, the team learned that one of the main reasons for Ms. May's listlessness (she was said to "sleep all the time") was that she has epilepsy and had reduced her medication dosage by two-thirds because she didn't like some of its effects. As a result, she was having daily seizures that took hours to recover from. She had not had her medication evaluated since her pregnancy and her son's recent birth, nor had a neurologist seen her.

Her health problems, not her capacity or disinterest in parenting, were the primary reason that she couldn't consistently provide the parenting her children needed. It also became clear that Ms. May was depressed, further limiting her energy and resourcefulness. And in a powerful and courageous admission, Ms. May revealed that she felt alone and estranged from her family because she believed that the mother, who could be a possible source of support, "does A-- , love me." It became clear to the team that Ms. May had several underlying and complex needs that could not be addressed by the parenting classes and homemaking services she had been receiving. Immediate attention was needed to assess her epilepsy and medication, to treat her depression, and to respond to her overwhelming isolation.

It was not until Ms. May felt the support and respect of the team, and, in turn, felt that she could trust its members, that she could take the risks of revealing the depth of her struggles. Having the team begin the conference by genuinely affirming the strengths they saw was a critical factor in gaining her trust.

"The process of working with families as complete units—not only talking with the mother is very important. The child typically has far more family members in his life than just his mother, so it only makes sense to involve as many of those people as you can when it comes to making decisions as to what is best for the child. It is also critical that the formal support workers engage the people who already act as support for the family. You have to consider that the family's friends—the people they rely on for help—see them every day, which a typical worker could never hope to do. If we engage these supports, planning with them and working with them, the family stands to gain so much."

Shawonna Anderson Family Group Decision Making Program Manager/Facilitator

CRAFTING AN INDIVIDUALIZED COURSE OF ACTION

Ms. Hall, a single mother of a 10-year-old girl, Jean, and a 14-year-old son, Eric, came to the attention of the partnership initially because Eric was frequently truant from school. Eric's father had not seen him in two years. His grades were poor, he was defiant to teachers and fought with his peers. The school reported Ms. Hall for educational neglect after she failed to come to several teacher conferences that had been arranged to deal with Eric's truancy. Ms. Hall had previously been involved with CPS as a result of her boyfriend sexually abusing Jean when she was eight. He was reported by Ms. Hall and is now in prison.

“The most exciting thing about the ICA process to me is that we are finally taking something that we have been talking about in the theoretical and making it happen. We have been talking about this kind of thing for decades, and it is amazing that we are finally putting in place the kind of concrete supports and resources to make it real. The difference is really the commitment of staff and time. People are going beyond what they have previously known as good practice and are seeing results. It is so exciting to see the verbal commitment become a reality in our everyday work.”

Matt Hanlon, ICA Coordinator, Department of Human Services

In assessing the situation, the CPS worker discovered that Ms. Hall’s work rules and hours make it difficult for her to leave work for teacher conferences. The worker also learned that Jean’s school performance was poor and that she was sneaking out of the house to visit older boys in the neighborhood. Because her extended family lives elsewhere, Ms. Hall has few informal supports other than her minister, with whom she is close. She has no car, and often relies on her minister for transportation.

In looking at the family’s needs, and in particular at Eric’s needs as a first step, the following high-priority needs were identified with Eric’s help. The service or support identified to match the need is also listed.

Eric (who misses his father) needs the support of a strong male. The team will link Eric to a male church member who coaches youth basketball. The public agency will try to make contact with Eric’s father.

Eric (who may have a learning disability) needs to experience success in school. Eric’s teacher, who was at the meeting, agreed to secure an evaluation and during the summer will provide one-on-one tutoring for him, paid for by the Partnership with flexible funds.

Eric needs to understand the risks of truancy to himself and his mother and must attend school regularly. Eric, his mother, and Eric’s teacher agreed to a short-term behavioral exchange experiment that will permit Eric to attend weekly sports events (his favorite pastime) conditional upon a truancy-free week.

“The concept behind the family team meeting is magical—I cannot say enough about it. I have found it so empowering to participate in one and to see the barriers being broken down. So often it is the worker on one side of the fence and the family on the other. The family team meeting is the best thing I have seen to bring the two groups to the same side. It is inspiring to see the connections being made and to feel the energy from everyone involved in the meeting. You feel so much more confident, especially when you have the family’s own supports included in the planning, that the goals are realistic and the plan will be followed. It is such a lot of work, but it is so worth it, and I think that workers who see how much time and effort is put in on everyone’s part tend to be more invested themselves. That investment tends to translate into really good things for that family.”

Pauline Grant, Family Service Supervisor

These case excerpts reflect real-life solutions for families that were initiated in family team conferences that engaged the family, recognized and used the family’s strengths, assessed the

underlying needs, and crafted individualized courses of action. The teams also helped sustain the change and remained available to address new concerns. When families are served in this manner, not only are they more likely to resolve their current problems, but with the

Not only are they more likely to resolve their current problems, but with the support of the team, they are more likely to have the resources to address new needs independently. The Community Partnership sites are learning that the ICA process, particularly when family team conferences are employed, is an essential foundation of a strong community child protection network.

“The best part of the ICA process is the family conferencing. It is incredible to see it work. I have been amazed at how it succeeds in bolstering a family’s self-esteem. When they see their strengths listed out, they start to feel differently about who they are and what they are able to accomplish. Even the service coordination affects self-esteem. A family feels very important and cared for when all of the service providers have taken time out to sit in a room and talk with the parents, not to them. Eventually they put together a reasonable plan—and that helps the family’s self-esteem because they have taken part in it and want to see it succeed. I have seen the family conference change lives and I have two different families who are willing to talk about just that to everyone they meet.”

Sue Smith, Family Support Worker Family Resource Center

Paul Vincent and Linda Bayless from the Child Welfare Policy & Practice Group have worked with the sites on developing ICA practice. For more information contact: Child Welfare Policy & Practice Group, 2033 E. 2nd Street, Montgomery, AL 36106.

EMBRACING THE ICA CHALLENGE

Sites are committed to child safety and a better way of practice. This is reflected in the hard work being done to develop the ICA process. Nonetheless, making the ICA a part of everyday casework is tougher than anyone anticipated.

“There is so much that goes into the ICA even before you get to the family team meeting,” said Linda Bayless of the Child Welfare Policy and Practice Group. “There are practical issues that make this process hard—planning being one of them, but there are also core difficulties that go deeper than that. The biggest hurdle as I see it, is developing trust among the partners. An ICA process needs that trust, which can mean that a good part of the beginning stages of the ICA is spent developing it.”

In order for an ICA process to be successful, all parties involved must work hard to develop a trusting relationship. For family members, they may need to put aside past experiences when they felt criticized or monitored, rather than helped. For professionals, they must risk giving up some control and truly believe that the family can help make good decisions about the welfare of their own children.

It is common for people to resist change. The ICA process puts everyone in new roles. The professional needs to be willing to become a “coach” or guide for families, rather than a “supervisor” or manager. Parents and their natural helping systems must assume greater responsibility for Grafting “their” plan, and ensuring that it works.

Initiating the ICA process requires an added time commitment by professionals. It also requires skillful and creative assessment and engagement of family members. Selecting the right team and arranging for a team meeting is critical. The formation of a team of people who will support, coach, and work with the family through the ICA process is of great importance. The team should include service providers who already are involved with the family, as well as those who may have critical resources to be tapped. Knowing whom to invite to the family team meeting requires extensive planning and assessment. It also requires skillful engagement so that the family feels encouraged to include those people whom they view as natural helpers—extended family members, ministers, friends, or neighbors.

Ensuring that the plan crafted is put into place and modified as needed is a critical part of the ICA process. The plan, and commitment of the team, must guide what happens for a family. While getting the family team meeting set up seems a huge task, following through on the plan made at the meeting can be equally challenging. Similarly, keeping a family’s needs at the forefront of the plan forces everyone to look first at how to meet those needs instead of substituting an available service—which may not really meet the need at all. This is a very difficult process for professionals who have been trained to identify and use services to resolve problems. The first word of ICA is “individual” which means that if a family member needs a specific resource, the team should brainstorm about how to obtain it-or how to find a viable substitute.

While the ICA requires a significant commitment of time, talent, and resources, the sites are becoming more convinced than ever that this is a practice that shows promise and affords families and the helping network an opportunity to think “outside of the box,” make plans that

can work to improve child safety, decrease dependence upon formal helping systems, and enable families to find and use their own resources.

SafeKeeping is published by the Center for the Study of Social Policy and is funded by a grant from the Edna McConnell Clark Foundation. For additional copies, comments, or questions, please contact:

AN ICA FOR ANDREA'S FAMILY FROM SCENARIO #1:

Looking back at one of our three families, how might an ICA be developed and what would it look like? Andrea might be supported as follows:

The Partnership worker meets with Andrea. The two spend some time talking about the children, their births, their health status, who is involved with them. They also talk about how difficult it is to provide constant care for such young children. Andrea acknowledges that her children are too young to be left alone, and she and the worker problem-solve about whom she could call upon to take care of the children on short notice. The worker tells Andrea about a "safe-house" located nearby which will provide temporary care for her children. Together, they call the safe-house and Andrea talks to the safe-house helper. They make arrangements to meet the following day, and Andrea promises the worker that she will call the safe-house the next time she is tempted to leave her kids alone. The worker and Andrea decide to have a team meeting to come up with ideas to help Andrea with the care of her children. The team meeting includes Andrea, the CPS worker, the safe-house helper, the children's grandmother, and the local minister.

At the meeting, everyone agrees that Andrea loves her children and takes good care of them most of the time. They talk about her use of drugs and alcohol and determine that, while she binges on alcohol occasionally, she does not exhibit problems with alcohol on a daily basis. Issues of domestic violence and mental health problems are ruled out. While Andrea can clearly identify the risks of leaving her children alone, she expresses frustration at never getting out, having little money, and not finishing high school, which has prevented her from being able to find full-time work. She is particularly frustrated at the lack of furniture in her apartment that has only the basic necessities. As a result of the team meeting, the following plan was put into place:

1. The safe-house helper will take Andrea to a neighborhood support group for young moms in similar situations; she will also be available to care for the children on short notice when necessary.
2. The children's grandmother will spend a few hours each week individually with each child to provide them with undivided attention and activities that they might not otherwise receive. She and Andrea together will select modest decorative items and furnishings for the family's apartment, and she will purchase them.
3. The minister will provide Andrea with transportation to and from the church (along with child care) so she can participate in its GED and job readiness program.
4. The outreach worker from the local resource center will help enroll Andrea in cooking/nutrition classes that teach parents to "stretch" their food dollars. These classes will give Andrea a chance to meet other parents, and learn more about healthy eating for her family and how to budget.
5. Andrea agrees that she will not leave the children alone and will contact any of the team members if she is having difficulties. She will participate in the GED program and take advantage of the supports offered by all team members.

6. The outreach worker will provide Andrea with information on substance abuse supports and will help her to determine how she will participate in them.

7. The Partnership worker will check in with all team members weekly to make sure that everyone is doing what they agreed to.

The result? The plan is carried out, there are no reports to the Partnership, and, after six months, the case is closed to the formal Partnership agency, although the informal supports remain in place.

OUTLOOK

The Essence of Child Protection Reform: Improving Front Line Practice

Child protection improvement is the focus of regular reform efforts at many levels in the United States. Congress, national foundations, advocates, and public and private agencies constantly promote change and frequently are in the forefront of designing innovations for protecting children. These reform initiatives range from financing redesign to new legal sanctions for parents who mistreat their children. They may focus on policy, privatization, risk assessment tools, caseload reduction, primary prevention, or structural reorganization. Some of the more promising current avenues to child protection reform include neighborhood-based innovations, such as The Edna McConnell Clark Foundation's Community Partnerships for Child Protection initiative and variable CPS response efforts, now underway in several states.

For all the value of successful strategies in these areas, however, the most critical change must be in the quality of frontline practice. Unfortunately, all too often, practice quality can be the last issue to be addressed. Administrators and policymakers are frequently tempted to focus change strategies on management or technological improvements, policy, funding, and organizational structure. Essential as such infrastructure capacity-building may be, it will never be sufficient to improve child protection outcomes without a greater emphasis on improving front line practice.

Changing practice is not easy. Despite training and policy that attempts to reflect best practice values and beliefs, front line workers approach their work with a diverse array of personal values about the families they serve. In addition, no one can be fully immune to the influence of an organizational culture that is deficit-focused and symptom-based.

Training, itself, is hard to do well. Many of the training curricula in the field are knowledge-based, not experiential. Staff may have been informed of the elements of good practice, but rarely have the chance to see it modeled skillfully, attempt it themselves, and receive coaching and feedback from trainers or supervisors. Trainers may not be confident in modeling the practice skills required. Often their training role is part-time. Additionally, the expense of training, including the cost of developing effective curricula, adequately preparing trainers and absorbing the lost work time of training participants, may seem too challenging for agency leaders to undertake. As a result, child protection staff may not have the skills to implement the values and practice standards we establish. Unfortunately, the victims of this unpreparedness are the children and families we serve.

If reform is to improve outcomes in a meaningful way, sufficient progress will not occur until line staff are equipped to employ the fundamental skills required to affect the safety, stability, and well-being of children and families. Staff must be able to successfully engage families in the change process by establishing a genuine, trusting relationship. Assessment of risk and safety must address the underlying conditions of the family's functioning; not just its symptoms. The Grafting of plans should be strength-focused and needs-based, not deficit-driven and service-based. Families should be an integral part of the planning process, along with the family's own natural helping systems and neighborhood and community stakeholders. And the implementation

of plans should incorporate the continued support of a team of helpers who can sustain the family after formal supports are concluded.

The skills needed to improve safety are not intuitive, although clearly some staff have a greater facility to use them than others do. They are discrete helping interventions that must be used strategically. Ultimately, it is skilled practice and resourceful families that keep children safe.

Paul Vincent, Director, The Child Welfare Policy and Practice Group

**Want to know more about Family Group Decision Making?
Contact the Family Group Decision Making**

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Adapted from "1997 National Roundtable Series on Family Group Decision Making" Lisa Merkel-Holguin, MSW, Development Editor. SAFEKEEPING VOL. 2, NO 1 includes an in depth article on FGDM for copies contact the Center for the Study of Social Policy

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