Welcome to...

Case Planning and Family-Centered Casework

Agenda

I. Welcome and Introductions
II. Defining Case Planning
III. Engaging Families in the Case Planning Process
IV. Technology of Case Planning
V. Reassessment and Case Review
VI. Caseworker’s Role and the Casework Relationship
VII. Action Planning

Please Discuss:

■ Why is learning about case plans important to your job function?
■ What specifically is your role in case planning?
■ What are your learning needs for this workshop?
Case Planning

- A technology that guides the worker and family toward child permanence
- Based on identification of family strengths and needs
- Mutually agreed upon
- A "road map" for change

Goals of Child Welfare

- Identify children at risk of abuse or neglect
- Assure safety and prevent future harm
- Enhance family’s protective capacities
- Provide least restrictive, most homelike environment when placement necessary
- Provide permanent alternative or emancipation when needed

Planning:

A cognitive process whereby we carefully think through the best course of action to achieve a goal or to solve a problem prior to taking any action.
Reacting:

Responding without fully evaluating or thinking about the situation before acting

Often includes an emotional response

Types of Planning

- Safety Planning
- Case Planning
- Supplemental Planning
- Reunification Planning

Steps in the Case Planning Process

- Identify the presenting problem
- Engage the family in a collaborative partnership
- Assess the nature of the problem
- Formulate case goals and objectives
- Identify intervention activities
- Reassess and revise as needed
Purpose of the Case Plan Document

- Working contract
- Legal document for permanency planning
- Documents reasonable efforts
- Structures caseworker's thinking
- Statutorily required
- Facilitates case reviews
- Communicates with providers

For the Forrester Video:

- What did you like about how Carol engaged Ms. Forrester?
- What strategies did she use?
- What effect did these strategies have?
- Is there anything Carol did that you did not like? Why?
- How did Carol negotiate case plan activities with Ms. Forrester?
- What would you have done differently?

Additional Interview Strategies

- The Miracle Question
- Satellite Questions
- Scaling Questions
Review of Cultural Considerations

- Level of trust
- Awareness of cultural differences
- Respect
- View of outsiders
- Decision-making
- Language barriers
- The meaning of eye contact

Cultural Impact

- What are cultural issues specific to case plan development? What are your experiences so far?
- How would your family have reacted? What strategies might have helped?

General Principles of Change

- Pre-contemplation
  - Contemplation
    - Preparation
    - Action
    - Maintenance
**Family-Group Decision-Making**

- Belief that families can plan for safety and permanency
- Must serve the child’s best interests
- Coordination of a meeting that is supportive, non-judgmental and respectful
- Pre-work: who, why, how
- Staff facilitated
- Follow-up
- Ultimate agency responsibility

**Engaging Fathers in Case Planning**

- Importance of ….
- Barriers to ….
- Suggestions for ….

**The Johnson Family**

**Round One**

Safety Concerns
The Johnson Family
Round Two
Assessment Hypotheses

S.M.A.R.T.
- Specific
- Measurable
- Attainable
- Results-oriented
- Time-limited

Goals
- Comprehensive ends that represent the desired outcome toward which all case activities are directed
- Derived from the mission of child welfare
- Assumption that permanence in a family will be achieved
- May be two goals at once
- May change during provision of services
**Case Plan Goals**

- Child will remain with own family
- Child will be returned to own family
- Child will remain in a planned permanent foster home
- Youth will be emancipated to independent living
- Child will be legally adopted

**Objectives**

- Describe a specific, desired outcome or “end state”
- Must be measurable
- Must reflect behavioral change
- Must be derived from family assessment
- Should be time-limited
- Should be mutual

**Activities**

- Necessary steps to achieve each objective
- Step-by-step implementation of the plan
- Includes what steps, in what order, by whom, when, and where
- Should be jointly formulated
- Complex activities should be broken down
- Must be attainable and within a reasonable time
Importance Vs. Urgency

The Johnson Family
Round Three

Goals, Objectives, and Activities

Review of Johnson Case Plan
- Are the objectives:
  - Based on assessed problems?
  - Consistent with family-centered practice and respectful of parental rights?
  - Behaviorally specific, time-limited, observable, realistic, and understandable?
- Are the activities:
  - Addressing the objectives?
  - Clear, realistic, time-specific?
**Case Management**

- Help the family identify services
- Refer the family
- Prepare the provider
- Help the family access services
- Follow-up to assure services
- Communicate with providers
- Notify appropriate staff
- Collaborate with OWF workers
- Arrange emergency services

**Direct Service Provider**

- Supportive counseling
- Model parenting
- Education
- Engage child in play activities
- Accompany the parent and serve as advocate
- Help implement activities

**Supplemental Planning ...**

*An alternate permanency plan for the child if reunification is not possible*
Successful Supplemental Planning

- Intensive, time-limited work
- Early search for birth family
- Early identification of permanent options
- Well-written case plans
- Legal clarity about reasonable efforts
- Full disclosure conversations

The Johnson Family

Round Four

Supplemental Planning

Case Reviews

Purpose …

Monitor progress
Review major decisions
Assure agency is meeting legal obligations
**Case Reviews**

**Process ...**
- Conduct a formal review at predetermined, regularly scheduled intervals, at least quarterly
- Include family and providers
- Review all sections to assure current and accurate
- Discuss permanency
- Review to justify closure

**Case Reviews**

**Steps ...**
1. Update information
2. Revise goals and objectives
3. Revise activities
4. Close when plan completed

**Case Reviews**

**Types ...**
- Informal Case Review
- Semi-Annual Administrative Review
- Juvenile Court Review
**A Developmental Perspective**

- A continuous process
- Inherent strengths and capabilities
- Most people grow and develop throughout life
- Supportive interventions help further development
- Problem areas can be modified, compensated or eliminated

**To operationalize the developmental model:**

- Consider each interaction significant
- Use “teachable moments”
- Provide support for progress
- Identify strengths and abilities
- Adopt an optimistic outlook
- Break down complex tasks

**Additional Interviewing Strategies**

- Express empathy
- Confront behavior
- Develop discrepancy
- Avoid argumentation
- Support self-efficacy
- Roll with resistance
- Shift the focus
- Emphasize personal choice
- Reframe
Crisis...

A predictable emotional state resulting from overwhelming and unmanageable stress

Degree Of Crisis...

- Degree of stress
- Coping skills
- Perception of the event

Additional Interviewing Strategies

- Elicit Exceptions
- Elicit Fears and Anxieties
- Elicit Coping Strategies
The Home Visit

- The Purpose
- The Process
- Worker Safety

Case Closure

When?  How?

See you soon in Module VII!
Case Planning and Family-Centered Casework
Module VI

Agenda and Objectives

Section I  Welcome and Introductions

Objectives:

- Trainees and the trainer will introduce themselves to each other.
- Trainees will identify their learning needs specific to this workshop.

Section II  Defining Case Planning

Objectives:

- Trainees will understand the importance of case planning in child welfare.
- Trainees will understand the various types of case planning that are conducted in child welfare services.
- Trainees will be able to define and list in order the steps in effective case planning.

A. Planning vs. Reacting
B. Continuum of Planning in Child Welfare
C. The “Laundry List Approach” to Case Planning
D. Steps in the Case Planning Process
E. Purpose of the Written Case Plan Document

Section III  Engaging Families in the Case Planning Process

Objectives:

- Trainees will learn a variety of strategies for engaging families in the case planning process.
- Trainees will learn how issues of culture, motivation, and change impact the development of the case plan.
- Trainees will understand how family members can be involved in group planning and decision-making meetings.
- Trainees will develop skills in using interview strategies to engage families in case planning.

- Trainees will understand how to involve fathers in the case planning process.

  A. Engagement Strategies in Case Planning
  B. Cultural Issues in Case Planning
  C. Understanding Motivation and the Change Process
  D. Family Group Decision-Making
  E. Involving Fathers in Casework and Case Planning

Section IV  Technology of Case Planning

Objectives:

- Trainees will be able to identify the goals of case planning.

- Trainees will be able to correctly formulate objectives and activities to address the case plan goal.

- Trainees will understand how goals, objectives, and activities are recorded on the Comprehensive Assessment and Planning Model Interim Solution (CAPMIS) form.

- Trainees will understand fundamental concepts regarding supplemental planning.

- Trainees will understand the caseworker’s dual roles as case manager and direct service provider in meeting case goals and objectives.

  A. Johnson Family Round One
  B. Johnson Family Round Two
  C. Developing Goals, Objectives, and Activities
  D. Johnson Family Round Three
  E. Case Management and Service Delivery
  F. Supplemental Planning
  G. Johnson Family Round Four
Section V – Reassessment and Case Review

Objectives:

- Trainees will understand the importance of regular case reviews to monitor progress and modify case assessment, goals, objectives, and activities as needed.
- Trainees will understand their roles and responsibilities in the case review process.
  
  A. Purpose of Case Reviews
  B. Process of Case Reviews
  C. Types of Case Reviews
  D. Summary Exercise

Section VI - Caseworker’s Role and the Casework Relationship

Objectives:

- Trainees will learn interview strategies to help clients stay invested in the change process and to help the family through crisis.
- Trainees will understand how to use home visits effectively to provide casework services.
- Trainees will understand the need to consider issues of worker safety when interacting with clients.
- Trainees will know the factors to consider for appropriate case closures.
  
  A. The Continuing Client/Caseworker Relationship
  B. Helping Clients Stay Invested in the Change Process
  C. Helping Families in Crisis
  D. Using Home Visits Effectively
  E. Case Closure

Section VII – Action Planning

- Trainees will identify skill areas needing further practice and support.
CASE PLANNING AND FAMILY-CENTERED CASEWORK

COMPETENCIES

Skill Set #1: Ability to develop case plans that include objectives and service activities to address high priority needs and problems, and build on family resources and strengths

1. Aware of the potentially destructive impact on children and families of poorly constructed, incomplete or non-individualized family case plans

2. Knows the importance of involving family members in case plan development to assure their investment and motivation to work toward change

3. Knows the proper sequence of steps in the case planning process

4. Knows the difference between case goals, objectives and activities

5. Knows the criteria with which to prioritize family needs and case objectives

6. Knows the benefits of formally documenting the case plan in the case record

7. Understands the use of the case plan as the agency's formal negotiated contract with families to guide, monitor and evaluate the change process

8. Understands the need to formulate case objectives that reflect desired changes in the underlying conditions directly contributing to maltreatment in the family

9. Understands how case objectives are derived from information gathered during the family assessment

10. Understands the importance of identifying culturally relevant service providers and engaging families to help choose their own service resources

11. Understands how formal case plan documents are used in legal and court processes, and the importance of well-formulated case plan documents in supporting the agency's legal position
12. Understands how ineffective case planning contributes to premature closing of cases or keeping cases open for unnecessarily extended periods of time.

13. Understands the necessity of periodic case reassessment with the family to document changes and assure the continued relevance of services and activities.

14. Knows strategies to promote and support the involvement of immediate and extended family members in case plan development.

15. Knows the utility of a variety of service delivery strategies to protect children and meet families' needs including direct provision of services, using agency-based services, case management, referral to community providers, non-traditional and neighborhood-based resources, accessing or developing community support networks.

16. Knows how to engage the family in writing case plans in language that can be easily understood by family members.

18. Knows how to select and use specific interviewing strategies during case plan development.

19. Knows interview specific strategies to help parents remain motivated to safely parent their children.

20. Knows strategies to involve family members and service providers in periodically reviewing and revising case plans.

21. Knows factors to determine when a case should be closed.

22. Knows strategies that can be used at case closure to reduce recidivism or reopening of the case.

23. Can partner with family members to develop an individualized case plan that accurately reflects the family's unique needs, strengths and problems, and directly addresses contributors to maltreatment.

24. Can formulate observable, behavioral and measurable case goals and objectives.
25. Can identify, with family members, the most appropriate services and activities to achieve case plan objectives and address their individual needs

**Skill Set #2: Ability to work collaboratively with the family, including extended family members and service providers, to plan and coordinate services**

1. Aware of the caseworker’s role and responsibility as a case manager

2. Knows the types of formal and informal neighborhood and community resources that can be engaged to support families

3. Knows the liabilities of referring families to service providers without also assuring coordination of these services

4. Knows the intra- and inter-agency, environmental, cultural and community barriers that prevent access by families to needed services and resources

5. Knows strategies to ensure the caseworker’s safety during on-going family services work with families

6. Understands the value of home visits in learning about available services and resources in the family’s neighborhood and home community

7. Understands the importance of identifying naturally occurring support systems within the extended family, neighborhood and community

8. Understands the importance of gathering family members’ recommendations of culturally responsive service providers in their communities

9. Understands the caseworker’s role as an advocate to assure that families receive high quality and timely services

10. Understands the importance of coordinating services delivered by multiple community-based service providers and the difficulties experienced by families when they are not well coordinated

11. Understands the caseworker’s responsibility to monitor and evaluate the effectiveness of services provided by other agencies or providers
12. Can intervene with immediate, extended and care giving families to support, empower and strengthen them to care for children at risk of harm and to concurrently ensure the children's protection and permanence.

17. Can recognize when cultural differences impact and the family assessment.

18. Can facilitate coordination of services to families being served by multiple service providers.

19. Can collaborate with staff in other agency units to integrate and coordinate service planning and delivery.

**Skill Set #3: Ability to initiate permanency planning activities, including supplemental case planning, to assure children's safety and stability**

1. Knows the role and purpose of supplemental case planning in assuring timely permanence for children.

2. Knows the importance of beginning permanency planning at the time of first contact with a family.

3. Knows the circumstances when a formal supplemental case plan should be developed.

4. Knows the necessary elements that should be included in a supplemental case plan.

5. Understands the dynamics of family members' discomfort when discussing alternative permanent placements for the children.

6. Knows strategies to introduce the discussion of permanency issues during the family assessment and to engage and empower immediate and extended family members to focus on permanence for the children throughout the life of the case.

7. Can discuss permanency issues and alternative permanent placement options without communicating a lack of commitment to reunification.
8. Can determine when the supplemental case plan should become the focus of casework activities

**Skill Set #4: Ability to complete case documentation and organize and maintain family case records**

1. Knows the importance of timely, accurate case documentation for agency accountability

2. Knows the multiple types, purposes and uses of case documentation

3. Knows the scope and type of information that should be gathered from community service providers for inclusion in the case record

4. Understands how inaccurate or insufficient case documentation contributes to service ineffectiveness

5. Knows what information can be provided to other service providers to promote open communication and collaboration in planning and service delivery

6. Knows how to use summarized case documentation, including risk assessments, safety assessments and case plans, to guide supervisory case reviews and periodic formal case review conferences (Semiannual Administrative Reviews)
<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>PURPOSE</th>
<th>BENEFITS</th>
<th>LIABILITIES</th>
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<tbody>
<tr>
<td>Closed-Ended Questions</td>
<td>• To gather factual information regarding a specific content area</td>
<td>• Can obtain a considerable amount of information in a short period of time</td>
<td>• Limits potential responses of family members to those directed by the interviewer</td>
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<td>Probing Questions</td>
<td>• To obtain answers to specific questions</td>
<td></td>
<td>• May be threatening to family members; may encourage evasiveness or lying</td>
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<td>Yes/No Questions</td>
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<td>Open-Ended Questions</td>
<td>• To gather a lot of information about a wide range of topic areas</td>
<td>• Worker may discover information that he may not have thought to ask about.</td>
<td>• Takes considerable time</td>
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<td></td>
<td>• To gain insight regarding a client's feelings and perceptions about the situation</td>
<td>• Provides information to be used in the assessment; helps identify &quot;process&quot; level issues</td>
<td>• Worker may need to sort through irrelevant information to identify pertinent issues.</td>
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<td>Supportive Responses</td>
<td>• To communicate and demonstrate the caseworker's interest and concern</td>
<td>• Builds trust and communicates worker's interest and willingness to listen and help</td>
<td>• Person may use open format to digress and avoid discussing important topics.</td>
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<td>Active Listening</td>
<td>• To establish a positive casework relationship</td>
<td>• May have an enabling effect on the client</td>
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<td>Clarification</td>
<td>• To promote insight into one's own behaviors and actions to enable change and participation in the casework process</td>
<td>• Helps move to process level in interview</td>
<td>• Client has considerable control of the direction of the interview. Little change may be generated; few goals set. Does not always promote action</td>
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<td>• To enable the worker to better understand family dynamics, needs, and problems</td>
<td>• Allows worker to make accurate assessment of causal and contributing factors to family problems, and family strengths</td>
<td>• May be threatening to family members, who may be unaware of, or not want to discuss issues raised by the worker</td>
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<td>Summarization</td>
<td>• To keep the interview focused and on track</td>
<td>• Helps family gain insight into own situation</td>
<td>• May increase family members' resistance</td>
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<td>Redirection</td>
<td>• To help the person organize her information</td>
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<td>Giving Options, Advice,</td>
<td>• To offer a range of possible solutions to the family's problems</td>
<td>• Provides family members with potential solutions they had not previously considered</td>
<td>• People who are redirected may feel cut off, as if the worker is not listening.</td>
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<tr>
<td>or Suggestions</td>
<td>• To direct family members into positive action</td>
<td>• Encourages families to try new solutions</td>
<td>• Overdirection by worker may lead to moving too quickly off a topic, thus missing important information.</td>
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<td>Confrontation</td>
<td>• To push family members to acknowledge problems, feelings, or behaviors, when other less directive interventions have failed</td>
<td>• Can precipitate movement quickly</td>
<td>• May prevent family from arriving at their own solutions to problems</td>
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<td>• Can cut manipulations and digressions and focus on the critical issues</td>
<td>• Worker may be blamed for failures if solution does not work.</td>
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<td>• Can help family members become aware of their own resistance</td>
<td>• Cannot be used without a well-established and supportive relationship</td>
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<td>• May increase resistance if not successful</td>
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<td>• May require considerable follow-up support from the worker; takes time and commitment</td>
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Additional Interviewing Strategies

A. Strategies to Explore Motivation

The Miracle Question

The Miracle Question can be used to elicit clients' goals and needs for his/her family. Asking this question begins to shift the focus from problems to imagining a future when the problem is solved. A sample Miracle Question would be:

"Suppose while you are sleeping tonight a miracle happens and your problem is solved. What will be different in the morning that will tell you that a miracle has happened?"

There are many variations to this theme. Some clients may react negatively to the use of the word "miracle." Variations might include:

"If everything were perfect in your family, what would it be like?"
"When these problems are solved, what will your relationship with your son be like?"

Satellite Questions

Satellite questions to the Miracle Question help clients identify specific feelings and, most importantly, behaviors that they themselves and others might notice if the miracle happened. They include questions such as:

"What is the first thing you will notice?"

"What will your husband (child, friend) notice that would give them an idea that things are different?"

"When they notice, what will they do differently?"

"When they do that, what might you do?"

Scaling Questions

In this technique, the worker asks the client to rate something on a scale of one to ten (ten being the highest, one being the lowest). This gives the worker precise information about the clients thoughts, feelings, or anxieties about a situation and provides a shared understanding. As a follow up
question, the client can be asked what it would take to move up on the scale. This technique automatically requires the participants’ involvement in developing solutions to his or her problem. It is useful in determining level of motivation, degree of difficulty in accomplishing a task, fear or anxiety about change, etc.

"On a scale from one to five, with one being terrible and at your wit's end, and ten being the best you’ve every felt, how would you rank your feelings right now?” A client ranked herself at a two. She said she was close to a one but was not there yet. Next the caseworker asked “What would need to happen for you to be able to rank yourself one step higher?”

By asking this scaling question, the mother would be immediately involved in developing her own solutions. She is the one who knows her situation better than anyone. Scaling questions are an easy way to begin the process of inviting clients to engage in the casework relationship.

This type of question can also be helpful in identifying possible barriers to the client/worker relationship. For example,

“On a scale from one to ten, could you rate how helpful my work with you is? Ten means that I am helping you a lot, one means that I am not helping you at all.” When the client responds, the worker can then ask, “What would it take for you to move up one spot on the scale?”

B. Strategies to Help the Client Stay Invested in the Change Process

Express empathy

The worker should express an appreciation for the client’s situation and the client’s emotions, frustrations, anxieties, etc. “This has got to be really hard to see all these things you need to do. They aren’t easy changes to make, but I hope you can see what we’re working for. There is an end in sight.”

Use constructive confrontation

The ultimate purpose of many interactions with clients is to have them confront their own behavior; to bring maladaptive patterns of behavior to their conscious awareness so that change is possible. Confrontation does not need to be aggressive, loud, or unkind. We confront the behavior,
not the person. While this may appear to be a fine distinction, saying, “You said you went to the class but you didn’t. Now we have to figure out what to do next” is more constructive than saying, “You’ve lied to me”.

Develop discrepancy

Clients are often caught in a cycle of repeating maladaptive behavior that is not helpful, but may be the only way they know to cope with the problem. The worker should gently help the client become aware that the behavior is not producing the desired results. In other words, there is a discrepancy between the client’s goal and her behavior. The worker can pose questions which ask the client whether the behavior is obtaining the intended results, or he can ask about the benefits and liabilities of the behavior. This allows the client, rather than the worker, to present a reason for changing and ultimately, provides better motivation. This is a gentle form of confrontation; demeanor is important. He must remain genuinely interested and curious, not judgmental or punitive.

Examples:

“How well is this working for you?”
“Is yelling at your son making it better or worse?”

Avoid argumentation

Caseworkers may feel the need to argue a point, particularly if the client is clearly wrong, not telling the truth, or failing to see reason. No one usually concedes their point and the argument often increases hostility. It’s possible the client knows he’s wrong or has done something inappropriate. We need to state our view and empower the client to accept or not accept that.

Support self-efficacy

The worker’s belief in the client, belief that she can influence her own thoughts and behavior, is an important motivator. Hope and faith are important elements of change. The message must be that parents can do it; they can change.

Roll with resistance

In this technique, the caseworker uses the client’s resistance to good advantage. For example, a client says, “All you care about is Lisa!” The
worker responds with "Sounds like I need to spend some time thinking about how you're feeling." This client expected the caseworker to defend his or her interest in the child’s well being and may be surprised by the interest in her.

This technique is also helpful when clients complain about not getting along with the worker. The worker can respectfully respond to the resistance: "Yes, I feel tension in our relationship too. I’d like it to be different, so that we can work together better. What do you think we could do to improve things between us?"

**Shift the focus**

It is sometimes more productive to go around a barrier rather than address it head on. This may not be possible when initially intervening to keep a child safe. But, when working with a client on an on-going basis, there are times that a caseworker can choose to defuse resistance by shifting a client’s focus away from what seems to be a barrier toward progress. For example, the client may say, "I know you want me to stop seeing my boyfriend altogether but I'm not going to do that!" The worker may say, "Let’s take it one step at a time. We don’t need to make any decisions yet. Let’s first talk for a few minutes about joining that support group."

**Emphasize personal choice**

Many clients feel powerless in our system and, as a result, will respond by asserting themselves or trying to regain control of the situation. Assure the person that in the end, it is the client who determines what happens. Acknowledging individual choice does not mean that the caseworkers give up his or her authority to assure a child’s safety. It just acknowledges a client’s right not to change.

Client: “You can’t tell me what I can do! If I want to drink, that’s what I’ll do.”

Caseworker: “You’re right. I can’t make you change your behavior. It’s completely up to you. My job is to make sure you understand the results of that choice".
Reframe

This occurs when a caseworker hears what a client says but offers a new meaning or interpretation for him or her. By restating the thought in a new form, there is a greater chance the client will view the intervention as helpful (Miller and Rollnick, 1991).

Client:  "It is just so hard to have to visit my own son in the foster home all the time.

Caseworker: “Yes, but I remember when we first set that up. You didn’t think you could go at all and now you never miss a visit.”

C. Strategies to Help Families in Crisis

Ask Questions that Elicit Exceptions

Eliciting exceptions is especially useful in helping clients identify their strengths, identify how they successfully handled problems in the past, and identify coping mechanisms that could be further developed. This type of questioning explores past successes and uses them to work toward solutions.

Questions to elicit exceptions to the current problem ask the family to reflect on times when a problem could have occurred, but did not. The worker then explores what the client did to avert the problem.

“Have you been in this situation before? What did you do that helped?”

“Clearly, there are many times when you do keep track of your daughter, even when you come home from work exhausted. Can you tell me how you do that?”

“You said earlier that it’s not always like this between you and your teenage daughter. Can you tell more about the other times?”

Once the exception has been identified and explored, the caseworker can help the family deliberately and routinely use this strategy in their current situation.

“So, it seems that counseling has helped in the past. That may be a good place to start with this problem as well.”
Ask Questions that Elicit Fears, Anxiety

During times of crisis, clients are often immobilized by fear or anxiety about what may occur or about the uncertainty of change. These fears are often kept hidden and tend to take on more significance as the client tries to avoid them. It is often helpful to calmly, openly discuss these fears so that the client can move from immobilization to productive problem solving. This process involves three steps:

1. Eliciting the fear or anxiety. Usually a direct question is most useful.
   
   Worker: “What’s the worst that could happen if your husband and son can’t resolve this?”
   
   Client: “I’m afraid he might file charges against him in juvenile court!”

2. Realistically assessing the likelihood that the fear will be realized.

3. Helping the client develop a plan for how to cope with the feared situation, if it should occur. This helps move from immobilization to problem solving. “If your husband does file unruly charges on your son, how will you handle that?”

Ask Questions that Elicit Coping Strategies

These questions recognize the client’s strengths, while demonstrating empathy and understanding regarding the client’s current situation. This strategy simultaneously engages the client and gathers information about coping strategies.

Examples:

“You’ve had so much do deal with lately. These circumstances would have been hard for anyone. How have you been able to keep taking care of your family?”

“I’m sure there are times when you feel like giving up. What keeps you from doing that?”
"I can only imagine how hard it is to juggle all your family's needs. How do you take care of yourself?"

References


Case Scenario for
Miracle, Scaling, and Satellite Questions

You are the 24-year-old single mother of 4-year-old Anthony. He has been diagnosed with severe hyperactivity with attention deficit disorder. You know that he really tries to be good, and sometimes you can be patient with him; other times, it’s more than you can take and you spank him, often leaving bruises.

Lately, you feel that you are spinning into a crisis. Anthony’s father has stopped paying child support and your finances are low. Your sister won’t baby sit anymore as Anthony is quite a handful. Your boss won’t give you any more spare time off to find new child care.

Last week, you over-disciplined Anthony for bad behavior. You spanked him too hard and left bruises again. After that incident, you asked your neighbor to watch him for a while, so that you could have some time alone to calm down.

The next day Children’s Services came out to investigate the situation. You agreed to open the case, because you knew you needed help.

Your case was assigned to an ongoing worker. She has just arrived at your house to talk with you about this situation, and how the agency might help you.
Cultural Aspects Impacting the Case Planning Process

1. What are some cultural issues to consider, specific to the development of a case plan? Have you had an opportunity to experience any of these and if so, what did you do?

2. How might your family or a family member of your cultural group have reacted if asked to develop and implement a case plan? What strategies might have been successful in engaging your family?
Remembering Changes

Think of a situation in which you made a significant change in your life. Please answer the following questions.

1. What was your initial reaction to this change?

2. Why did you decide to make this change? Was it forced on you?

3. Did your reactions to this process change over time?

4. Who or what helped you make this change?

5. What risks were involved in making this change?

6. Many changes involve loss. What did you lose when you made this change?
The Putative Father Registry

The Putative Father Registry was established in Ohio in 1996. It was developed:

1. To reduce the likelihood of a traumatic separation for a child as a result of improper termination of paternal rights;

2. To require the putative father to take a proactive step in planning for his child’s future; and

3. To protect the rights of fathers.

The Putative Father Registry gives an opportunity for a putative father to voluntarily come forward to be involved in the planning for his child. He has ten months (nine months of gestation and 30 days following delivery of a child) in which to register.

The Putative Father Registry impacts the placement of all children voluntarily surrendered for adoption, born after January 1, 1997.

The Putative Father Registry is an additional resource for finding and involving birth fathers and does not remove other forms of notice required by law prior to termination of parental rights.

**Procedures**

Agencies **must** request a search of the Putative Father Registry in every voluntary surrender for purposes of adoption, whether the adoption occurs through a public or private agency or through an independent attorney. **Agencies are required to request a final search no sooner than 31 days after the birth of the child.**

The public is informed about the Putative Father Registry through posters in agencies, hospitals, courts, etc. The contact number for the Putative Father Registry is **1-888-313-3100**. To be registered, fathers complete ODJFS form 1694 and submit it to the Registry any time between the child’s conception and 30 days following birth.

When the worker completes the Application for Search of Ohio Putative Father Registry and submits it to the Registry, a response will be made within seven (7) working days.
The Johnson Family

Presenting Problem at Intake

The Johnson family was referred by the elementary school teacher because the Johnson's 11-year-old daughter, Anna, had collapsed on the school playground complaining of pains in her chest and upper abdomen. The teacher indicated there were three other Johnson children attending the school; Todd, age 10; Raymond, age 7; and Kayla, age 6. The teacher indicated there had been multiple signs of problems during the past year and that the children's situation had seemed to be worse during the past few months. The teacher provided the following information.

- Eleven-year-old Anna has had a chronic, low-grade fever, wheeze, and bad cough. She told the school nurse she had not been to the doctor. The school nurse examined Anna when she complained of chest pains, and the nurse expresses concern about chronic bronchitis and possible pneumonia.

- The children were often absent from school, sometimes for days at a time. When the school called their mother, Patricia Johnson, she routinely said the children were "sick."

- The children were generally poorly clothed for the weather; they had no boots, wore lightweight sweaters in severe winter weather. Their clothing was often soiled.

- Seven-year-old Raymond was often observed playing alone on the school playground long after school was out, without supervision.

- Todd, the 10-year-old, had developed severe behavior problems, and referral to an SBH classroom was being considered by the school. The school couldn't assess whether he had a learning disability or had ADHD, but he showed signs of both.

- Six-year-old Kayla cried with little provocation, sometimes sitting by herself in the corner. She was often withdrawn and appeared shy and fearful.

- The teacher had called Mrs. Johnson many times, and usually got no answer. The one time the teacher did reach Mrs. Johnson, she agreed to come to the school to meet with the teacher, but never did.
• The children often came to school hungry, indicating they hadn't had any breakfast.

Investigation

The caseworker, Laura Douglas, called Mrs. Johnson on the phone and got no answer. She made an unannounced visit to the home and woke Mrs. Johnson at 2:30 p.m. Laura talked first to Mrs. Johnson and then to the four children when they returned home from school. Mrs. Johnson was subdued and withdrawn, but she answered the worker's questions. She claimed she was sorry the worker had to get involved, they usually handled their own problems just fine. She said they didn't have much money, but the family's income was usually enough to "get by." The food in the home was limited. Mrs. Johnson claimed she "hadn't gotten to the store" recently, and money was a little short the past month, so she hadn't gotten much other than the necessities. She claimed she knew Anna had a cold. When asked why she hadn't taken her daughter to the doctor, Ms. Johnson shrugged and said "I was hoping it would go away by itself. It usually does, and I don't have the money for a doctor."

The home was marginally adequate. It consisted of three bedrooms, a living/dining room, a small kitchen, and one bath. It was dirty and cluttered, and furnishings were sparse, but there were no obvious physical hazards. The children stated their mother slept a lot, and was "sick" very often. Anna said she often had to feed and dress the younger children for school. Anna also claimed she often cared for the younger children while their mother slept or went out. Ten-year-old Todd was restless and uncontrollable throughout the home visit, and he would not respond to any of his mother's requests to "sit down and be quiet." He periodically punched and teased 7-year-old Raymond when he thought nobody was looking.

During the home visit, the worker identified a fifth child, a baby girl. Mrs. Johnson said the baby, Lissa, was 10 months old. The worker noted the baby appeared listless and inactive. She was lying on her back in her playpen, barely moving, although she was awake. When the worker picked up the baby, her muscle tone was weak, her head wobbled, and she felt very slight for a child of her age. She had a bald spot on the back of her head, indicating a lot of time spent lying on her back on a flat surface such as a playpen or crib mattress. She did not make direct eye contact nor respond to the worker's attempts to engage her. The baby had on lightweight, dirty clothes, a soiled diaper, and had an encrusted residue on her face from a chronic runny nose. The worker attempted to
sit the child on her lap -- the baby wobbled and could not maintain herself in a sitting position.

During the visit, the mother dutifully answered questions but offered little additional information. She was sullen and withdrawn, appeared to be easily distracted, and seemed uneasy in the worker’s presence. She displayed no overt hostility or anger, but did seem anxious. She occasionally appeared to lose focus and asked, "I'm sorry, what did you just say?"

**Safety Issues**

Be prepared to discuss the following questions in a large group discussion.

1) Are any of the children currently unsafe -- i.e., currently being abused or neglected, recently abused or neglected, or at risk of imminent harm? Which children, and why?

2) Does this family need a safety plan to assure the children's immediate protection while a further assessment is completed?

3) If a safety plan is needed, what activities and interventions should be included in the plan to protect the children with the least amount of trauma?

4) What additional information may be needed to complete a safety plan?

5) What information suggests issues that may need more in-depth exploration at a later time?
FACT SHEET:

Dynamics of Domestic Violence

Description

Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners.

Specific Age, Gender, Cultural Features

Domestic violence crosses ethnic, racial, age, national origin, sexual orientation, religious and socioeconomic lines. It is the leading cause of injury to women in the United States, where they are more likely to be assaulted, injured, raped or killed by a male partner than by any other type of assailant. It is estimated that as many as four million instances of domestic abuse against women occur annually in the U.S. About one-fourth of all hospital emergency room visits by women result from domestic assaults.

Domestic violence is far more likely to be an issue of control than of anger. It is clear that the most dangerous time for a woman is when she is leaving or has just left an abusive partner and that partner is losing control of her. Her chances of being killed are increased dramatically.

This violence takes a devastating toll on children who are exposed to violence in the home. Approximately 2.4 million children are abused by their parents each year. Children whose mothers are victims of wife battery are twice as likely to be abused themselves as those children whose mothers are not victims of abuse. When children witness violence in the home, they have been found to suffer many of the symptoms that are experienced by children who are directly abused.

There are cultural considerations in domestic violence assessment and services. Codes of conduct and beliefs regarding traditional relationships between partners, the expectation that women be subservient to men, and prohibitions against involving “outsiders” in family business can all discourage a victim from disclosing the abuse. Furthermore, the victim may fear being shamed in the eyes of her community and may fear there will be gossip about her.

Indicators of Domestic Violence

The following behaviors should be considered an indication for a referral for services:
Physical Harm:

- Punching, hitting, slapping, kicking
- Burns
- Threatening with a weapon
- Mutilation of the victim
- Rape, forcing unwanted sex
- Forcing victim into pornography or sex in front of children
- Physical restraints, being tied up

Emotional Harm:

- Isolation from family and friends
- Embarrassing, name-calling, harassing the victim
- Threatening the victim or children
- Sleep deprivation
- Mutilating / killing pets, destroying objects
- Following, stalking
- Using children to spy on or assault the victim
- Degradation in front of children, belittling
- Control of victim’s friends, phone calls, clothes, whereabouts

Economic Harm:

- Not letting the victim get / keep a job
- Making the victim ask for money
- Withholding money, information about money
- Stealing from the victim
- Ruining credit
- Sabotaging public assistance
- Withholding documentation / verification

Other indicators that you may see:

- Bruises, cuts, swollen eyes
- Wearing unseasonable clothing to cover injuries
- Having dark glasses indoors
- Perpetrator is overly affectionate toward unresponsive victim
- Children repeating negative terms the perpetrator uses in reference to the victim
- Perpetrator will not allow the victim to be interviewed alone
Services

Through the Family Violence Prevention and Services Act, the Administration for Children and Families (ACF) is responsible for several activities which address domestic violence. Grants are provided to state agencies, territories and Indian Tribes for the provision of shelter services to victims of family violence and their dependents and for related services, such as alcohol and substance abuse prevention and family-violence prevention counseling. The National Resource Center on Domestic Violence (800-537-2238) provides information and resources, policy development, and technical assistance designed to enhance community response to and prevention of domestic violence.

There are many community-based services throughout Ohio that address the immediate needs of families involved in violence. Child welfare professionals have collaborated with advocates from the domestic violence community to develop protocols for joint cases. Professionals from both areas believe that the first priority is always safety of children. Workers should consult and collaborate with local advocates for guidance in working with this complicated and often dangerous family dynamic.

Anger management and couples counseling have not been found to be effective services in reducing the violence. Batterer intervention programs are most often based on the need to alter the batterer’s thought processes that include the need to control their partners and their negative views of women. These are learned behaviors.

While it is not the role of the child welfare worker to advise an adult victim of domestic violence to leave an abusive partner, the worker must consider the safety of the child and the mother, whether she stays or leaves. The worker can open up discussion regarding domestic violence by using the following non-judgmental statements. These statements are intended to inform the suspected victim that you are aware that there may be a problem with domestic violence, you are open to discussing it, and that there is help available. The victim may not enter into a discussion with you at first; however, as you demonstrate your trustworthiness she may open up about it later. It is essential that all your communication be non-judgmental and non-blaming.

- Violence is against the law.
- You deserve to be safe.
- I’m concerned for your safety.
- I’m concerned for your children’s safety.
- There are ways to plan for safety.
**Regarding the development of case plans:**

There are sometimes conflicting priorities in families where there is domestic violence. Protecting children is always the first priority but to do that, there are options. For example, it may be necessary to develop two case plans. One reason this is done is to make the batterer accountable for his own objectives/activities. Objectives may include cessation of verbal, emotional, physical, and sexual abuse; cessation of interference with their partner’s efforts to parent children safely; and compliance with protection orders and other court-ordered mandates, including those imposed by probation, parole, and perpetrator intervention programs.

Another reason for separate case plans is for issues of safety and confidentiality. If the mother and child are in a shelter or if there is danger in the batterer knowing the mother’s activities, the plans should be separate.

**Assessment Interviewing Questions**

Because of the high percentage of women visiting emergency rooms due to partner abuse, the American Academy of Family Physicians has developed three brief screening questions to detect partner abuse. While these would not be the only questions asked by workers in child protection, they may provide some initial assessment data. It should also be noted that similar assessments should be made throughout the life of the case as victims may not initially trust the worker or may fear for their lives or the lives of their children if they tell.

Initial screening questions may include:

- “Have you been hit, kicked, punched, or otherwise hurt by someone within the past year?”
- “Do you feel safe in your current relationship?”
- “Is there a partner from a previous relationship who is making you feel unsafe now?”

Additional questions may include:

Has your partner ever:

- Kept you from seeing your family or friends?
- Followed you to see where you go?
- Accused you of being unfaithful?
Controlled your money?
Called you a degrading name?
Made threats to you or to the children?
Made threats to commit suicide?
Been violent outside the family?
Threatened to report you to Children Services or to take away the children?

Is the abuse happening more often than usual?

Is the abuse getting more severe?

Additional information may be found in Child Protection in Families Experiencing Domestic Violence, published by the U.S. Dept. of Health and Human Services, available through Child Welfare Information Gateway at www.childwelfare.gov
Fact Sheet
Substance Abuse

The following information is adapted from the Field Guide to Child Welfare (Ryczus and Hughes, 1998.)

Description

The abuse of drugs and alcohol by parents has become an increasingly frequent contributor to child maltreatment. The risks to children can be quite high. Children of alcoholic mothers may be born with fetal alcohol syndrome, which is characterized by growth deficiency, learning disabilities, behavior problems, and various degrees of mental retardation. Infants whose mothers used crack cocaine during pregnancy are likely to have neurological, behavioral, and other developmental problems.

Children with substance-abusing parents are also at higher risk of physical abuse, neglect, and sexual abuse. As an example, it has been estimated that up to 75% of all incest incidents involve use of alcohol on the part of the perpetrator (Thompson, 1990). Problems with substance abuse exist in an estimated 40% to 80% of the families of children confirmed by CPS as victims of abuse and neglect (CWLA, 2001).

Drug abuse can be defined as the use of a drug for other than medicinal purposes, which results in the impaired physical, mental, emotional, or social well-being of the user, or others who are dependent upon the user. Commonly abused drugs are alcohol, prescription drugs, sedatives, stimulants, marijuana, narcotics, inhalants, hallucinogens, phencyclidine, cocaine, methamphetamine and crack. These drugs affect the user's feelings, perceptions, and behavior by altering the body chemistry. Users often experience these physiological changes as mildly to intensely pleasurable – altering mood, reducing anxiety and depression, and creating feelings of euphoria sometimes referred to as a "high."

With some drugs, continued use sufficiently changes the body chemistry to increase tolerance. The user then requires increasing amounts of the drug to produce the same effect. The user may also become physically and/or emotionally dependent on the drug to function. This dependence, also referred to as addiction, makes it extremely difficult to control or stop use of the drug. Withdrawal can cause a wide range of
unpleasant, painful, and potentially dangerous physical and psychological symptoms.

Clearly, not all persons who use drugs or alcohol are drug dependent. The scope, frequency, and circumstances of parents' drug or alcohol use will determine the ultimate risk to their children. Drug use can be limited in scope and frequency, more or less controlled, and it may not significantly affect the user's functioning or parenting ability. However, for many people, recreational use of drugs and alcohol can be a "slippery slope," quickly becoming more chronic and serious, leading to abuse or addiction. This is particularly true of crack cocaine, a highly addictive substance. Zuckerman (1994) states that while becoming addicted to alcohol, heroin, or intranasal cocaine may take years, with crack cocaine this progression from recreational use to addiction can occur within weeks or months of first use.

Effects on Parenting

Parental substance abuse is associated with a more than twofold increase in the risk of exposure to child physical and sexual abuse (Walsh, 2003). The Child Welfare League of America reports that children raised by parents who abuse alcohol and other drugs are almost three times more likely to be abused and more than four times more likely to be neglected than other children (CWLA, 2001).

Once addicted, the user has a "chronic, progressive disease in which there is a loss of control over the use of, and a compulsive preoccupation with, a substance, despite the consequences" (Zuckerman 1994). The addict's primary goal is to maintain use of the drug. Pervasive disruption in all aspects of the addict's life – physical, psychological, economic, familial, interpersonal, and social – is a common result. The effects of substance abuse on parenting can be pervasive. Since addicts consider their own needs first, their children's needs for basic physical care, nurturance, and supervision are often not met, placing them at high risk of harm. According to Zuckerman [1994] the "primary relationship" of mothers addicted to crack "is with their drug of choice, not with their child."

Howard (1994) reports that mothers who are dependent on crack were found to be significantly less sensitive, responsive, or accessible to their children, and without exception, their children exhibited insecure attachments. Secure attachments were seen only in children whose
mothers had been sober for at least six months prior to the testing procedure.

It is important to stress that in spite of the potentially serious outcomes of parental drug use for children, most drug addicts do not intend to harm their children, nor are they deliberately indifferent to their needs. They frequently exhibit extreme shame and guilt about the problems their drug use causes their children (Schottenfeld, Viscarello, Grossman, Klerman, Nagler, & Adnopoz 1994); and they often devise complicated strategies to protect their children from the effects of their drug use (Kearney, Murphy & Rosenbaum 1994).

The deleterious effects of drug use on parenting are pervasive. Heavy use of drugs and alcohol typically interferes with thought processes, judgment, organization, and self-control. Substance abusing parents are often disorganized in their thinking and actions, they lack follow-through in all their activities, and their parenting responses are unpredictable and inconsistent (Howard 1994). In addition, blackouts, binges, and drug or alcohol-induced stupors, which are common with heavy substance abuse, can create very dangerous situations in which children are left totally unsupervised, placing them at high risk of harm. In fact, Zuckerman [1994] contends that, “If the mother is addicted, the child’s safety can be assured only if an adult who does not use drugs is in the household and is willing to take care of the child, or if the mother is actively involved in treatment that regularly monitors the child.”

Methamphetamine use sometimes results in delusions, which can put the children and caseworker at risk of harm. Furthermore, “meth labs” are dangerous for children. The volatile chemicals used to produce “meth” can combust, causing the home to burst into flames. There are often “booby traps,” and guard dogs protecting the property, which can pose a safety risk for children.

**Difficulties with Identifying Substance Abuse**

In spite of high correlations between substance abuse and child maltreatment, substance abuse in maltreating families is not always identified. Many caseworkers are not aware of the signs and symptoms of substance abuse or addiction, and they may be uncomfortable asking the pointed questions necessary to determine the scope of drug or alcohol involvement. Denial is also a typical symptom of addiction. Substance abusers often deny that they use drugs or alcohol, or they may
contend that their drug use causes no problems for themselves or their children.

In addition, research by Kearney, et al. (1994) suggested that mothers on crack devised many strategies to hide their drug involvement, to shield their children from drugs and the drug life, and to make up for crack's negative effects on mothering. These strategies included keeping children physically apart from cocaine by never using the drug in front of the children; hiring babysitters or leaving children with relatives prior to using the drug; or waiting until the children were asleep or safely situated. Mothers also made certain their appearance did not reveal their drug-using status when they visited schools or other child-related settings, and they lied to agency officials or family members about their drug use. Most women described how they separated family money from drug money to assure that their children's needs were met. As their crack use became more frequent, they reported paying all their bills as soon as their paychecks or welfare checks arrived, because any unspent money was vulnerable. As a result, many of the mothers were able to hide the fact of their drug use from family, friends, and the community.

However, these compensatory strategies eventually broke down for almost 70% of the mothers in the study. Many were unable to reduce or stop drug use, and they eventually exhausted their emotional and financial resources. Many of the mothers then voluntarily entrusted the care of their children to family members, or their children were removed by protective service agencies. The mothers appeared to be more readily accepting of placement of their children if they themselves made the placement arrangements, than if the child protection agency removed their children without their consent. Drug use often escalated after placement of the children, reportedly as they now had no mothering responsibilities, and as an attempt to deal with the pain and sadness of losing their children.

**Indicators of Substance Abuse**

Because there are a wide variety of substances used, and an equally wide variety of indicators and symptoms, it is usually not possible for caseworkers to accurately diagnose which drug is being used or to what degree. Users may also concurrently use more than one substance. Anyone suspected of drug abuse or addiction should be evaluated by a professional in the field of substance abuse.
The most common general indicators of substance abuse are: altered mood states (euphoria, anxiety, irritability, excitability, sluggishness, or depression); changes in appetite and sleep patterns; temperamental or erratic behavior; poor memory and judgment; confusion and inability to concentrate; moodiness and restlessness; lack of concern about personal appearance; lack of attention to the environment; and clumsiness and coordination problems.

Caseworkers should become familiar with the dynamics of commonly abused substances in order to recognize when substance abuse is a contributor to maltreatment. Additional information is provided in the Field Guide to Child Welfare, including descriptions and indicators of alcohol abuse, inhalants, cocaine and crack, stimulants, depressants, narcotics and hallucinogens.

Prognosis for Treatment

Currently, the prognosis for the treatment of substance abuse is quite equivocal. Different treatment programs report widely differing degrees of success with addiction to different drugs. Further, the need for drug abuse treatment far exceeds the availability of treatment resources. For example, in 1990 it was estimated that of the 105,000 pregnant women who needed drug treatment annually, only 30,000 received it (Nunes-Dinis & Barth 1993).

The prognosis for treatment of crack cocaine addiction is, at present, limited. Howard (1994) reports that most of the mothers in their study continued to use drugs, despite efforts by program staff to help their clients identify, enter, and stick with drug treatment. Only 15% of the mothers in the study remained abstinent for one year. Besharov (1994) concurs, suggesting that with crack cocaine addiction, "relapse is the rule, not the exception," and treatment success is defined as successfully increasing periods of remission, and controlling the damage done during relapses, rather than achieving permanent abstinence.

Wald (1994), however, cites a growing body of evidence to support the claim that the lack of success in treating crack cocaine addiction is at least partially related to the inadequacy of available treatment programs.
Substance abuse is difficult to treat because of the complexity of conditions and factors related to drug use. Several studies have noted the high percentage of drug-abusing mothers whose personal histories included physical and/or sexual abuse, neglect, drug use, violence, multiple separations, discontinuous relationships, and other physical and emotional hardships (Howard 1994; Kearney et al. 1994; Chavkin, Paone, Friedmann, & Wilets 1993, Grella, et. al., 2005). It is posited that the euphoric mood and feelings of well-being that are typical effects of many drugs may be used as an antidote to anxiety, depression, hopelessness, and shame. However, the etiology of drug addiction is not that simple, and the effects of individual personality, physiological make-up, environmental factors, and social factors must be considered concurrently with the user's history.

The prognosis for individual drug users varies considerably, depending upon several factors: the type of drug used; the scope and frequency of drug use; the longevity of the user's habit; the degree of tolerance or dependence; the individual's personal, and interpersonal strengths and resources; and the supportiveness of the user's family and social environment. The following "strength" conditions would, in general, increase the likelihood of successful treatment. The "risk" conditions, in general, are likely to make treatment more difficult.

**Strengths That Can Mitigate the Effects of Substance Abuse**

- Parents acknowledge their substance abuse, and fully understand the negative impact it has on their children.
- Parents are willing to engage in some form of substance abuse treatment, and attempt to remain involved in a treatment program. This may include self-help and peer-help organizations such as Alcoholics Anonymous and Narcotics Anonymous.
- Parents make alternative caregiving arrangements for their children when they recognize themselves to be incapable of providing proper care.
- Parents are willing and able to separate themselves from friends, family-members, spouses, or others who continue to use drugs and support their continued use by the parents.
• Parents have a strong support network of family and friends who do not use drugs and who support their attempts to discontinue drug use.

• Parents have a history of adequate social, occupational, and personal functioning prior to the onset of drug use.

• Parents are able to recognize when a relapse is likely and make plans for their children, call in friends or family members to provide care for the children, or seek help.

• Parents exhibit shame and distress about the effects of drug use on their parenting.

• Parents have a history of successful parenting prior to the onset of drug use and have a strong identity as a parent.

**Conditions That Increase Risk of Maltreatment**

• Parents whose drug abuse seriously impairs their judgment, reliability, and ability to meet their children's needs.

• Parents whose involvement in a drug culture lifestyle places their children at continuous and serious risk of harm.

• Drug abusing parents who deny the existence of the problem, and refuse to consider treatment, or who verbalize a desire for help but never follow through.

• Parents with no history of adequate social, occupational, and personal functioning prior to the onset of drug use.

• Parents whose primary social contacts and support networks are also habitual drug users; parents with no social support network of nonusing family or friends.

• Parents with little or no history of successful parenting prior to onset of drug use, and limited identity as a parent.
Services

Highly specialized treatment must be provided to address the problems related to substance abuse. When substance abuse is a primary contributing factor to child maltreatment, little change in the home situation can be expected until the substance abuse problem has been dealt with and resolved. Additional information about self-help programs, pharmacological interventions, and multi-faceted approaches can be found in the Field Guide to Child Welfare.
Substance Abuse Resources for Professionals

Child Welfare Information Gateway has reorganized and substantially updated the Substance Abuse section of its website. Designed for child welfare, substance abuse, and other related professionals working with children, youth, and families affected by substance abuse, the section provides an overview of the impact of substance abuse on child welfare, resources for families, and information on the following topics:

- Prevention
- Assessment
- Casework practice
- Treatment services
- Cross-system collaboration
- Drugs of particular concern

Visit the updated section at www.childwelfare.gov/systemwide/service_array/substance
References


FACT SHEET:

Mental Health Concerns

The following information is adapted from the Field Guide to Child Welfare (Rycus and Hughes, 1998.)

**Depression**

A depressed parent may not have the emotional energy to attend to the children's needs. Depressed feelings and behaviors may be situational, of relatively recent origin, and may be in response to a traumatic loss. Clinical depression is more chronic, normally long standing, less related to situational causes, and often has a physiological basis. Depression can also result from taking certain medications, including those for treatment of high blood pressure. Depression can also occur post partum. Some people who experience depression with psychotic features such as delusions. Depression can lead some individuals to commit suicide.

**Specific Age, Gender, Cultural Features**

The core symptoms are the same between children and adults. However, certain symptoms such as somatic complaints, irritability, social withdrawal are particularly common in children; psycho-motor retardation, hypersomnia, and delusions are less common in pre-puberty than in adolescence an adulthood.

Studies indicate that major depression occurs twice as often in women as in men. Some women experience depression for a few days following the beginning of menses. Some women experience post-partum depression, usually within four weeks of the birth of the baby. The presence of delusions about the baby can result in the mother harming the baby. Women with post-partum depression often have severe anxiety and even panic attacks.

There are cultural differences in how depression is experienced and described. In some cultures, depression may be expressed in mostly somatic complaints, rather than feelings of sadness or guilt. For example, there may be complaints of “nerves” or headaches in Latino and Mediterranean cultures, weakness, tiredness or “imbalance” in Chinese and Asian cultures, or problems of the “heart” (in Middle Eastern cultures), or of being “heartbroken” in the Hopi (American Indian) culture.
**Diagnostic Indicators: Major Depression**

Symptoms include the following, which occur most of the day, nearly every day, for at least a two-week period.

*Mood:* depressed mood, including feeling sad, empty, tearful, hopeless and helpless either by self-report or observation by others, often expressed in adolescents as "I'm bored";

*Loss of interest in activities:* markedly diminished interest or pleasure in all, or almost all, activities;

*Motivation:* general apathy, decrease in school or work performance, reduced attendance at school, failure to complete school or work assignments;

*Eating patterns:* significant weight loss when not dieting; weight gain; or, change in appetite;

*Sleep patterns:* regular insomnia (inability to sleep) or hypersomnia (sleeps all the time);

*Activity level:* agitation and restlessness, or slow, lethargic motor activity; fatigue or loss of energy;

*Feelings about self:* feelings of worthlessness, or excessive or inappropriate guilt, such as, "I can't do anything right," "I'm so stupid";

*Concentration:* diminished ability to think or concentrate; indecisiveness; children may daydream at school or show a decrease in attentive behavior

*Suicidal thoughts:* recurrent thoughts of death, recurrent suicidal thoughts without a specific plan, a suicide attempt, or a plan to commit suicide. Verbalizations may include: "I'd be better off dead," "I should just 'off' myself," "I'm so stupid."

**Treatment**

A variety of medications are used to treat depression. It is sometimes difficult to determine the optimal medications and dosages for some people, especially adolescents. Some medications do not take effect for approximately three weeks. Some individuals may become frustrated with this and should be encouraged to continue the medication as specified by the prescribing physician.
Some people are not helped by medication. A knowledgeable physician should monitor medication at least monthly.

Mental health counseling is usually also necessary to treat depression. The therapy may focus on a variety of issues, such as coping with the depression, and resolving emotional, social or life situations that may have contributed to the depression. Parents should be involved in therapy to understand and help the child or adolescent who has depression or bi-polar disorders, and to deal with the resulting difficult behaviors.

Individuals who show any signs of suicidal thoughts, such as talking about suicide, saying goodbye to friends and loved ones, or giving away possessions, should be seen immediately by a mental health professional to ascertain the risk of suicide and determine whether psychiatric hospitalization is necessary.

**Bipolar Disorders**

Bipolar disorders (sometimes called manic-depressive disorder) combine manic and depressive behaviors. The cycling between manic and depressive behaviors can be quite lengthy, with several months of each type of episode or rapid cycling, with only hours of each type of episode.

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood
- Inflated self-esteem
- Grandiosity
- Decreased need for sleep
- More talkative than usual
- The subjective experience that the individual’s thoughts are racing
- Distractibility
- Significant increase in goal-directed activity
- Excessive involvement in pleasurable activities that have a high potential for painful consequences

Adolescents who experience manic episodes are more likely than adults to include psychotic features. Adolescents in manic episodes may engage in antisocial behavior (including aggression), school truancy, school failure, or substance abuse.
Assessment Interviewing Questions

Specific interviewing questions can be developed by formulating specific questions for each diagnostic criteria. Similar questions can be used when interviewing collateral contacts, or when interviewing a parent regarding his/her child. It is often helpful to ask the client to rate the degree of severity or frequency of the symptom (scaling questions). For example, 0 indicates no problem, 1 indicates a mild problem with severity or frequency, 2 indicates a moderate severity or frequency, 3 indicates extreme severity or frequency. In general, open-ended questions are preferred, as that allows the individual to explain whatever is troubling him. However, some clients, especially children, are not able to respond to open-ended questions, and require more specific questions in order to communicate with the worker.

The following are suggestions. Each worker should adapt these to the situation, the developmental level of the person being interviewed, and the worker’s style.

Questions regarding depression

"Do you ever feel sad? If so, how often? How bad are these feelings?" 
"Do you ever have thoughts about killing yourself? If so, have you thought of how you might do this?" (Usually, having a specific plan and the means to carry out the plan indicates a higher risk of suicide. However, any thoughts of suicide should be taken seriously, and a mental health practitioner should see the person.)

"How do you feel about yourself?"
"How do you feel about the future? Or, Do you ever feel as if there is no hope for you?"
"Do you find that you have less interest in activities that used to interest you?"
"Do you find that you have trouble concentrating?"
"Is it hard to get motivated?" Or, "Is it hard to get things done?"
"Are there any changes in your sleep patterns?"
"Are there any changes in your eating habits?"
"What about your activity level? Do you feel tired, restless, agitated?"

Questions regarding manic episodes

"How is your mood?"
"Is your activity level unusually high?"
"Do you find that you don't need as much sleep as you usually do?"
"How do you feel about yourself?"

"Do you ever feel irritable?"
"Do you find yourself thinking that you can anything, that anything is possible?"
"Does it seem like your thoughts are racing, and you can't slow them down?"
"Are you more talkative than usual?"
"Are you more distractible than usual?"
"Do you find that you must participate in activities that bring you pleasure, regardless of the consequences?"

**Borderline Personality Disorder**

“Parents who have personality disorder display dysfunctional patterns of behavior in all aspects of their lives.” (Rycus, 1998 Vol II). A large number (but not all) individuals with borderline personality disorder (BPD) were abused or neglected as children. Borderline Personality Disorder is a contributor to child abuse and neglect. People with borderline personality disorder have considerable difficulty in the following areas:

**Interpersonal Relationships**

Individuals with Borderline Personality Disorder have considerable difficulty forming and maintaining interpersonal relationships. “They fluctuate quickly between idealizing and clinging to another individual and devaluing and opposing that individual.” (Sperry, 2003) They may develop relationships very quickly and intensely; however, these relationships are often shallow and unstable. Adults may have a long series of short term romantic relationships.

They have an extraordinary fear of rejection and will make frantic efforts to avoid real or imagined abandonment. For example, they may engage in indiscriminate sexual affairs, they may have considerable difficulty allowing their teenaged children to become independent, and they may depend on their children to meet their needs for love and affection.

Casework with persons with BPD is often marked with significant difficulty in balancing a supportive/facilitative role with appropriate authority. Clients with BPD may be extremely demanding of caseworkers for attention and services. They may create some type of crisis to avoid closing the child protective services case in order to keep the caseworker involved in his/her life.

Relationships between children and parents who have BPD are often disturbed, because children are not equipped to cope with the emotional neediness and fluctuations of intense mood.
**Behavior**

People with Borderline Personality Disorder are impulsive and engage in self-damaging acts suicide gestures, self mutilation, have difficulty controlling their anger, and often provoke fights. They often work in jobs that are less than their intelligence and ability would warrant and may change jobs frequently.

**Emotional Functioning**

They often have marked mood shifts and frequently and easily erupt into inappropriate and intense rage, and have difficulty controlling their anger. They may also have feelings of emptiness and boredom.

People with BPD have an external locus of control and usually blame others when things go wrong. Their emotions often fluctuate between hope and despair since they feel powerless to change their circumstances. Additionally, they often rely on manipulation of others to meet their needs, which further contributes to their inability to maintain relationships. They may, for example, make excessive demands of caseworkers.

They tend to have rigid, rapidly fluctuating perceptions of others, as either “all good” or “all bad” and may intensely like someone one minute and intensely dislike them the next. For example, a client with Borderline Personality Disorder may like the caseworker, and emotionally cling to him/her one day (when the caseworker is doing something the person perceives as positive) but claim to hate the caseworker the next day (when the caseworker confronts the person, is unable to immediately meet his/her need, or otherwise frustrates him/her).

**Treatment**

It was once thought that treatment of BPD was largely ineffective. However, recent advances in mental health treatment and in the use of medications have resulted in better prognoses. An accurate differential diagnosis from a psychologist or psychiatrist, and a treatment approach tailored to the individual is critical to treating people with Borderline Personality Disorder.
Johnson Family Round Two
Version A

The worker took Mrs. Johnson and all five children to the children's hospital emergency clinic, where Anna was diagnosed with and hospitalized for treatment of severe pneumonia, and Lissa was admitted to the pediatric unit for observation and assessment for possible failure-to-thrive.

During the hospital visit, the investigation worker talked further with Mrs. Johnson and learned the following.

- Mrs. Johnson's second husband, Ralph, the father of her two younger children, had left her for another woman one year earlier.

- Mrs. Johnson has never worked. She has managed to "get by" on public assistance and some child support from her first husband, Lewis Dawes. She used to earn a few extra dollars a week babysitting for a neighbor, but when the baby was born, she didn't have the energy.

- Mrs. Johnson has no family and few friends in the area. She talks to the neighbor at times, but they are not close. She claims she's been to church in town a few times but doesn't go regularly. She claims she rarely leaves the house except to go to the grocery store.

- Mrs. Johnson is "ashamed" to call her family, who live in another state. This is the second time she has been left by a husband.

- Mrs. Johnson claims that all her children have been sick on and off throughout the winter, but she hasn't taken them to the doctor because "it's such an exhausting trip to spend the whole day at the clinic, and it costs so much."

- Mrs. Johnson has no car. She claims she used to do everything herself by taking the bus, including grocery shopping, laundry, paying bills, and other errands, and she knows her way around the city on public transportation. Since Lissa was born 10 months ago, it's been too much effort. Sometimes she leaves the children home, with Anna watching them, and rides to the store with her neighbor.
• When asked about her own health, the mother indicated it wasn't good. She reported chronic headaches and stated she was without energy. She claimed she was "tired all the time. All I want to do is sleep." She had lost her appetite, and sometimes couldn't think about food. She fed her children "whatever was easy -- it's too much effort to cook." She had seen a doctor six months earlier for a back problem, and "he didn't do anything - just charged me an arm and a leg and told me to take Advil." She did not want to go back to the doctor, stating, "They'll think I'm crazy." After gentle questioning by the worker, she admitted to crying bouts that sometimes lasted for hours at a time. She usually went to bed when it happened and tried to sleep it off. When asked whether she'd mentioned it to anyone, she said no, she was afraid that "they'll lock me up, and then who will care for my children?" She has had these symptoms for almost a year. They began shortly after her husband left, about the time her youngest child was born.

Questions:

1) Based on what Ms. Johnson told you during your brief conversation, what hypotheses can you generate about some of the possible contributing factors and underlying conditions to the neglect of her children?

2) What additional information do you need to collect during the family assessment to further explore these hypotheses? How will you get this information, and from whom?

3) What are the implications for the case plan if your hypotheses are accurate?

4) What could be an alternative hypothesis? How could you check it out?
Johnson Family Round Two
Version B

The worker took the mother and all five of the children to the children's hospital emergency clinic, where Anna was diagnosed with and hospitalized for treatment of severe pneumonia, and Lissa was admitted to the pediatric unit for observation and assessment for possible failure-to-thrive.

During the hospital visit, the investigation worker talked further with Mrs. Johnson and learned the following.

• Mr. Ralph Johnson is the mother's second husband and the father of her two youngest children. She said he was rarely at home. He "works all the time" but doesn't make a lot of money. He often doesn't return from work until very late at night. The mother doubts he's at work all that time, but he won't tell her where he's been. Sometimes she thinks he's been "visiting with his friends" at a bar. When asked by the worker whether that bothers her, Mrs. Johnson said, "I guess not.... he works hard, and he's entitled to some time by himself with his friends."

• Mrs. Johnson had worked prior to her marriage to Mr. Johnson, even though she was parenting three children from her first marriage. When her fourth child, Kayla, was born she had a complicated delivery and developed health problems. She found it impossible to care for four children and also work. Once Lissa was born, it "took so much out of me that I haven't even been able to get my work done around the house, much less work a job." Besides, she said her husband thought it better for her and the children if she stayed home. She has managed to keep her family together on her husband's earnings when he is working.

• Mrs. Johnson has no family and few friends in the area. She talks to the neighbor at times, but they are not close. When she married Mr. Johnson, they moved away from her home community. She would call her family more often, but she said her husband didn't make enough money to cover a lot of long-distance phone calls and he gets upset when the phone bills get too high. He says she doesn't need anyone but him anyway.

• The family attends church together, and she knows a few women at the church well enough to talk to them after services, but she does not see
them at other times. Her husband is very active in the church and "knows a lot of people."

- Mrs. Johnson claims that all her children have been sick on and off throughout the winter, but she hasn't taken them to the doctor because "it's such an exhausting trip to spend the whole day at the clinic, I can't get anything else done, and my husband gets upset if the house is in a mess and dinner isn't ready when he gets home. Besides, medical care is so expensive these days, and we can't really afford it."

- Mrs. Johnson has no car. She stated during her first marriage, she used to do everything herself by taking the bus, including grocery shopping, laundry, paying bills, and other errands, and she knows her way around the city on public transportation. But she feels so overwhelmed now; she is happy to let her husband and her children handle things or let them go altogether. Her husband didn't like her going places without him anyway.

- When asked about her own health, Mrs. Johnson indicated it wasn't good. She reported chronic headaches and stated she was without energy. She claimed she was "tired all the time.. all I want to do is sleep." She had lost her appetite, and sometimes couldn't think about food. She fed her children "whatever was easy -- it's too much effort to cook." She agreed that her children's health was of concern, and she wished she had done more to help them. Her husband often got on her for not being a better wife and mother.

- When asked if her husband was often angry at her, she said, "He gets mad sometimes, but I guess I deserve it. I'm not much of a housekeeper, and I'd be a better mother if I didn't have five children to look after. But he's always concerned about us, and he doesn't mean to hurt me. He took me in when I was alone with three children, and I don't know where I'd be without him."

Questions

1) Based on what Ms. Johnson told you during your brief conversation, what hypotheses can you generate about some of the possible contributing factors to the neglect of her children?
2) What additional information do you need to collect during the family assessment to further explore these hypotheses? How will you get this information, and from whom?

3) What are the implications for the case plan if your hypotheses are accurate?

4) What could be an alternative hypothesis? How could you check it out?
Johnson Family Round Two
Version C

The worker took Mrs. Johnson and all five children to the children's hospital emergency clinic, where Anna was diagnosed with and hospitalized for treatment of severe pneumonia, and Lissa was admitted to the pediatric unit for observation and assessment for possible failure-to-thrive.

During the hospital visit, the investigation worker talked further with Mrs. Johnson and learned the following.

- Mrs. Johnson’s husband, Ralph, the father of her two youngest children, has been "away" for several months. She never knows where he is. He leaves, saying he’s going "looking for work" and may be gone days or weeks at a time. He claims he drives a truck cross-country. He may come back and stay for a while but never for long. Sometimes he leaves her money for the kids. She claimed she never should have married him -- she should have known better, considering she was on the rebound at the time after separating from the father of her first three children.

- Mrs. Johnson says she has worked on and off her whole life, but even though she’s worked a lot of jobs in a lot of different places, has never found any job worth keeping. She estimated the longest she’s stayed at a job was six months. She said she often left jobs because "they treat you like dirt, don’t pay you much, get mad if you don’t do what they say, and can you when you stand up for yourself.” She claims she makes enough money to "get by” and gives her children whatever she can.

- Mrs. Johnson said she knew her kids had runny noses and such, but "so do all kids, especially in winter, and my kids aren't any sicker than anyone else's kids.” She said Anna should have told her how bad she felt. She had no idea Lissa had any problems. She thought she was just a quiet baby who didn't demand much.

- Mrs. Johnson says she sleeps because she’s always tired. Sometimes the stress gets so great she can’t settle down, so she takes some pills her doctor gave her that make her really sleepy and then she doesn’t wake up until the middle of the next day. She said Anna is very responsible and can be trusted to look after the younger ones while she sleeps.
• Mrs. Johnson says she has a lot of family, but she never knows whether they’ll help her or not when she needs it. Her sister and mother, especially, get mad at her and think she’s a "really terrible mother." She said, "My mother raised three and my sister only has one -- they just don’t get what it’s like having five children."

• Mrs. Johnson said Lissa was "an accident." She never planned to get pregnant again. Her husband had been gone for many weeks, and she just got so bored and lonely sitting at home, she went "out on the town" with some girlfriends one night and ended up going home with her girlfriend’s brother, who was home on leave from the Army. "Next thing I know, I’m pregnant. I honestly don’t even remember it happening, but it must have. Babies don’t just happen, you know." The brother has gone back to active military duty and claims it’s totally impossible for him to be the father of Mrs. Johnson’s child.

• Mrs. Johnson claims she generally takes good care of her children, and has no idea why the baby would be so sick. She attributed Anna’s pneumonia as "an oversight - I thought it was just a cold."

Questions:

1) Based on what Ms. Johnson told you during your brief conversation, what hypotheses can you generate about the contributing factors to the neglect of her children?

2) What additional information do you need to collect during the family assessment to further explore these hypotheses, how will you get this information, and from whom?

3) What are the implications for the case plan if your hypotheses are accurate?

4) What could be an alternative hypothesis? How could you check it out?
**DESCRIPTIVE LANGUAGE**

For each vague phrase, write a specific example of the phrase in clear, behavioral terms.

<table>
<thead>
<tr>
<th>VAGUE PHRASE</th>
<th>BEHAVIORAL EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has poor peer relations</td>
<td>Physically fights with classmates on the playground during recess</td>
</tr>
<tr>
<td>2. Lacks supervision</td>
<td></td>
</tr>
<tr>
<td>3. Is uncooperative</td>
<td></td>
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<tr>
<td>4. Parents inappropriately</td>
<td></td>
</tr>
<tr>
<td>5. Neglects child</td>
<td></td>
</tr>
<tr>
<td>6. Fails to protect</td>
<td></td>
</tr>
<tr>
<td>7. Has poor self-esteem</td>
<td></td>
</tr>
</tbody>
</table>

**BONUS:**

8. Identify a vague phrase used in your agency
“Phuzzy Phrases”

Please provide a clearer, more specific example of each of the following phrases. Also decide if the phrase you write is an Objective or an Activity.

Mr. Walker will be involved with his child.

Mrs. Graef will discipline her children appropriately.

Mr. Donner needs to go to counseling.

The worker will provide services as needed.

Mr. Chan needs to find an apartment.

Ms. White will learn about childcare in her neighborhood.

The worker will help Mrs. Baker as appropriate.

Mrs. Quill will not drink.

Mr. Johnson will understand good parenting.

Mr. Lopez needs to improve his temper.
Johnson Family Round Three  
Version A

The Johnson case was opened for service and transferred to an ongoing service worker. Anna was treated with antibiotics and released to Mrs. Johnson with instructions for a return visit within a week. Lissa remained hospitalized for severe dehydration, anemia, and developmental delay. She was expected to be in the hospital for a few weeks before the cause and full extent of her physical and developmental problems could be determined. The ongoing services worker met with Mrs. Johnson to begin the family assessment and also talked with several collateral contacts to gather the following information.

- Mrs. Johnson married her first husband, Lewis Dawes, when she was 16. She gave birth to three children, Anna, Todd, and Raymond, in four years. Mr. Dawes left her shortly after Raymond was born, leaving her with no dependable source of support. She eventually was given a small child support subsidy. She moved in with a friend to reduce her expenses and almost immediately became involved with a man, Ralph Johnson, who lived in the neighborhood. She got pregnant and they were married two months later. They were together for five years, until Mrs. Johnson got pregnant with the youngest baby. Mr. Johnson became more and more distant, and right after the baby was born, he filed for divorce and moved in with a young woman who was the receptionist at the garage where he worked. Mrs. Johnson doesn’t know the current whereabouts of her first husband. Mr. Johnson still works at the same garage but won’t have anything to do with her. He claims there’s no way Lissa is his. Mrs. Johnson claims it’s because he doesn’t want the responsibility of child support.

- Mrs. Johnson states her childhood was "OK -- we were really poor and I was the third of 12 children, so my mother was pretty busy with the younger kids. All I ever did was housework and babysitting. I quit school in 8th grade to help take care of the younger kids. That was one of the reasons I got married and left home at 16 - I thought I’d be free of the hassle. Looks like I’m following in my mother’s footsteps."

- Mrs. Johnson was ashamed and embarrassed to let her family know how much difficulty she was having, but she eventually agreed to let the caseworker contact them and see if they could offer her any help, although she doubted they’d be able to, since none of them had much money.
• Mrs. Johnson's mother, Mrs. Peters, was appalled to learn of her daughter's situation, but because she herself was a single parent, had very limited income, had her own serious health problems, and was caring for several minor children still at home, she couldn't do much more for her daughter. She said she'd see if any of the aunts and uncles might be able to help. She offered to have Mrs. Johnson move back home with her and her other children, even though "it'd be mighty crowded, with six more people in the house. We barely have any room as it is, but I guess we'd manage if we had to."

• Mrs. Peters said her daughter had always been "a little odd" in her behavior and seemed to be prone to long periods of sadness and daydreaming. She remembered one time when Mrs. Johnson was 18, just after Todd was born, when she quit talking to anyone and didn't go out of her house for about six months. Then she just seemed to "come out of it" and went around like nothing had happened. When the worker asked Mrs. Johnson about this, she acknowledged she had "spells" all her life. It was like someone had stuck a pin in her and let out all the air. She just didn't have the energy to do anything but sleep. She had been feeling this way ever since her baby had been born and her husband left, but this time she just couldn't seem to "shake it off."

• When questioned about her children's care, Mrs. Johnson seemed to know the rudiments of child care, but seemed very surprised that Lissa was sick at all and particularly sick enough to be admitted to the hospital. She said she had no idea - she thought all babies spent a lot of time in their cribs, even though this baby was "quieter than my others." She couldn't tell the worker when Lissa had last been fed. "I feed her when she seems hungry -- but she doesn't eat a lot. She's different from my others -- she acts like she doesn't want to be held or anything. Doesn't want me bothering her. I figured she was just happier being left alone." She wasn't aware that Kayla "cried all the time" at school. She said Kayla was "always a little more touchy than the others, but I didn't think it was anything." She seemed distressed and embarrassed that her children were having such difficulty.

• Mrs. Johnson claimed she really loved her children, even though they were generally quite a lot of work. The worker observed only fleeting attentiveness to their needs. Often, the children had to shake and yell at
their mother to get her attention. Mrs. Johnson rarely initiated interaction with the children, except to ask them to do something for her. In isolated moments, the worker observed her watching one of them, smiling quietly to herself.

Questions

1) What has this additional information told you about the possible causes of neglect in this family? Do you need to revise your hypothesis?

2) Do you need any additional information to begin development of a case plan? How would you get this information?

3) Based on the information currently available, what would you identify as the family’s needs and strengths?

4) Identify the case goal.

5) Develop three objectives and activities for a case plan, based on the family’s needs as identified from the assessment.
Anna was treated with antibiotics and released to Mrs. Johnson with instructions for a return visit within a week. Lissa remained hospitalized for severe dehydration, anemia, and developmental delay. She was expected to be in the hospital for a few weeks before the cause and full extent of her physical and developmental problems could be determined.

The next morning, Mr. Johnson called the intake supervisor to demand a meeting to determine why his baby daughter was being held in the hospital, when she could be cared for just as well -- probably better -- at home. The intake supervisor told him the baby was extremely ill, the case was being transferred, and an ongoing service worker would meet with him very soon.

The Johnson case was opened for service and transferred to an ongoing service worker. The ongoing services worker scheduled an appointment to meet Mr. and Mrs. Johnson to begin the family assessment. During the course of the assessment the worker talked with both parents and several collateral contacts to gather the following information.

- When the worker made the assessment home visit, Mr. Johnson opened discussion by making it clear that the family was doing just fine, and there was no need for children's services to be involved. He would see to it that both his children continued to get the medical attention they needed -- immediately, and the agency could close the case. When the worker suggested the other three children were showing developmental and emotional problems as well, he indicated he would follow up and make sure they got the help they needed.

- Mr. Johnson claimed his wife had been "ill" on and off during their marriage, and that while it certainly took its toll on him and their children, there was nothing more to be done. She worked hard and had a lot to do, with five children to care for. Child care wasn't easy these days with everything being so expensive.

- Mr. Johnson believed himself to be an excellent and attentive father and husband. He was very involved in his family -- he looked after his children and his wife, and made sure they got what they needed. He took them to church regularly and played with the children on weekends when
he wasn't working. He helped his older children with their homework. When asked why the children didn't have proper clothing or medical care, he said that work had been inconsistent lately, and even though he was trying hard, he wasn't bringing home very much money, and they couldn't afford things other families could. But, they did very well on what little money they had, and he fully expected "things will turn around soon."

- Mr. Johnson blamed the inconsistency of work on a bad economy and job market. When asked whether his wife might help out by working, he stated that was a really bad idea -- how could she possibly work when they had five children who needed her at home?

- Mrs. Johnson was quiet during much of this interview. When asked a direct question, she looked to her husband to help her answer and often deferred to him.

- Mr. Johnson said he had never been married before meeting Mrs. Johnson. When he met her, he was 35 and she was 20. He said she had really needed help -- she was alone with three young children, and had no source of support, and she should be grateful that he was willing to take them all under his wing without protest. "She'd be living on the streets if it weren't for me." Mrs. Johnson nodded in agreement.

- The worker did a follow-up interview with Mrs. Johnson while her husband was at work. Mrs. Johnson was nervous about the circumstances, suggesting the worker come back at some time when her husband was home, but she was willing to answer questions when asked. She volunteered very little additional information.

- Mrs. Johnson was one of five girls born to her parents within a seven year period. Her parents were both factory workers, and they lived in another state until her father's death of a heart attack at age 49. Her mother then moved to Florida. She said her father was a pretty good provider, but he drank a lot and "wasn't always very nice" to the family. When pressed, Mrs. Johnson said he was verbally abusive and sometimes "slapped her mother around." She remembered a few times that her mother took the children and went to stay with her grandmother, but she always reconciled with her husband in a few days. She said her father yelled at her a lot but had never hit her.
• Mrs. Johnson strongly denied that Mr. Johnson ever laid a hand on her or any of her children.

Questions

1) What has this additional information told you about the possible causes of neglect in this family? Do you need to revise your hypothesis?

2) Do you need any additional information to begin development of a case plan? How would you get this information?

3) Based on the information currently available, what would you identify as the family's needs and strengths?

4) Identify the case goal.

5) Develop three objectives and activities for a case plan, based on the family's needs as identified from the assessment.
Johnson Family Round Three  
Version C

The Johnson case was opened for service and transferred to an ongoing service worker. Anna was treated with antibiotics and released to Mrs. Johnson’s care with instructions for a return visit in one week. Lissa remained hospitalized for severe dehydration, anemia, and developmental delay. She was expected to be in the hospital for a few weeks before the cause and full extent of her physical and developmental problems could be determined. The ongoing services worker met with Mrs. Johnson to begin the family assessment and also talked with several collateral contacts to gather the following information.

- Mrs. Johnson is one of six children. Her family still lives in the area. She lived with her mother until she was 3 years old, and then all six of the children were placed into foster care because of neglect. She remembers being in and out of foster care until she was 12, when she was returned to her mother. At age 15, she ran away and never went home again. She moved in with her boyfriend when she was 16 and he was 18, and they had three children in four years. They lived together on and off for several years before they split up. Mrs. Johnson said he "went downhill fast" after they split and is now in jail for drug dealing and armed robbery.

- Mrs. Johnson was very concerned that the agency might be thinking about foster care for her children, and said she’d get a lawyer and fight if that’s what the agency was thinking. She’d had enough of foster care in her own life – and she wasn’t going to let any child of hers experience what she had. When pressed, she said she had been physically beaten by one foster mother, and repeatedly fondled and eventually “forced to have sex” by the teenage boy who lived next door to the foster family when she was 11. She claimed she reported this to her foster mother, but nobody believed her.

- Mrs. Johnson said she has lots of friends. They meet in dance clubs around the city. Sometimes they go to each others’ houses and "party till the cows come home." But she said she always leaves her children in the care of the woman who lives down the hall, a grandmotherly woman who does child care as her primary means of support.

- School personnel indicated that Mrs. Johnson rarely returned phone calls and almost never came to the school. Once Ms. Johnson appeared at a
school function and appeared to have been drinking, as she smelled of
alcohol and was slurring her words.

• When asked about her use of pills, Mrs. Johnson said they were sedatives
because she had a hard time sleeping, and she drank on occasion, but not
all the time. She denied using any other drugs. She admitted drinking
beer and wine but never to the point of being drunk.

Questions

1) What has this additional information told you about the possible causes of
neglect in this family? Do you need to revise your hypothesis?

2) Do you need any additional information to begin development of a case
plan? How would you get this information?

3) Based on the information currently available, what would you identify as
the family’s needs and strengths?

4) Identify the case goal.

5) Develop three objectives and activities for a case plan, based on the
family’s needs as identified from the assessment.
Full Disclosure Conversation Regarding Supplemental Planning

**Purpose**

The purpose of open communication regarding supplemental planning is to inform families about the supplemental planning process and the agency’s commitment to permanency for children. This process respects the parents’ rights to have information about their children and is consistent with the philosophy of family-centered practice.

The full disclosure conversation should occur fairly early in working with the family. This provides the family with full information about the agency’s policies and procedures on this matter. Having the conversation early also allows the worker to gain information about possible relative or kin placement should the family disengage from the casework relationship.

Many agencies have specific policies and procedures regarding supplemental planning, including when to have this conversation with families and what must be discussed. You should learn about and follow your agency’s policy and procedures.

**Content to be included in the conversation**

The conversation with the parent regarding supplemental planning should include the following:

- Inform the parent of the agency’s commitment to permanency and safety for all children. Inform the parent that the uncertainty of long term foster care is not good for children. Children need stable, secure, permanent homes in order to develop properly.

- Inform the parent you are committed to reunification and will only seek termination of parental rights if all efforts to reunify fail.

- Inform the parent of federal and state laws requiring child welfare agencies to provide permanent homes for children in a timely manner. State law requires that the agency file for termination of parental rights when the child has been in placement 12 of the last 22 months. The only exceptions are if the agency has not been able to provide the services needed by the family to resolve the problems that led to placement, or if it is not in the child’s best interest to have parental rights terminated.
• Ask the parent to help you identify the most appropriate permanent home for his/her child(ren). This could be a relative or kin home. The parent should also be asked to identify any relative or kin homes that would be inappropriate for the child. For example, there could be a relative who has a history of maltreating other children.

• Inform the parent of the process you would use to find a permanent home. This would include asking relatives if they could provide a home for the child, conducting home studies of those relatives, etc. This would, of course, include a continued effort to locate and consider a non-custodial parent. Inform the parent that you will consider their recommendations about appropriate relative or kin placements for the child.

**Strategies**

One of the major challenges for workers is their own anxiety about conducting this conversation. This is a delicate subject to discuss and requires considerable finesse from the worker. The following ideas may help with this conversation:

• Many parents are probably already worried about whether their children will be removed permanently. Openly discussing it may be a relief.

• Most parents, whether or not they are involved with child protection, have thought about designating a guardian for their children (informally or through wills) in case something should happen to them. This is a right and a responsibility and is an integral part of supplemental planning.

• Remind parents that planning for a permanent home for the child demonstrates considerable love, concern, and responsibility for the future well being of the child.

• Remind parents that you will file for termination of parental rights only if they are not able to provide a safe home for the child.

**Worker Safety**

Carefully consider whether the parent may react violently to this conversation. Discuss this issue with your supervisor. If you believe that your safety may be compromised, make appropriate arrangements. For example, you may need to have this conversation at the office, with a supervisor or security guard available who can handle any problems that may occur.
Johnson Family Round Four
Version A

Two weeks later, Laura summarized all she had learned from collateral contacts and from follow-up assessments of both Mrs. Johnson and the children. At the caseworker’s request, the entire family was evaluated at the community mental health center, as a family and individually.

- Mrs. Johnson had been diagnosed with severe depression. It appeared she had chronic depression that appeared to be exacerbated both after childbirth and by significant losses, such as the loss of her husband. The therapist indicated both medication and supportive therapy were indicated, and referred her to a psychiatrist to be evaluated for medication.

- The baby, Lissa was diagnosed with failure to thrive. In the hospital, with proper nutrition and focused attention, she gained weight rapidly and began to display more interest in her environment. The pediatrician noted she was still quite developmentally delayed, but would not venture a long-term diagnosis. He recommended a very stimulating and nurturing environment and special care for several months, during which time it would be determined whether Lissa’s delays were from organic causes or the result of neglect, and whether, in a stimulating environment, she would catch up.

- Mrs. Johnson visited with Lissa in the hospital, but interacted with the baby only in a superficial manner, even when the nursing staff tried to get Mrs. Johnson to hold, feed, and cuddle her.

- Todd was diagnosed with attention deficit disorder with hyperactivity, complicated by what appeared to be an underlying anxiety disorder. He was approximately three years behind in his developmental age. He was referred to a psychologist for further assessment, and to a psychiatrist to determine whether medication would help him.

- Anna and Kayla were both diagnosed with mild depression, and both girls were in the low-normal developmental range.

- Raymond was developmentally delayed in all domains but showed no significant emotional problems.
Mr. Johnson was contacted and explained that four of Mrs. Johnson's children were definitely not his, and while Kayla was born while they were married, he felt sure she wasn't his child either. He claimed Mrs. Johnson was always "too tired to have sex" and when Kayla was conceived, he hadn't "been with her" for months. He was initially resistive to taking a paternity test, and said he would think about it.

Mrs. Johnson knew of no one who could provide a temporary home for Lissa, and preferred that the agency find a foster home for the baby. Laura put in a request for a home that cared for infants with special developmental needs.

Questions

1) Considering the extent of Mrs. Johnson's depression, how would you engage and involve her in the development of a case plan?

2) Based on the additional information you have just been given, complete or revise your case objectives, activities, and time frames for the family's case plan.

3) What kinds of services would you recommend for each of the children?

4) Because Lissa is being placed in a foster home for an indefinite period of time, explain how you would engage Mrs. Johnson in developing a supplemental plan for Lissa, and what would be its terms? What permanent options might be available for Lissa? How would these affect the four other children?

5) What strategies would you include in your plan to assure continued contact between Lissa and the rest of her family?

6) Under what, if any, circumstances would you consider out-of-home placement for the other four children?

7) If you were developing a reunification plan for Lissa, what would be its terms and conditions?
Johnson Family Round Four  
Version B

Two weeks later, Laura summarized all she had learned from collateral contacts and from follow-up assessments of both Mrs. Johnson and the children.

- Laura had referred the family to the community mental health center for evaluation. In spite of having agreed to go, the family members did not keep their appointment. Laura called Mrs. Johnson to reschedule, and the family failed a second appointment, as well.

- The physicians at Children’s Hospital diagnosed Lissa with failure to thrive. In the hospital with proper nutrition and focused attention, she began to gain weight and to display more interest in her environment. Further, an unusual bend in her left arm had prompted full-body x-rays, which showed an old, healed fracture of her upper left arm, the nature of which suggested abuse. The pediatrician noted she was significantly developmentally delayed, but he would not venture a long-term diagnosis. Because of the need for a protected, stimulating, and nurturing environment, the pediatrician recommended out-of-home placement until the cause of the abuse and developmental delays could be determined, and Lissa’s condition could be further assessed.

- The caseworker insisted that the four other children be thoroughly examined and interviewed in the children’s hospital abuse unit, and she transported Mrs. Johnson and the children to this appointment. Mr. Johnson refused to go and threatened to prevent his family from going. When told he had a choice of letting them go voluntarily or being forced to by court order, he agreed to the appointment but refused to go himself.

- Anna and Kayla were diagnosed with anxiety and depression, but no significant developmental delays. Todd was identified as having ADHD and was also found to have several old scars on his neck, shoulders and back. There were no recent cuts, bruises, or abrasions. He said a couple times when he had been really bad, his father had "whooped him" with a switch. Raymond showed delays in all domains, and was functioning below normal for his age. Anna, Kayla, and Raymond showed no signs of abuse and none admitted to ever having been abused.
• Anna told the pediatrician that she didn't like hospitals. She said her mother had gone to the hospital a few months back with a broken arm and a black eye. She said her mother told her she had fallen down the stairs. She wore "a cast and sunglasses.. even in the house" for several weeks, and Anna had to help with the housework. When the worker asked Mrs. Johnson about this, she confirmed she had tripped, fallen down the stairs, and hit her head on the banister, and berated herself for being so clumsy.

• Mr. Johnson's employer confirmed his employment, and indicated that in general, Mr. Johnson was a reliable employee. The company was having financial problems, and work was sporadic. The pastor at the Johnson's church said the Johnsons attended regularly and seemed like a really nice family, although there were times Mrs. Johnson seemed withdrawn and sad. With the exception of Todd, who was "a handful," the children were generally well-behaved. The pastor had never seen the baby, and in fact, was unaware the Johnson's had a fifth child.

• A screen of Mr. Johnson's police record indicated several traffic violations, one old arrest for DUI which resulted in a 6 month suspension of his license, and one old incident of involvement in a bar brawl. There were no felony convictions. There were, however, several restraining orders that had been filed against him by his prior girlfriend, who had alleged that he had threatened to kill her.

• In a phone call to Mrs. Johnson's mother, the worker learned that nobody in the extended family knew much about Mr. Johnson. They rarely saw him, he had never talked about his own family or background, and Mrs. Johnson had told them very little.

Questions

1) How would you handle the suspicion of abuse of both Todd and Lissa, and the possibility that Mrs. Johnson's injuries and behaviors may indicate spousal abuse?

2) Considering the extent of Mr. Johnson's resistance and Mrs. Johnson's passivity, how would you engage and involve them in the development of
a case plan for their family? What would you do if either one cannot be engaged?

3) Based on the additional information you have just been given, complete or revise your case objectives, activities, and time frames for the family’s case plan.

4) What kinds of services would you recommend for each of the children? For Mrs. Johnson? For Mr. Johnson?

5) Because Lissa is being placed in a foster home for an indefinite period of time, explain how you would engage Mr. and Mrs. Johnson in developing a supplemental plan for Lissa, and what its terms would be? What permanent options might be available for Lissa? How would these affect the four other children?

6) Under what, if any, circumstances would you consider out-of-home placement for the other four children?

7) If you were developing a reunification plan for Lissa, what would be its terms and conditions?
Johnson Family Round Four  
Version C

Two weeks later, Laura summarized all she had learned from collateral contacts and from follow-up assessments of both Mrs. Johnson and the children. She tried to locate Mr. Johnson and was unsuccessful. At the caseworker's request both Mrs. Johnson and the children were evaluated at the community mental health center.

- Mrs. Johnson agreed to be seen for a psychological assessment and drug screening. She did not have any mental illness or serious emotional problems but did have a low-normal IQ and indications of borderline personality disorder.

- The drug and alcohol screening indicated significant recreational drug use but no obvious addiction. The drug counselor was concerned, however, that Ms. Johnson's use of drugs was impacting her care of the children and brought this to her attention during the counseling.

- The baby, Lissa, was diagnosed with failure to thrive. In the hospital, with proper nutrition and focused attention, she gained weight rapidly and began to display more interest in her environment. The pediatrician noted she was still quite developmentally delayed but would not venture a long-term diagnosis. He recommended a very stimulating and nurturing environment and special care for several months, during which time it would be determined whether Lissa's delays were from organic causes or the result of neglect, and whether, in a stimulating environment, she would catch up.

- Mrs. Johnson visited with Lissa in the hospital daily for several days, did what she was asked by the nurses, and seemed very eager to help. Then she failed to visit for four consecutive days. When she returned, she told the hospital staff she had been "out looking for work."

- Todd was diagnosed with attention deficit disorder with hyperactivity, complicated by what appeared to be an underlying anxiety disorder. He was approximately three years behind in his developmental age. He was referred to a psychologist for further assessment and to a psychiatrist to determine whether medication would help him.
Raymond was developmentally delayed in all domains but showed no significant emotional problems.

Anna and Kayla were both diagnosed with depression and anxiety, and both girls were in the low-normal developmental range.

Anna told the therapist who evaluated her that her mom didn't take very good care of her, and she felt a lot of times she was the mom in the family, not her mother. She also didn't like all her mom’s boyfriends. Sometimes they had loud arguments, and sometimes it sounded like her mom was being hurt really bad because Anna heard her crying and moaning all night. One of the boyfriends kept coming into her bedroom at night and woke her up. Anna said he didn't come around much any more. She denied having ever been touched or fondled. She said she really liked Mrs. Andrews, the neighbor. She called her "Grandma" and liked staying at her house, because Grandma looked after her and made her cookies.

Mrs. Johnson wasn't happy about Lissa's placement in a foster home, but she couldn't offer any suggestions about someone in her family to care for Lissa. She said she was willing to do "whatever was best for Lissa."

Questions

1) Considering the extent of Mrs. Johnson's erratic and inconsistent behavior, how would you engage and involve her in the development of a case plan?

2) Based on the additional information you have just been given, complete or revise your case objectives, activities, and time frames for the family's case plan.

3) What kinds of services would you recommend for each of the children?

4) Because Lissa is being placed in a foster home for an indefinite period of time, explain how you would engage Mrs. Johnson in developing a supplemental plan for Lissa, and what would be its terms? What permanent options might be available for Lissa? How would these affect the four other children?
5) What strategies would you include in your plan to assure continued contact between Lissa and the rest of her family?

6) Under what, if any, circumstances would you consider out-of-home placement for the other four children?

7) If you were developing a reunification plan for Lissa, what would be its terms and conditions?