Skill Sets and Competencies

Skill Set: Basic understanding of the kinds of problems in primary families that result in children being placed, and the importance of those families to children in care.

- Aware of the possible reasons children need placement.

- Aware of the emotional and social outcomes for children who do not have contact with their primary families. Aware of the importance of helping children have positive relationships with their primary families.

- Familiar with the types of problems that can contribute to abuse and neglect of children and teens. Aware of the types of family resources and strengths that can reduce the likelihood of maltreatment.

- Aware of the importance of supporting children’s positive feelings and memories about their primary family members.

- Aware of the grief process parents experience when their children are placed in care. Aware of behaviors that indicate grieving.

- Aware of the importance of involving primary families in case planning, daily decision-making, and other activities to help the child return home.
Handout #1

Benefits and Challenges

Benefits that are likely to result when birth families and foster, adoptive, or kinship families work together in a collaborative manner:

- Separation trauma and anxiety are greatly reduced.
- Continuity of care and attachments are maintained for the child in care.
- Planning and implementing visits are simplified, making it possible to visit more frequently, and helping to assure more productive visits.
- Reunification can occur more quickly, or an alternative plan for permanence can be made in a timelier manner.
- The birth family can use the caregiving family as a role model and can be mentored to make changes that enhance their personal development and parenting skills.
- When the two families work collaboratively, loyalty issues for the child are reduced, and the child is less likely to create divisiveness and resentment between the two families.
- Caregiving families can maintain contact with the child after reunification, which prevents additional separation trauma.
- Caregivers can become a permanent support system for the child and family.

Challenges that are likely to result when birth families and foster, adoptive, or kinship families work together in a collaborative manner.

- Families may have different values, backgrounds, cultures, parenting styles, beliefs, knowledge, and skills. This may create disagreements, particularly on the best means of caring for the child. These disagreements may need to be negotiated before the families can work together successfully.
- The families may not like one another. This may interfere with the establishment of a relationship. In some cases, unresolved disagreements may lead to distance in the relationship.
- The caregiving family may be fearful of birth family members. Some families who have had their children removed may behave in a hostile, sometimes irrational manner. Birth parents may at times have substance abuse problems or mental illness, which may make it difficult to predict their behavior. Parents may have been convicted of serious offenses or
crimes. It may be difficult for caregivers to discern when birth parents are simply acting out their anger or frustration, or are dangerous. This must be fully discussed with the caseworker.

- The birth family's presence may, at times, interfere with the caregiving family's schedule, habits, traditions, or decisions. This may increase the difficulty of caregiving and contribute to disruption.

- The birth family may be jealous of the foster family and may believe the foster family can offer their child more than they can. The family may feel embarrassed and ashamed, and may worry that the children may not want to return home. They may respond by competing with the foster caregivers for the children's attention and affection.
## Handout #2

### Myths and Realities

<table>
<thead>
<tr>
<th>Myth</th>
<th>Reality</th>
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<tbody>
<tr>
<td>Birth parents who abuse, neglect, or relinquish their children do not care about them.</td>
<td>Birth parents do not plan to abuse or neglect children. Maltreatment of children usually occurs following overwhelming stress. Parents who maltreat their children may, in fact, love their children dearly, but may not be able to cope with circumstances or may not know how to parent successfully. Furthermore, parents who voluntarily relinquish their children usually do so with tremendous ambivalence; they do not walk away from these relationships without significant, lifelong grief.</td>
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<tr>
<td>Most birth parents are violent, dangerous people who pose a threat to the foster families caring for their children.</td>
<td>Some birth parents have a history of violence or mental health problems that indicate risk for caregivers. Most birth parents, however, can build a collaborative relationship with foster or kinship parents that can be invaluable in the rapid reunification of the family. When the caseworker or foster parent is unsure about the level of risk posed by a birth family, relationships should be built with deliberate care along a continuum of openness, with the safety of the foster caregivers of paramount concern.</td>
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<tr>
<td>Foster families are expected to function as caseworkers or therapists for birth families.</td>
<td>Foster families may serve in key roles as mentors with birth families. When foster and birth families develop a partnership, this will be part of a total intervention plan developed by the child welfare team. The intervention planning will involve the foster parent and will spell out the expectations for the foster parents, when those interventions will occur, and why they are planned to improve the outcomes for the child.</td>
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<tr>
<td>Myth</td>
<td>Reality</td>
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<tr>
<td>The agency is &quot;setting up&quot; foster families to be hurt by dangerous birth parents.</td>
<td>The agency will not expect foster families to place themselves at risk in working with birth families. The agency will always consider risks when developing a partnering plan for birth and foster families, and foster families will be involved in the development of the plan. Communication between foster and birth families may, at times, need to occur through an agency intermediary, usually the caseworker, to protect the safety of the child and the foster family.</td>
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<tr>
<td>Foster families are expected to work with all birth families of children who come into foster care.</td>
<td>Foster families are expected to communicate with the birth parents of all children. That communication may take many forms, depending on the characteristics of the birth family, the wishes of the foster family, and the stage of the developing relationship between the foster and birth families. Relationships may begin with a journal of the child's progress, move into telephone calls between the birth and foster parents, meetings during supervised visits at the agency, and eventually evolve into unsupervised visits at the foster or birth home prior to reunification.</td>
</tr>
<tr>
<td>Foster parents will be responsible for caring for the birth parents as well as the child.</td>
<td>The role of the foster parent is to provide a safe, temporary home for children who are unable to remain in their birth homes. Foster parents are part of a team whose primary goal is reunification. Visitation and communication are essential to achieving that goal. However, caring for the birth parent is not an expectation of the foster parent; it would actually be counterproductive to the development of adult, responsible behavior by the birth parent.</td>
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Handout #3

**Guidelines to Produce Positive Outcomes for Children and Their Families**

**Respect for one another**--The primary team members must recognize that each member brings individual viewpoints, values, and culture to the team process. The primary care team should seek to utilize diversity to achieve benefits for the child.

**Seek conflict resolution**--The primary care team must be committed to resolving differences of opinion regarding the case plan or intervention strategies. Differences of opinion that do not affect the case plan are irrelevant to the case planning process.

**Permission for honesty**--The primary care team needs to set an atmosphere of honesty with one another regarding case goals and planning. Each member needs to be honest regarding the actual agenda for the case process. There must be freedom for members to explore the meaning of behaviors and words with one another.

**Focus on the best interests of the child**--The primary care team must agree to act in a manner that helps children. The primary care team must keep revisiting what is best for the children.

**Communication**--The primary care team must have established channels of communication that provide information in a timely and efficient manner.

The primary care team should:

- Be committed to using effective methods of communication
- Communicate their expectations through a well-written case plan
- Communicate clearly and document progress through the use of monthly reports
- Use journals that can be passed between the foster parent and the primary family to prevent miscommunication (these journals need to have some structure so they can be useful--materials concerning journaling are available at your local Regional Training Center).

Should the goal of the case plan change, the primary care team continues to plan for the best interest of the child. The actual caregiver may change as in situations of adoption and kinship care, but the primary family can remain involved in the planning process.
Anticipated Behaviors of Parents
Whose Children Come Into Care

Shock or Denial

- The parent acts in a robot-like fashion, and does not display feelings.
- The parent agrees with the agency.
- The parent denies the need for services or evaluations.
- The parent avoids the agency professional or caseworker.
- The parent believes the paramour over the child’s allegations of abuse.

Anger or Protest

- The parent is verbally aggressive to agency caseworker, foster parents, or related professionals, and appears irritable when dealing with the system.
- The parent writes letters to the editor complaining about Children’s Services.
- The parent gets an attorney.
- The parent threatens to sue the agency caseworker or foster parent.
- The parents threaten to hurt the agency caseworker or foster parent.
- The parent tries to get the child to recant, sometimes using threats to the child or others in the primary family.
- The parent tells the child the placement is his or her fault.
- The parent criticizes the way the child is dressed.
- The parent destroys property of the child, foster parent, or agency.
- The parents tell the child not to listen to the foster parent.
- The parent complains about the agency.

Bargaining

- The parent promises to do anything necessary to get the children back.
- The parent promises to stop drinking or using drugs, or to get rid of a perpetrator in order to have the children returned.
- The parent is basically compliant.
- The parent requests more visits in exchange for completing part of the case plan.
- The parent calls the foster home at 2 a.m. to ask the foster parent the time of the visit the following day.
- The parent tells the child that he has to get better grades and do his chores before he can come home.
The parent buys the child elaborate gifts.
• The parent promises unrealistic things to the child upon returning home.
• The parent compares himself to other parents to prove that they are not as bad as the other parents, or makes statements that the foster family does improper things and that they get paid to take care of the children.

**Depression**
(The following are symptoms of depression, whether the depression is caused by grief or other sources, such as chemical imbalances in the brain.)

• The parent forgets appointments or visits.
• The parent acts whiney or helpless.
• The parent exhibits little initiative or ambition.
• The parent sees everything as futile.
• The parent resumes or begins using alcohol or drugs (note: this behavior could appear at other stages).
• The parent seems to have unresolved or undiagnosed “somatic” complaints.
• The parent seems to take unnecessary risks or reverts to earlier harmful patterns of behavior, such as prostitution.
• The parent spends much energy that is misdirected or diffused.
• The parent begins steps to complete tasks but does not complete them.
• The parent seems irritable and may make suicidal gestures.

**Resolution and Acceptance**

• The parent fails to respond to the team after a period of apparent cooperation.
• The parent stops visiting.
• The parent does not show up for court or does not offer defense in court.
• The parent voluntarily moves to a home with too few bedrooms for the children.
• The parent sells the children’s beds or possessions.
• The parent gets pregnant.
• The parent marries someone with children.
• The parent makes statements such as “The children would be better off without me,” or “Look what an adoptive family can offer her.”
Handout #5

Symptoms of Chemical Use Progression

1. **Experimentation**
   - Users learn that chemicals make them feel good.
   - The degree of the good feeling is controlled by the amount of substance the users consume.
   - Users form “friendships” or “love relationships” with the chemical.

2. **Seeking the Mood Swing**
   - Users begin to look forward to the next time they can use.
   - Overall, users’ behavior is still appropriate; there are embarrassing moments but, compared to the high, “it was worth it.”
   - Users may experience a few hangovers.
   - Users would not be overly disappointed if a situation arose in which chemicals were unavailable.
   - If anyone raises concerns about their use, users rationalize the concerns away.

3. **Misuse and Abuse**
   - Users’ tolerance increases (more chemical is needed to feel any positive effects).
   - The emotional price for chemical use is increasing.
   - Users often use to relieve feelings of guilt, fear, and anxiety (originally brought on by chemical use).
   - External consequences often follow an episode of using.
   - Deterioration in many areas of life (socially, physically, intellectually, and spiritually) although the users may not recognize the changes.
   - Users are preoccupied with the next chemical use (may spend more time obtaining, using, and maintaining supply).
   - Users begin to break promises and compromise morals (loss of control begins).
   - Users rationalize use by blaming others, having excuses and alibis, and by being defensive about use.
   - Users believe own excuses “next time will be different.”

4. **Addiction and Chronic Dependency Stage**
   - Users are depressed nearly every day, chemical use no longer makes them feel high.
   - All of the symptoms and feelings in the harmful stage are intensified.
   - Use is necessary to feel normal.
   - Users may have physical problems related to chemical use.
   - Users are emotionally, physically, and spiritually sick (may have faulty memory and impaired judgment).
   - Urgency to use chemicals is increased.
   - Chemical tolerance may go down (due to deterioration of the body).
   - Users often have paranoid thinking (high anxiety, feels hopeless, isolated).
   - Users experience a complete loss of control.

Developed by Dr. Denise Goodman for the Cuyahoga Department of Children and Family Services
Handout #6

Chemical Abuse vs. Dependency

Social use – The use of any drug or combination of drugs in social situations, or for social reasons. If such social use causes harm, physical or otherwise, to the user or others, it is also considered abuse.

Binge drinking – Periodic heavy use of alcohol (five or more drinks consumed on the same occasion, at least one day in the past 30).

Substance abuse – The characteristic feature of abuse is the presence of dysfunction related to the person’s use of alcohol or other drugs. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) produced by the American Psychiatric Association for diagnosing substance abuse and mental health disorders, substance abuse is a “maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of a variety of possible symptoms or impairment, including failure to fulfill major role obligations, recurrent use in physically hazardous situations, substance related legal problems, continued substance use despite having persistent or recurring social or interpersonal problems related to substance abuse.” (DHHS 1999, pp. 11-12, DSMIV pp. 182-183).

Addiction or chemical dependency – A disease in which the substances have caused changes in the person’s body, mind, and behavior. The DSM-IV distinguishes dependence from abuse primarily by the presence of more abuse symptoms (three or more, rather than at least one), and the possible presence of tolerance (needing more of the substance for the same intoxicating effect) or withdrawal (physical symptoms when the substance is not used) (DHHS 1999, p. 12).
**Handout #7**

**BRIDGING THE GAP OF SEPARATION BETWEEN CHILDREN AND THEIR FAMILIES**

**A CONTINUUM OF CONTACT FOR FOSTER PARENTS**

<table>
<thead>
<tr>
<th><strong>Actions</strong></th>
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<tbody>
<tr>
<td>• Exchange letters with child’s family via SW</td>
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<tr>
<td>• Call child’s parents on phone</td>
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<tr>
<td>• Request pictures of child’s family to display in child’s room</td>
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<tr>
<td>• Give parents pictures of child</td>
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<tr>
<td>• Share copies of homework &amp; report cards with family</td>
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<tr>
<td>• Have positive view about BP</td>
</tr>
<tr>
<td>• Talk openly about family to child</td>
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<tr>
<td>• Send snack/activity for visit</td>
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<tr>
<td>• Praise parents’ progress</td>
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<tr>
<td>• Dress child up for visits</td>
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<tr>
<td>• Provide written report for SAR</td>
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<tr>
<td>• Share monthly progress reports</td>
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<tr>
<td>• Host/arrange sibling visits</td>
</tr>
<tr>
<td>• Brag to parent about child</td>
</tr>
<tr>
<td>• Request cultural information from BP</td>
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<tr>
<td>• Transport child to visit</td>
</tr>
<tr>
<td>• Talk with parent at visit</td>
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<tr>
<td>• Encourage parent to phone child</td>
</tr>
<tr>
<td>• Meet child’s family at placement</td>
</tr>
<tr>
<td>• Non-threatening attitude</td>
</tr>
<tr>
<td>• Refer to child as “your child” to BP</td>
</tr>
<tr>
<td>• Share parenting information</td>
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<tr>
<td>• Attend staffings, SARs, reviews</td>
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<tr>
<td>• Help BP find community resources</td>
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<tr>
<td>• Encourage/reassure reunification</td>
</tr>
<tr>
<td>• Share child’s life book with parents</td>
</tr>
<tr>
<td>• Attend training to learn how to work directly with parent</td>
</tr>
<tr>
<td>• Learn about, understand, and respect birth parent’s culture</td>
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<tr>
<td>• Transport child to/from parent’s home</td>
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<tr>
<td>• Review child’s visits with parents</td>
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<tr>
<td>• Give parents verbal progress reports</td>
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<tr>
<td>• Ask parent to come to appts.</td>
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<tr>
<td>• FP transports BP to meetings</td>
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<tr>
<td>• Invite child’s family to attend school programs</td>
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<tr>
<td>• Assist in planning child’s return to birth home</td>
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<tr>
<td>• Welcome child’s parents into your home</td>
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<tr>
<td>• Attend parenting classes with parents</td>
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<tr>
<td>• Serve as support to family following reunification</td>
</tr>
<tr>
<td>• Foster parent provides respite care</td>
</tr>
<tr>
<td>• Include BP in farewell activities</td>
</tr>
</tbody>
</table>

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