QUARTER 2
PIP 2.3.1
RURAL

State of Nevada Division of Child and Family Services (DCFS)
PIP item 2.3.1., "Evaluate and revise standards in consultation with the NRC that will guide the caseworker's contact with children and parents."

Current State policy (0205.0 Caseworker Contact with Children, Parents and Caregivers) requires at minimum monthly contact between the Caseworker and child whether the child is in-home or out-of-home placement. The policy however is silent to contact requirements between caseworker and parent, and caseworker and caregiver. The 2009 Child and Family Services Review found the quality of caseworker contact with parent, children, and caregivers needed improvement and improved caseworker contact was an identified goal in the Performance Improvement Plan. Contributing factors that indicated improvement was needed included frequency of worker-parent visits, concerns regarding the quality of worker-parent visit, and lack of agency efforts to contact fathers. The following information is intended to provide instruction to caseworkers regarding frequency and quality of contact with parents and caregivers as the policy directly addresses expectations regarding frequency and quality of contact with children.

DCFS is in the process of implementing a new practice model called, Safety Assessment and Family Evaluation (hereafter refereed to as SAFE). **The Protective Capacity Family Assessment (PCFA) Model Summary and Practice Protocol** (attached) will be the standard for guiding caseworker engagement with families. Motivational Interviewing is a practice embedded within the SAFE practice model which also has specific contact requirements for the caseworker-parent and caseworker-caregiver.

Introduction:
Pursuant to the State of Nevada Policy 0205 Caseworker Contact with Children, Parents, and Caregivers the following are guidelines to assist caseworkers in facilitating meaningful and productive monthly contacts with children, parents, and caregivers to assess the safety, permanency and well being of children in the legal and/or physical custody of the child welfare agency.

Children in custody of the child welfare agency must be seen face-to-face minimally one time per month. The contacts must occur in the child's placement more than 50% of the time. The contact information must be documented in the UNITY system as a child contact.

The purpose of the contact must focus on case planning, service delivery, review of the child's safety, adjustment, and wellbeing. Additionally, by having meaningful, quality contacts with the child, caregiver, and parents, the contact provides the opportunity to build ongoing relationships and rapport. By building positive and strong helping relationships, this will enables the family to more effectively respond to crisis and provide them the ability to meet the child's needs.

For a meaningful quality contact the caseworker should do the following:

1. Preparation for the contact prior to the visit. Caseworker should review case notes, contact with collateral resources/providers (therapist, teachers, caregiver, parents, and any other person with pertinent information about the child) to obtain updated information and identify needs for the child.

2. Spend a portion of the visit alone with the child
3. Spend time with the caregiver to discuss the child's adjustment and wellbeing (this may occur alone if requested or necessary).
4. Assess the child's safety and wellbeing.
5. Review case plan progress specifically related to services and goals.
6. Prior to the visit's end, the caseworker should summarize any areas identified during the visit that requires action. The caseworker will identify the responsible party and timeframe for completion.
7. After the visit, the caregiver will follow up on items requiring action in a timely manner and communicate the findings to the necessary parties.
8. The caseworker will document the contact within 5 days in the UNITY system; the documentation will include the following:
    a. Date of visit;
    b. Parties in attendance at the visit;
    c. Location of visit (51% must be in child's placement);
    d. Summary of visit;
    e. Current case plan progress;
    f. Identification of current strengths/concerns/needs and other essential information;
    g. Outcome of visit, including any follow up needing attention.

Caseworker visits can determine the child's current and overall progress; wellbeing, safety and/or risk of harm; and case progress toward case goals and permanency for the child. This is achieved through caseworker observation, discussion/questions and assessment during the visit.
Addressing the following areas during the visit will help ensure the caseworker captures the necessary information to make such determinations.

1. Ongoing Intervention / In-Home Contact with Parents (from whom a child was removed)

Caseworker contacts with parents are the foundation for engaging the family in an effective casework relationship. The visit should focus on safety, case planning, family progress, and identification of the strengths and needs of the family. The caseworker should provide appropriate referrals to the family to achieve the case plan goals and permanency plan. The visit should occur at a time and place favorable for the parent.

The results of the PCFA will guide the intervention and visits with parents whose children have been removed (Protective Capacity Family Assessment Model Summary and Pratice Protocol attachment.

If the permanency goal is reunification, the caseworker shall make, at minimum, monthly contact with the parent. It is preferred and considered ideal for a minimum face-to-face contact occurring in the parental home every other month. Increased contact may be specified by the PCFA and case plan.

If there are other children remaining at home, the caseworker is responsible for observing and monitoring the parenting skills exhibited with those children and the safety

of those children. The caseworker shall also assist the parent or caregiver to assess and secure community resources which may be needed for the children (e.g., medical, education, social, mental health, alcohol and other drug abuse treatment, etc.)

If the permanency goal is other than reunification, monthly contact shall continue if parent-child visitation is still occurring. If parental rights are terminated, no further contacts are necessary.

2. Ongoing Intervention and Contact With Foster Families / Relative Caregiver in Out-of-Home Cases Should Include Assessment and/or Discussion of the Following Areas:

Wellbeing -

1. Follow up on identified needs from previous visit
2. Discuss the child's current health status and identify any new behavioral or medical health needs and/or barriers to meeting the child's heath care needs. Ask if the child has been prescribed any medications and the use of medications both prescribed and over-the-counter. Determine child's health needs are met on an ongoing basis (medical, dental, mental/behavioral health). If the child is in the custody of the Division the Monthly Medical History Form must be obtained from the caregiver and health information MUST BE entered in UNITY each month.
3. Assess child's developmental growth and milestones.
4. Determine child's social and recreational needs are met. Identify unmet needs if applicable.
5. Assess child's adjustment to and well being in caregiver's home. To include adjustment to:
    a. Caregiver family
    b. Daily routine
    c. Parenting
    d. House rules
    e. Discipline
    f. Assess for placement stability
6. Discuss caregiver questions or concerns regarding child (may require privacy).
7. Discussion of child, / caregiver immediate needs and possible solutions/resources. Identify needs of caregiver (respite, support services, training, reimbursement for travel or unusual expense etc).
8. Inform child, caregiver, parent in regards to upcoming events (appointments, CFT, court, visits, etc.)
9. Discuss any family-child, sibling visitation that occurred since the last contact, if the caregiver supervised the visitation. If the visit was not supervised by the caregiver, discuss any visible changes the caregiver noticed in the child after the visit occurred. If parental visits are not occurring per the service plan, or sibling visits are not occurring, develop a plan to ensure the visits begin within the next two weeks.
10. Discuss the child's educational needs and progress. Obtain copies of child's grades and attendance at each semester end. Obtain copy of IEP annually if applicable.
11. Ensure the caregiver's understand their responsibility in assisting the child/youth in the development of day-to-day skills within the home environment.
12. Share with the caregiver any important new information about the child, subject to confidentiality provisions, that are necessary for the proper care of the child.
13. Acknowledge and address attachment issues for the foster parent may have with the child and its effect on the foster parent's support of the permanency goal.

14. Inquire routinely if the foster parent needs additional training or support. If so, this information should be shared with the caregiver's licensing worker.
15. Discuss the impact of the placement on the caregiver's own children.

Safety –

1. Observe the caregiver's home for any health and safety issues (if evidence or circumstances indicate that a child's health and safety may be in jeopardy, a safety assessment must be completed.) If workers observe licensing violations, they shall make a referral to the licensing unit (licensed caregiver only). Observation should include the child's sleeping area and belongings.
2. Observation of interactions between child and caregiver family, or child and family Recognize, assess, and address any indication of unusual stress or problems within the home as it affects the caregiver's ability to care for the child, regardless of whether the worker or the caregiver raises the problem.
3. Ensure child is receiving appropriate supervision and basic needs are met.
4. Identify significant changes within the household (wellbeing of relationships, changes in household composition, illness, changes in sleeping arrangements, house remodel, etc)
5. Private time with the child; to include discussion of:
    b. Health
    c. School
    d. Cultural, ethnic or religious issues
    e. Emotional or social issues
    f. Placement and caretaker relations
    g. Quality of visitation with bio family members; and sibling contact
    h. Any problems, needs or concerns

6. Discuss with the caregiver their responsibilities such as transporting children to counseling and/or medical appointments and allowing approved visitation or contact with siblings and biological parents. If the caregiver is not fulfilling these responsibilities or is in any way impeding the permanency plan for the child, the worker should discuss this with his or her supervisor.

Permanency -

1. Discuss importance of developing and maintaining a "Life book" for the child
2. Encourage opportunities for the child to stay connected with approved past persons or activities; pastor, family friends, child friends, girl/boy scouts, soccer, etc.
3. Query effects/outcomes of visits with bio family
4. Discuss case goals / progress toward goals / case plan revisions

3) Contacts with Reunification Cases

During the first month following reunification, the caseworker shall make weekly face-to-face contact with the family and must observe the child victims for possible injuries and interview them, if verbal. Children are not to be interviewed with alleged perpetrator or parent present. Caseworker must get supervisory consultation to decrease contacts the following month.

4) **Contact with Children Placed in Residential Facilities (In County)**

Caseworkers are expected to maintain regular contacts with youth in residential facilities and must visit the facility and meet, in person, at least monthly, with the residential provider and youth to review treatment progress and the planned discharge date.

5) **Contact with Children in Out of State or Out of County Placements – Residential Facility**

Children who are placed out of state in a residential facility must be visited annually by the agency caseworker (NRS 432.0177). Monthly contact with the child and residential provider must be documented regarding child's well-being and case progress.

Children placed in residential facilities in state but out of county must be visited once every six months with monthly contact made by phone to the child and provider to document child's well being and case progress.

6) **Time and Location of Worker Contacts and Visits**

Whenever it is necessary to have face-to-face contact with parents, children, or foster parents and relative caregivers, with the exception of required unannounced visits and those visits that must be made in the home, caseworkers shall make substantial efforts to be flexible and attempt as much as possible to schedule visits at a time and place where the persons they need to see can attend. Staff shall take into consideration parents work schedules, school age children's school attendance, transportation issues, availability of interpreters (if the parents' primary language of communication is other than English), and any other barriers that might prevent parents from participating. Parents should be reminded that failure to meet with the caseworker may be considered by the Division and the Court as a lack of reasonable progress.

7) **Telephone Contacts**

The caseworker shall formulate a plan for communication between the worker and the child's parent(s), worker and the child/youth, and the worker and the caregiver. Workers should return all telephone calls within 48 hours, if possible. The worker shall provide the members of the child and family team with a contingency plan for emergency situations, for times when a worker is unable to return the call for any reason (vacation, illness, training, etc.), such as making sure that they have the supervisor's phone number.

Protective Capacity Family Assessment
Model Summary and Practice Protocol

Introduction

The Protective Capacity Family Assessment (PCFA) begins after the determination has been made to provide a family with ongoing CPS interventions. The Protective Capacity Family Assessment represents the first essential ongoing CPS intervention with families where children have been identified as unsafe. The Protective Capacity Family Assessment provides ongoing workers with a structured approach for engaging and involving caregivers and children in a case planning process. With respect to promoting client change, the Protective Capacity Family Assessment has the following four purpose(s):

1. Engage caregivers in a collaborative partnership for change.
2. Facilitate caregivers in identifying their own needs and the needs of their children.
3. Facilitate self awareness and agreement regarding what needs to change in a family in order to create a safe home environment.
4. Involve caregivers and children, as appropriate, in the development and implementation of changed based strategies identified in case plans that are individualized and most likely to address what needs to change to assure that children are not maltreated and are safe.

The Protective Capacity Family Assessment is designed to be an interactive method for achieving the four purposes outlined above. There are specific decisions and objectives for the Protective Capacity Family Assessment that are associated with the designated purposes. The decisions and objectives represent the end results or outcomes of the Protective Capacity Family Assessment and, therefore, they inform the framework for the assessment approach.

The Protective Capacity Family Assessment objectives are as follows:

- Verify Safety Plan Sufficiency.
- Elicit caregiver perception(s) regarding identified impending danger (safety threats).
- Focus on impending danger threats as the highest priority for change.
- Identify existing caregiver protective capacities.
- Identify diminished caregiver protective capacities associated with impending danger (safety threats).
- Evaluate caregiver stage of change related to impending danger and diminished protective capacities.
- Create a change strategy with the caregivers that includes both caregiver and child needs.
- Establish and document case plans related to what must change to address diminished protective capacities and eliminate and/or manage impending danger.

The Protective Capacity Family Assessment decisions are as follows:

- Are safety threats being adequately managed and controlled?
- How can existing enhanced caregiver protective capacities be used to help facilitate change?
- What is fundamentally the impending danger to the child based on how safety threats are manifested in the family?
- What caregiver protective capacities are diminished and, therefore, resulting in impending danger to the child?
- How ready, willing and able are caregivers to address impending danger and diminished protective capacities, and what are the implications for continued ongoing CPS worker engagement and facilitation with the family?
- What change strategy (case plan) will most likely enhance caregiver protective capacities and decrease and/or eliminate impending danger?

The assessment objectives and decisions are achieved by applying specific fundamental practice concepts. The conceptual basis for the Protective Capacity Family Assessment provides greater definition, focus and precision to ongoing CPS workers when interacting with families. The use of key concepts support and drive practice within standardized stages of intervention and are intended to help CPS case managers and families accomplish the assessment objectives and decisions. The delineation of the ongoing worker's role in the family assessment process as well as the use of specified interpersonal/interviewing skills and techniques will enhance worker competency and performance throughout the assessment's stages of intervention.

The following sections of the assessment model summary and practice protocol will identify and explain how the Protective Capacity Family Assessment objectives and decisions will be achieved through the use of conceptual constructs, the ongoing CPS worker's facilitative role, the assessment and case planning stages of intervention and the use of specific interpersonal skills and techniques.

Protective Capacity Family Assessment Constructs

There are several concepts, theories and principles that form the basis for the design of the Protective Capacity Family Assessment. These constructs must be well understood by ongoing case managers if they are to be effectively applied in the case planning process. As previously mentioned, it is through the use of key constructs that the Protective Capacity Family Assessment objectives and decisions are achieved.

The Protective Capacity Family Assessment constructs are as follows:

Caregiver Protective Capacities

The concept of caregiver protective capacities is central to the design of the Protective Capacity Family Assessment. It is through the understanding and use of the concept of caregiver protective capacities that case managers and caregivers can formulate case plans that enhance family/family member functioning and caregiver role performance and, in doing so, reduce impending danger.

Caregiver protective capacities are personal and parenting behavior, cognitive and emotional characteristics that specifically and directly can be associated with being protective of one's children. Caregiver protective capacities are "strengths" that are specifically associated with one's ability to perform effectively as a parent in order to provide and assure a safe environment.

When families are opened for ongoing case management services, the Protective Capacity Family Assessment takes into account caregiver protective capacities that exist (as identified by the NIA) and considers how those capacities or strengths might be utilized in case planning. On the other hand, the presence of impending danger in a family is an indication of caregiver protective capacities that are significantly diminished or essentially non-existent. A child is determined to be unsafe when impending danger exists and caregiver protective capacities are inadequate to assure a child a protective and a safe home environment. The Protective Capacity Family Assessment is designed to produce case plans that will address child safety by sufficiently enhancing diminished caregiver protective capacities which, in turn, will eliminate or reduce impending danger to the point where a family can adequately manage child protection.

Impending danger

Safety threats represent the presence of impending danger in the Initial Assessment process. Impending danger is the standard used for determining child safety in Wisconsin at the conclusion of the IA process and throughout ongoing CPS. The impending danger safety standard is one of the essential constructs applied in the Protective Capacity Family Assessment. Developing change strategies that eliminate impending danger or make impending danger manageable by the family is the essential purpose for case plans. The focus on impending danger during the Protective Capacity Family Assessment is intended to bring precision as well as a clearer rationale for the case planning process by directing the attention of the ongoing worker and the family to consider what must change in order to reduce and eliminate the safety threats and create a safe home environment.

Impending danger is a **clearly defined** family condition or situation or family member behavior, emotion, temperament, motive, perception or function that is **out-of control** (unpredictable, chaotic, immobilizing, etc.) and occurs in the presence of a **vulnerable child.** Given the out-of-control nature of the family condition or family member function coupled with the presence of a vulnerable child, the prudent judgment is that there is reasonably a **threat of severe harm** to a child in the **near future.** This defines the safety threshold.

Safe Environment

The prime mission and goal of ongoing CPS is that children are protected from maltreatment by enabling caregivers to provide for a safe environment. *A safe environment is the absence of perceived and/or actual threats to child safety. A safe environment provides a child with a place of refuge and a perceived and felt sense of security and consistency.* The Protective Capacity Family Assessment is the first step toward establishing a safe environment for children by attempting to produce case plans that are individualized, "family owned" and focused on decreasing impending danger and enhancing protective capacities.

Family Centered Practice

The Protective Capacity Family Assessment is designed to focus intervention on family engagement, the family's perspective and "world-view," family needs, family strengths and collaborative problem solving. The belief that families are involved with ongoing case managers as a full partnership is a central practice tenet. When children are identified as unsafe, the ability to create safe environments exists within the family. Necessary change and sustainable change in caregivers and children are more likely to occur when families are involved, invested and able to maintain self-determination and personal choice. Family agreement with needed change is assertively pursued during the Protective Capacity Family Assessment. Case plans that are created as a result of the assessment process are intended to be collaborative change strategies and are specifically tailored to the uniqueness of each family.

Solution Based Intervention

This is a methodology associated with family based services. The principal philosophy of this approach is that the best way to help people is through strengthening and empowering the family (Berg, 1994). The source or answer to problems is viewed as being present within the family. The intent of the ongoing CPS worker when collaborating with the family is to "spring loose" the solutions that are embedded within the family. This intervention provides a practice mentality and specific techniques that are useful in facilitating people through the stages of change. The CPS-family relationship serves as the catalyst for change and, therefore, this is an essential facilitative objective throughout the Protective Capacity Family Assessment.

The Trans-Theoretical Model (TTM)

Trans-Theoretical Model (TTM) provides a way to understand and intervene in human change. The premise of (TTM) is that human change occurs as a matter of choice and intention and that intervention can facilitate the process. The Protective Capacity Family Assessment is the first structured intervention with families once a case has been transferred to ongoing CPS and, as such, it provides ongoing case managers with the initial opportunity to begin engaging family members in a process whereby the facilitation of client change can occur. There is one systematized concept of TTM that you should be familiar with when intervening with families during the Protective Capacity Family Assessment: The Stages of Change.

Stages of Change

The stages of change represent the dynamic and motivational aspects of the process of change. They are a way of dividing up the process of change into discrete segments that can be associated with where people are with respect to change. There are five sequential steps that people move through during change and also move back and forth within during change. In other words, people may progress through one stage after another until change is complete or they may revert back to previous stages as they move forward some, back some, forward some and so on. The stages of change are:

Pre-Contemplation *Not Ready To Change!*
The person is yet to consider the possibility of change. The person does not actively pursue help. Problems are often identified by others. Concerning their situation and change, people are reluctant, resigned, rationalizing or rebelling. Denial and blaming are common.

Contemplation *Thinking About Change*
The person is ambivalent and both considers change and rejects it. The person might bring up the issue or ask for consultation on his or her own. The person considers concerns and thoughts but no commitment to change.

Preparation *Getting Ready to Make a Change*
This stage represents a period of time when a window of opportunity to move into change opens. The person may be modifying current behavior in preparation for further change. A near term plan to change begins to form.

Action *Ready to Make a Change*
The person engages in particular actions intended to bring about change. There is continued commitment and effort.

Maintenance *Continuing to Support the Behavior Change*
The person has successfully changed behavior for at least 6 months. He or she may still be using active steps to sustain behavior change and may require different skills and strategies from those initially needed to change behavior. The person may begin resolving associated problems.

(The material on the *stages of change* is paraphrased from the work of Carlo Di Clemente and J. Prochaska.)

The Involuntary Client

The reality faced by ongoing CPS case managers is that they are often attempting to provide services to an involuntary client. The Protective Capacity Family Assessment takes into account ideas concerned with working with involuntary clients. The following definition of the involuntary client is consistent with the vast majority of those served by CPS: *"one who feels forced to remain in the (CPS) relationship; coerced or constrained choices are made because the costs of leaving the (CPS) relationship are too high; a person who feels disadvantaged in the current (CPS) relationship" (Rooney, 1992).* Families often transfer to ongoing CPS and begin the Protective Capacity Family Assessment as involuntary clients. These families can be divided between those that are mandated clients because of a court order or some legal restraint and non-voluntary clients who feel pressured by the agency or others to stay in the relationship.

Intervention related to the involuntary client points out, particularly in reference to CPS, how crucial power, control and choice are in facilitating change. The CPS intervention, in and of itself, establishes and can perpetuate a sense of loss of autonomy and power. Thus, working with the involuntary client requires a re-establishment of a person's self-determination and reclaiming of personal choice. This can be the essence of facilitating change and include the interpretation of consequences related to personal choice. The Protective Capacity Family Assessment acknowledges the reality of where families are at the point they are transferring to ongoing CPS and attempts to increase motivation to change by focusing and clarifying intervention; encouraging personal choices and sense of control; empowering with information by educating and socializing people to necessary roles, expectations and tasks; and involving families (caregivers) in goal and activity/service selection.

(Adapted from the work of Ron Rooney, *The Involuntary Client*)

Motivation and Readiness

Motivation and Readiness are related concepts associated with the stages of change and the involuntary client. Motivation and readiness are important to the Protective Capacity Family Assessment in the sense that the perspective that the ongoing worker has regarding client/ caregiver motivation and readiness will influence his/her approaches to intervention. Often it is merely the ongoing worker's intervention approach that will result in a more or less effective assessment with a family and development of a case plan.

Motivation refers to the causes, considerations, reasons and intentions that influence individuals to behave in a certain way (Di Clemente, 1999). This definition reframes motivation in such a way that the notion that someone is unmotivated is not necessarily accurate. In other words, all individuals are motivated to do something or to behave a certain way; it just may not be a behavior that everyone agrees is acceptable or adaptive. This means that all individuals proceeding into ongoing CPS are motivated.

When conducting a Protective Capacity Family Assessment and considering what must change, it is helpful to be prepared for determining what family members are motivated toward and what they are motivated against. Motivational readiness refers to a person's position in relationship to the stages of change and the ability or readiness to move through a particular stage of change. Individuals who engage in the Protective Capacity Family Assessment process and who begin to acknowledge the need to address what must change are demonstrating increased readiness. Readiness to change refers to the current state of mind of a caregiver who has resolved denial, resistance and ambivalence and is inclined to change.

Case managers routinely experience family members who are not ready to change and are, in fact, resistant or highly motivated against the idea of change. When attempting to engage seemingly resistant family members during the Protective Capacity Family Assessment process, it is necessary to consider why someone would present themselves as not wanting to change. Miller and Rollnick (1991) indicate that there are four reasons: reluctance, rebellion, resignation and rationalization.

Reluctance
When assessing for the presence of reluctance as an explanation for remaining in pre-contemplation, the ongoing CPS worker should look for those with a lack of knowledge or inertia. These people are uncertain about their problems because information has not been available to them or they haven't fully processed the information about the problems, or the impact of the problems has not become fully conscious. These clients are not resistant but indecisive, hesitant or disinclined.

Rebellion
These clients have a heavy investment in the problem behavior. Additionally, they are highly motivated toward independence and making their own decisions. They are resistant to being told what to do. They may be afraid and therefore defensive. They are argumentative.

Resigned
Resigned pre-contemplators lack energy and investment. They are emotionally tired. This may also include depressed people and those who hold a fatalistic world view. They may feel overwhelmed by the problem.

Rationalizing
This person has all the answers about why problems are not problems and why there is no need for change. They know the odds for personal risk and loss related to change leading to a conclusion not to even get started. "Yes-But" discussions, debates and intellectualization are examples of styles of communication among individuals who rationalize behavior.

Active Efforts

The Protective Capacity Family Assessment provides an organized process for ongoing CPS intervention that promotes active and intentional efforts when working with families. The Protective Capacity Family Assessment is the first essential step in assuring that families are provided with individualized, culturally responsive and appropriately matched treatment services intended to enhance caregiver protective capacities. While the law does not specify the delineation of active efforts, the Protective Capacity Family Assessment uses practice methods consistent with the "spirit" of active efforts. These include:

- Utilizing family input and perspective when identifying needs, concerns and strengths;
- Timely response and facilitation of case movement through the CPS intervention process;
- Consistent, structured and focused assessment and case planning;
- Collaborative development of case plans that are relevant to family/family member needs;
- Approaching intervention from a family centered/family system orientation; and
- Facilitating the access and use of effective and culturally responsive case plan services and service providers.

The Ongoing CPS Worker's Role during the Protective Capacity Family Assessment

The ongoing worker-caregiver collaboration that occurs during Protective Capacity Family Assessment requires workers to be versatile and competent when it comes to the "use of self" as a facilitator. The Protective Capacity Family Assessment is an activity that cannot be effectively completed in the absence of a ongoing worker actively facilitating the assessment process. The Protective Capacity Family Assessment is the fundamental ongoing CPS intervention with families and, as such, it relies heavily on the ongoing worker's mentality, skills, techniques and direction.

Facilitation

Ongoing CPS worker/ case manager facilitation in the context of the Protective Capacity Family Assessment refers to the interpersonal, guiding, educating, problem solving, planning and brokering activities necessary to enable a family to proceed through the assessment process resulting in the development of a change strategy that can be formalized in a case plan.

A case manager's primary objectives for facilitating the Protective Capacity Family Assessment include:

- Building a collaborative working relationship with family members,
- Engaging the caregivers in the assessment process,
- Simplifying the assessment process for the family,
- Focusing the assessment on what is essential to child protection and safe environment,
- Learning from the family what must change to create a safe environment,
- Seeking areas of agreement regarding what must change to create a safe environment,
- Stimulating ideas and solutions for addressing what must change, and
- Developing strategies for change that can be implemented in a case plan.

Facilitation in the Protective Capacity Family Assessment involves four roles and several related responsibilities. The four facilitative roles within the Protective Capacity Family Assessment are: guide, educator, evaluator and broker. (Adapted from *Techniques and Guidelines for Social Work Practice* 4th ed. - Sheafor, B.W., Horejsi, C.R. and Horejsi, G.A. 1997)

Guide

The role of the guide involves planning and directing efforts to navigate families through the assessment process by coordinating and regulating the approach to the intervention and focusing the interactions with families to assure that assessment objectives and decisions are reached.

- Engage family members in the assessment process and change.
- Establish a partnership with caregivers.
- Assure that caregivers are fully informed of the assessment process, objectives and decisions.
- Adequately prepare for each series of interviews; be clear about what needs to be accomplished by the conclusion of each of your series of interviews.
- Consider how best to structure the interviews in order to achieve facilitative objectives.
- Focus interviews on the specific facilitative objectives for each intervention stage.
- Redirect conversations as needed.
- Effectively manage the use of time both in terms of the individual series of interviews and also the assessment process at large.

Educator

The role of the educator involves empowering families by providing relevant information about their case or about "the system," offering suggestions, identifying options and alternatives, clarifying perceptions and providing feedback that might be used to raise self-awareness regarding what must change.

- Engage family members in the assessment process.
- Be open to answering questions regarding CPS involvement, safety issues, practice requirements, expectations, court, etc.
- Support client self-determination and right to choose.
- Inform caregivers of options as well as potential consequences.
- Promote problem solving among caregivers.
- Provide feedback, observations and/or insights regarding family strengths, motivation, safety concerns and what must change.

Evaluator

The role of the evaluator involves learning and understanding family member motivations, strengths, capacities and needs and then discerning what is significant with respect to what must change to create a safe environment.

- Engage family members in the assessment process.
- Explore a caregiver's perspective regarding strengths, capacities, needs and safety threats.
- Consider how existing family/family member strengths might be utilized to enhance protective capacities.
- Focus on impending danger (safety threats) and diminished protective capacities as the highest priority for change.
- Clearly understand how impending danger is manifested in a family and determine the principal threat to child safety.
- Identify the protective capacities that must be enhanced that are essential to reducing impending danger.
- Seek to understand family member motivation; identify the stage(s) of change for caregivers related to what must change to address child safety.

Broker

The role of the broker involves identifying, linking, matching or accessing appropriate services for caregivers and children as needed related to what must change to create a safe environment.

- Engage the family in the case planning process.
- Promote problem solving among caregivers.
- Seek areas of agreement from caregivers regarding what must change.
- Consider caregiver motivation for change.
- Collaborate and build common ground regarding what needs to be worked on and how change might be achieved.
- Brainstorm solutions for addressing impending danger and caregiver protective capacities.
- Have knowledge of services and resources and their availability.
- Provide options for service provision based on family member needs.
- Create change strategies with families and establish case plans that support the achievement of the change strategy.

The following are some basic principles for interacting with family members during the Protective Capacity Family Assessment:

- Interpersonal engagement is fundamental to facilitation.
- Fully informed caregivers make for better working partners.
- Be prepared to work with an involuntary client.
- Empathetic responses encourage client engagement and participation.
- Developing partnerships with families requires that ongoing CPS does not take a paternalistic approach to intervention.
- Feel comfortable enough with your authority to consider ways to increase a family's sense of power and autonomy, specifically in terms of caregiver options and choices.
- Acknowledge that resistance to change and motivation to maintain certain behavior (status quo) is common among everyone.
- Be open to considering the healthy intentions embedded in problematic behavior.
- Demonstrate acceptance for individuals; maintain objectivity.
- In a collaborative working partnership, there are responsibilities for both CPS and the family; be clear about CPS' role and reasonable about what CPS can be expected to achieve.
- Recognize that ultimately the responsibility for change rests with caregivers/the family.
- Avoid arguing, demanding or expecting compliance; these are not intervention strategies.
- You can bring a horse to water but you cannot make it drink.
- Be clear about CPS expectations and the limits to negotiating, compromising or dismissing.
- The CPS mission is assuring child protection by establishing a safe environment.

Child Protective Services System Integration:
Nevada Initial Assessment (NIA) and Protective Capacity Family Assessment

CPS represents a continuum of intervention that begins at the point that a report is received by the agency and concludes when a case closes and children are safe and in a permanent home. The effectiveness of a CPS/child welfare system of care is contingent on a cohesive rationale for how the various aspects or functions of the system work together to achieve outcomes. As a family proceeds through the steps or decision-making points in the CPS process, there are six basic purposes for intervention: problem identification, control and management of impending danger threats, understanding and determining what must change, planning for change, implementing and managing change strategies and measuring progress of change. CPS interventions are more effective when the system is highly integrated. CPS becomes integrated when there is a clear definition of who CPS should serve; there is greater clarity regarding what must change with families who are involved with CPS; there is a clear expectation regarding what constitutes success in cases; and the various CPS interventions apply consistent concepts, criteria, standards and approaches for decision-making.

The integration and interdependence of the Nevada Initial Assessment with the Protective Capacity Family Assessment is established on the following guiding principles for CPS intervention and change:

- CPS should be primarily about the business of child protection.
- CPS should seek to identify and provide ongoing services to those families where children are unsafe.
- CPS effectiveness and success should be based on the determination that services have resulted in children being in permanent safe environments and that impending danger has been eliminated or caregivers have sufficient protective capacities to manage impending danger and assure child safety.
- CPS should focus on improving family/family member functioning that is associated with impending danger by targeting treatment services on diminished caregiver protective capacities.
- CPS should consistently apply safety intervention concepts, safety threshold criteria, standardized safety threats and the concept of protective capacities throughout the case process.

Description of Integrated Approach

Child protection and safety is the essential focus for CPS intervention. Child safety is a concern throughout the case process with specific implications for structuring CPS intervention and decision-making. CPS is concerned about child safety at the point a report is made, during the IA process, at the conclusion of the IA process, at the point a family transfers to ongoing case management, during case planning, during treatment service provision and at the conclusion of CPS involvement with a family. Due to the constant concern for child safety, it is essential that CPS intervention be designed in such a way to reflect how child safety is specifically addressed at various points in the CPS case process. The Protective Capacity Family Assessment builds upon safety intervention that occurs during the Initial Assessment by using safety concepts and criteria to provide direction and focus for ongoing case management.

CPS Function	CPS Integrated Intervention	Time Frames
Access	1. Screen Report. 2. Determine Response Time: *Indications of Present Danger.*	Within 24 hours
Nevada Initial Assessment	3. Initial Contact with Family: 3a. *Indications of Present Danger* 3b. *Control Present Danger as needed.* 4. NIA Information Gathering: *Problem Identification and Family Strengths* 5. Conclusion of NIA: 5a. *Determine if children are unsafe due to Impending danger and Diminished Protective Capacities.* 5b. *Implement Safety Plan to control Safety Threats (Impending danger).* 5c. *Confirm the need to serve.* 6. Transfer case to ongoing Case Management.	Day 1 ↓ Completed within 60 Days
Protective Capacity Family Assessment	7. Receive case from NIA. 8. Preparation for the Protective Capacity Family Assessment: 8a. *Review NIA documentation.* 8b. *Confirm the sufficiency of the Safety Plan and respond as needed.* 8c. *Consider approach for conducting the Protective Capacity Family Assessment.* 9. Conduct series of assessment interviews: 9a. *Impending danger as the focus for treatment and change* 9b. *Consider how to build upon existing strengths and protective capacities.* 9c. *Identify caregiver protective capacity characteristics that must change to address Impending danger.* 10. Develop Case Plan: 10a. *Create change strategy to enhance Protective Capacities which can reduce or eliminate Impending danger.* 10b. *Implement Case Plan.*	Day 1 ↓ Completed within 60 Days

Implications for Case Managers

The use of impending danger and protective capacities in the Protective Capacity Family Assessment allows ongoing CPS workers to build upon the significant amount of information collected during the IA process. Although the NIA and Protective Capacity Family Assessment have distinct objectives and decisions, the consistent use of safety concepts in the NIA and PCFA results in a more seamless intervention process for families that need to be involved with ongoing CPS. At the point that ongoing workers managers begin involvement with families, there should already be a significant amount of comprehensive information regarding family system/family member functioning that can be used during the Protective Capacity Family Assessment process. To some extent, an ongoing CPS worker should approach the Protective Capacity Family Assessment as a continuation of intervention that began with the NIA. While consideration is given to all NIA information, (maltreatment, strengths, risk influences and safety threats), the Protective Capacity Family Assessment narrows the scope of CPS intervention to concentrate attention on specific aspects of NIA that are essential to identifying what must change—existing strengths, protective capacities, impending danger, safety analysis and safety plans.

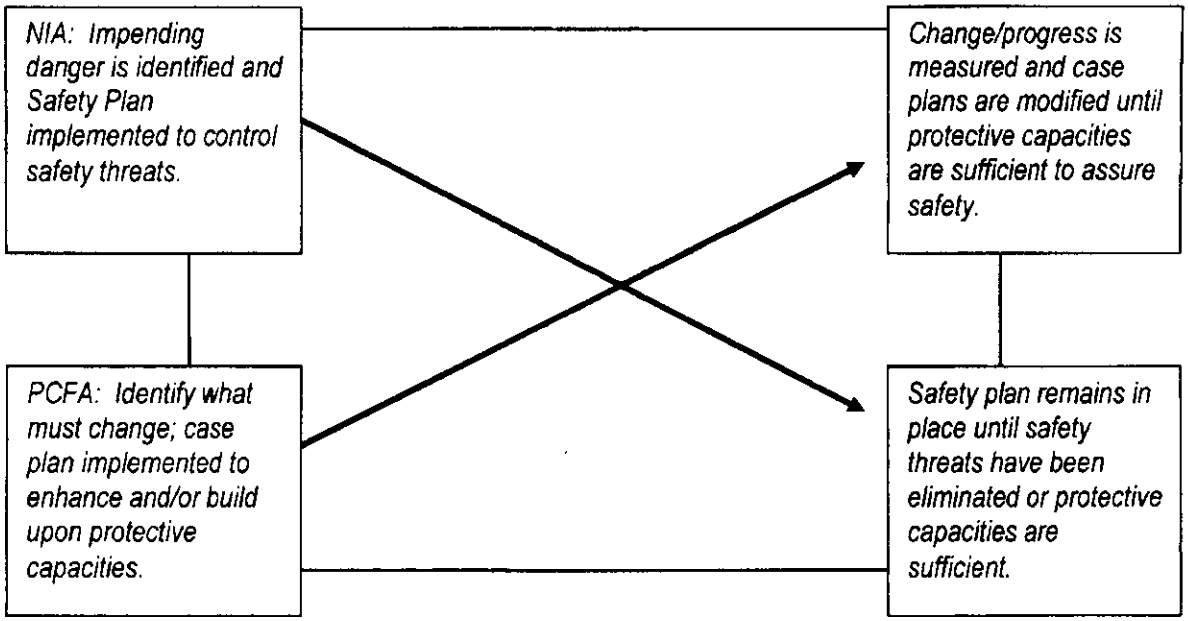
Protective Capacity Family Assessment Concept for Change

The concept for promoting change used in the Protective Capacity Family Assessment is essential based on two premises:

1. treatment services identified in case plans should focus on safety concerns (impending danger) and

2. the way to reduce, manage or eliminate impending danger is by enhancing and/or building upon caregiver protective capacities.

To create safe environments for children, ongoing CPS relies on the simultaneous use of the safety plan and the case plan. The safety plan controls and prohibits threatening behavior from having an effect on a child (i.e., assuring that a child is not left unsupervised) while the case plan changes and/or enhances a caregiver's protective capacity characteristics associated with the impending danger (i.e., caregiver demonstrates impulse control, appropriately recognizes child's needs and limitations, etc.).



A concept for change is central to the ongoing CPS practice approach. A concept for change provides the direction and the operational framework for the Protective Capacity Family Assessment. A concept of change sets out an overarching goal for ongoing CPS which gives rise to expected results at case closure. The structural parts of ongoing CPS (i.e., activities, decision making instruments, roles and responsibilities and record keeping) are determined and formed by a concept of change.

The concept for change related to the Protective Capacity Family Assessment and the overall ongoing CPS approach is illustrated below. This represents a logical "if-then" progression beginning with the identification of families that CPS primarily seeks to serve and ending with the goal for ongoing CPS intervention. The concept for change and subsequently the intervention approach is influenced or shaped by specific dynamic factors. These factors include the following:

1. characteristics of the cases being served,
2. the involvement of children,
3. the value of caregiver involvement,
4. the stages and process for change,
5. the defined role of the worker,
6. supervisory oversight and consultation,
7. the focus of intervention,
8. the understanding and application of practice concepts and criteria,
9. the philosophy of practice,
10. the practice requirements and expectations,
11. the design of the specific remedial strategies, and
12. the interpersonal skills and techniques used to promote change.

The concept for change is used to qualify the purpose for the Protective Capacity Family Assessment and, therefore, informs the structure of the assessment and case planning process. The objectives for the Protective Capacity Family Assessment interviews, the role of the worker, the focus of discussions with caregiver during the assessment and case planning process, the treatment goals identified in case plans, the intent of treatment services are all based on the concept for change.

The concept for change applied in this ongoing CPS approach specific to the Protective Capacity Family Assessment is as follows:

- The PCFA is designed to result in workers having a clear understanding of threats to child safety and the relationship between impending danger and absent or diminished caregiver protective capacities.

- The PCFA determines what must change related to diminished caregiver protective capacities.

- The PCFA encourages caregiver involvement, engagement in a process for change, acceptance of what must change and motivation to begin change.

- The PCFA is expected to result in a case plan containing individualized goals and services directed at enhancing the diminished caregiver protective capacities.

Ongoing CPS Practice Paradigm: Concept for Change

Goal: Caregivers are able to assure the protection of their children on their own.

Primary Client Population: *What families CPS primarily seeks to provide services?*	Influences on Intervention: *What contribute to the intervention approach?*	Intervention Approach: *What must the Protective Capacity family assessment result in to inform the case plan?*	Intervention Objectives: *What is the target of treatment services?*	Anticipated Intervention Outcomes: *What constitutes Ongoing CPS success?*
• Families where children are determined to be unsafe due to impending danger and diminished caregiver protective capacities	• Children • Caregivers • Ongoing CPS worker • Supervisor • Intervention assumptions • Intervention constructs • Federal regulations • State intervention standards • Service design	• A thorough understanding of how impending danger is manifested in a family • Identify caregiver protective capacities that exist and can be used to promote change • A determination regarding the relationship between impending danger and diminished caregiver protective capacities • Identification of what must change associated with enhancing diminished caregiver protective capacities	• What must change as identified in the case plan associated with diminished caregiver protective capacities • Measure and evaluate progress related to enhancing diminished caregiver protective capacities	• The elimination or reduction of threats to child safety (impending) danger and the enhancement of caregiver protective capacities to assure child safety

Protective Capacity Family Assessment: Stages of Intervention

There is a critical need for forming collaborative partnerships with families which includes involving children and caregivers in the mutual development of change strategies that will enhance the capacity of caregivers to provide for their children's safety. To promote family involvement in the case planning process that will result in the development of individualized change strategies, the Protective Capacity Family Assessment provides four stages of intervention: *Preparation, Introduction, Discovery, and Change Strategy and Planning*. The four intervention stages identify the actions and level of effort of the ongoing case manager, the facilitation objectives for assessment interviews, specific assessment content and questions to be considered during each intervention stage.

The four sequential stages of the Protective Capacity Family Assessment enable ongoing CPS workers to guide families through a structured process that encourages collaboration, is strength seeking, focuses on the use of key concepts and directs the assessment toward problem identification, solution thinking and planning. It is important to note that family engagement in a working partnership is emphasized throughout the assessment process. Family engagement is crucial with respect to the development of individualized

case plans as well as the belief that change in caregiver functioning will not occur unless the caregiver recognizes and accepts the need to change. Increasing information about one's self and areas of want and need, and raising self-awareness and expression of feelings regarding what needs to change and how change might occur begins for the ongoing CPS worker at the point that the Protective Capacity Family Assessment begins.

A progression through the four stages of the Protective Capacity Family Assessment encourages families to share their perspective regarding:

- Identified impending danger (safety threats);
- Strengths and protective capacities that exist;
- Diminished protective capacities needing to be developed and/or enhanced; and
- Possible strategies that will address what must change.

While the four stages of intervention delineate specific assessment content questions and facilitative objectives, the assessment approach is flexible in terms of the interaction with families. The transition from one stage to the next should be cohesive in the sense that discussions with families evolve smoothly between thinking about needs and solutions.

Of the four stages of the Protective Capacity Family Assessment, three stages will require face-to-face contact with family members. This does not necessarily mean that every family will require three separate series of interviews/meetings. Depending on the family, the Protective Capacity Family Assessment may be completed in less than three series of interviews.

The four intervention stages of the Protective Capacity Family Assessment are as follows:

Intervention Stage 1: Preparation

Level of Effort	Assessment Content	Actions
Preparation for assessment Become fully informed regarding NIA information and decisions. Complete prior to first series of interviews with family. 1-2 Hours	What are the safety threats in the family? What caregiver protective capacities appear to exist? Does NIA information sufficiently support decision-making? Are there apparent gaps in information related to caregiver protective capacities, safety threats, child vulnerability? What further information gathering seems indicated? Is it clearly understood how impending danger is manifested in the family? Does the safety plan appear to be sufficient to manage safety threats (impending danger)? Appropriate level of intrusion? Adequate level of effort based on how safety threats are manifested? Is it clear how the safety plan is intended to work with respect to controlling safety threats? What has been the family's reaction to CPS involvement thus far? What are the information and assessment logistics that must be considered in order to conduct the Protective Capacity Family Assessment? Prior to beginning interviews with the family, is there anything that you need to be prepared to respond to promptly? Are there any immediate safety planning issues and/or general safety management issues (i.e., visitation arrangements) that need to be responded to prior to or at first contact with the family?	1. Review Nevada Initial Assessment. 2. Review Safety Assessment and Analysis. 3. Review safety plan. 4. Staff case with previous worker and/or consult with supervisor as needed. 5. Contact collaterals, including safety service providers as appropriate. 6. Respond to immediate safety management issues as indicated.

Intervention Stage 2: Introduction

Level of Effort	Assessment Content	Facilitative Objectives
Initiate Protective Capacity Family Assessment. Begin Engagement. Emphasize Rapport Building Techniques. 1st series of visits The time required to complete the introduction stage is dependent on family composition, case issues, dynamics and family participation.	Is it clear to the family how your role as an ongoing case manager is different from an NIA worker? What are the caregivers' understandings regarding why their family has been opened for ongoing CPS? What have caregivers been told regarding the identification of impending danger? What is their understanding regarding the identification of impending danger? What is their perception regarding the responsibility for protection and their belief regarding how that is achieved? What feelings prevail among family members regarding CPS involvement? What perceptions does the family have about itself, about its condition and/or problem areas? Are caregivers clear about the purpose for the safety plan? What is the caregiver(s)' perspective and attitude regarding ongoing safety intervention? Does the safety plan continue to provide the appropriate level of effort and degree of intrusiveness to assure child safety? What are skillful ways to promote caregiver self-determination and autonomy? What is the status of the caregiver(s)' commitment to participate in the Protective Capacity Family Assessment process?	1. Introduce self, role, responsibility in working with the family and expectations for involvement. 2. Begin attempting to form a working partnership with the family. 3. Debrief the family's experience with CPS intervention. 4. Review and clarify the safety threats that were identified as a result of the NIA. 5. Seek caregivers' perception regarding identified safety threats and their responsibility to provide protection. 6. Confirm the sufficiency of the safety plan. 7. Reinforce the caregivers' right to self-determination and emphasize personal choice. 8. Explain the Protective Capacity Family Assessment process and seek a commitment to participate and collaborate.

Intervention Stage 3: Assessment Discovery

Level of Effort	Assessment Content	Facilitative Objectives
Continue Protective Capacity Family Assessment. Continue to engage and seek a partnership with the family. Explore with the caregivers (and children as appropriate) what must change to enhance protective capacities and address safety threats. 2nd series of visits The 2nd series of visits may require more than one meeting with individual family members. Again, the time needed for completing the assessment discovery stage depends on case dynamics and caregiver cooperation.	What is the family's current level of commitment to engage in the assessment process? What is perceived as positive or as strengths within the family that contribute to child protection? What do caregivers identify as strengths about themselves as individuals and in the caregiver role? In what ways might existing strengths be used to increase diminished protective capacities and decrease impending danger? Do caregivers recognize or acknowledge impending danger? What do family members want to keep the same, what might they want to or be willing to consider changing related to their protective capacities? Do caregivers perceive any negative aspect in their ability to assure child protection/safety? What is the family's perception regarding diminished protective capacities that may be resulting in impending danger? What is the level of agreement between caregivers and CPS regarding diminished protective capacities and safety threats? Are caregivers ready, willing and able to consider necessary change related to diminished protective capacities? Are there specific protective capacities that caregivers are more receptive to working on?	1. Review purposes, objectives and decisions associated with the Protective Capacity Family Assessment process. 2. Reconfirm the mutual commitment (CPS and family) to work collaboratively toward developing solutions. 3. Identify and/or discuss family strengths and caregiver protective capacities. 4. Consider how existing caregiver protective capacities can be utilized to create a safe environment in the family. 5. Determine the relationship between safety threats (impending danger) and diminished caregiver protective capacities. 6. Identify the stage(s) of change that family members are in with respect to safety threats and diminished protective capacities. 7. Consider areas of agreement between CPS and the caregivers regarding what needs to change to create a safe environment.

Intervention Stage 4: Change Strategy and Case Planning

Level of Effort	Assessment Content	Facilitative Objectives
Conclude the Protective Capacity Family Assessment. Reinforce Partnership. Collaboratively develop a case plan with the family. Seek commitment to the working partnership and the case plan. 3rd and final series of visits In many cases, the collaborative development of a case plan will have already begun during the previous intervention stages. It is during this stage that the conversations from the earlier series of interviews results in the drafting of a specific case plan.	What diminished protective capacities associated with the safety threats (impending danger) must be addressed in the case plan which will enable caregivers to assure child safety? To what extent do caregivers acknowledge what must change? Are there areas of concern (impending danger and diminished protective capacities) that family members are more ready, willing and able to proceed with changing? What is the most logical place to begin focusing on change, setting goals and identifying potential service options? Are case plan goals/outcomes (enhanced protective capacities) precisely phrased (preferably using the family's own terminology) to establish a sufficient behavioral benchmark for evaluating change? How much flexibility does CPS have to negotiate the focus of intervention and the provision of case plan services? Are identified case plan services and activities acceptable, accessible and appropriately matched with what must change (protective capacities)? Is there an understanding regarding next steps and what is intended to occur in the case plan?	1. Acknowledge areas of agreement and disagreement. 2. Reaffirm family member self-determination, autonomy, personal choice and implications for consequences. 3. Focus on what behavior must change (enhancing protective capacities). 4. Consider common areas of perception and definition of what must change. 5. Develop a change strategy by prioritizing specific areas of change and considering a rational progression for change. 6. Establish realistic goals, outcomes and objectives for change. 7. Direct case planning toward enhancing diminished caregiver protective capacities. 8. Consider specific needs of child(ren) that must be addressed in the case plan. 9. Be prepared to offer and discuss possible change strategies and/or case plan service options. 10. Negotiate and seek agreement regarding case plan service options. 11. Identify specific case plan services and/or activity that are intended to enhance the specified protective capacities. 12. Evaluate your relationship with the family; talk openly with the family about relationship. 13. Identify the continuing roles and expectations for CPS and the caregivers in particular.