ARIZONA FAMILY CONNECTIONS INTERVENTION MANUAL (3RD EDITION)

2020

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Adapted with permission from the Original Family Connections Intervention Manual (DePanfilis, Glazer-Semmel, Farr, & Ferretto, 1997 and the 2003 version).

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CHAPTER 1: INTRODUCTION

The purpose of this Intervention Manual is to provide clear direction about the Arizona Family Connections (FC) practice, process, and components. The manual describes FC practice as it is intended to be delivered. The manual serves as the definitive source of information on the principles, components, processes, and expectations of Arizona FC practice. This manual was adapted with permission from the original Family Connections Intervention Manual (DePanfilis, et. al., 1999) to update literature and integrate Arizona policies, procedures, and standards that guide child welfare prevention and safety intervention programs in Arizona.

THE GOALS OF ARIZONA FAMILY CONNECTIONS ARE TO:

- Prevent child abuse and neglect and promote the safety of children;
- Strengthen parents' ability to keep their children safe, healthy, and well cared for;
- Serve children and their families in their neighborhoods of origin;
- Reduce the likelihood of entry into out-of-home care for children receiving in-home services;
- Reduce the likelihood of subsequent abuse and neglect reports;
- Reduce length of stay in out-of-home care for children who are able to safety reunify with a parent; and
- Reduce the likelihood of re-entry into out-of-home care after reunification.

Family Connections is a multi-faceted community-based practice model that works with vulnerable families in their homes, in the context of their neighborhoods, to help them meet the basic needs of their children, prevent child maltreatment and/or eliminate danger.

The essential components of FC practice are: (1) referral*; (2) outreach and engagement; (3) concrete/emergency services; (4) comprehensive family assessment, including the use of standardized assessment instruments; (5) outcome driven service plans with UBSMART goals; (6) change focused intervention; (7) evaluation of change; and (8) service closure. These core components are the foundation on which all FC learning programs, coaching, technical assistance, and consultation are based. In addition to the core components, contracted FC agencies are expected to follow DCS requirements to continually observe child well-being and conditions in the home, deliver the Family Connections program with fidelity and compliance to contract requirements, achieve the program's performance measures, and contribute to positive safety, permanency and well-being outcomes as defined by the Arizona Department of Child Safety.

Family Connection programs in Arizona support their staff to achieve and maintain fidelity to FC practice with the inclusion of trauma-informed approaches, strengthen the well-being of children within their families, support families in meeting conditions for timely reunification, prevent child abuse and neglect, and prevent entry into out-of-home care.

When a family receiving FC services has an open DCS case, the FCC develops a service plan with the family, provides change-focused interventions, and evaluates change toward the FC outcomes and UBSMART goals. DCS continuously assesses child safety and caregiver protective capacities, creates and oversees safety plans, and develops the case plan and permanency plan with the family.

** The Referral component in Arizona Family Connections is named Intake in the original Family Connection program model. As further described in Chapter 6, DCS staff determine program eligibility prior to referral. In the original Family Connections model, there were additional possible referral sources and an Intake process including review for eligibility by the receiving Family Connections program.*

*** The acronym for goals in Arizona Family Connections, UBSMART, is SMART in the original Family Connections program model. The two additional goal criteria components are reflective of current practice in Arizona's child welfare system. UBSMART goals are further described in Chapter 10.*

This manual is actively used as a day-to-day resource to guide work with families. A brief overview of each chapter follows.

CHAPTER	OVERVIEW
2	**FC HISTORY, SYNTHESIS OF RESEARCH** This chapter provides a brief overview of the history of Family Connections, and a summary of research on the efficacy of FC (DePanfilis & Dubowitz, 2005; DePanfilis, Dubowitz, & Kunz, 2008; Filene, Brodowski, & Bell, 2014; and James Bell Associates, 2011).
3	**HOW WAS FAMILY CONNECTIONS DEVELOPED?** This chapter provides an overview of prevention science and how FC is intended to strengthen protective factors, and decrease risk factors related to child abuse and neglect and entry into out-of-home care. The logic model illustrates the connection between FC intervention components and intended outcomes for implementing FC with families. A brief overview of implementation science is also included as the planning framework for implementing FC practice.
4	**THEORETICAL BASE TO FC INTERVENTION** Effective and accountable social work practice is grounded in solid theory. Family Connections operates from an ecological developmental model (Belsky, 1980) and draws on concepts articulated in 11 theoretical perspectives. Chapter 4 provides an overview of these theoretical perspectives and highlights how each is used in FC practice. Family Connections' family focused and community-based intervention draws from: (1) Psychosocial Theory (Martinez-Brawley & Zorita, 2017); (2) Problem-Solving Theory (Shier, 2017); (3) Life Model Theory (Gitterman, 2017); (4) Crisis Theory (Ell, 1996; Regeher, 2011); (5) General Systems Theory (Bowers & Bowers, 2017); (6) Role Theory (Kimberley & Osmond, 2017); (7) Cognitive Behavior Theory (Thomlison & Thomlison, 2017); (8) Cognitive Theory (Lantz, 1996; Chatterjee & Brown, 2017); (9) the Empowerment Approach (Dunst, Trivette, & Deal, 1988; Lee & Hudson, 2017); (10) Attachment Theory (Page, 2017; Sroufe, Egeland, Carlson, & Collins, 2005); (11) the Trans-theoretical Model of Change (DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992); and (12) trauma theory and trauma-informed care (The Trauma Informed Care Project, 2020).
5	**FC PHILOSOPHICAL PRACTICE PRINCIPLES** FC intervention is family-centered, community-based, preventive, comprehensive, and flexible and employs a set of practice principles that have evolved from what research has proven works best with vulnerable families (Dunst, Trivette, and Deal, 1988; 1994; Hopps, Pinderhughes, and Shankar, 1995; Kinney, Strand, Hagerup, & Bruner, 1994; and Schorr, 1989). Chapter 5 provides an overview of nine practice principles that guide FC intervention: (1) community outreach; (2) family assessment and tailored interventions; (3) development of a helping alliance; (4) empowerment approaches; (5) strengths perspective; (6) cultural competence; (7) developmental appropriateness; (8) outcome-driven service plans; and (9) emphasis on positive attitudes and qualities of helpers. These principles drive the way FC Consultants (FCCs) work with families and Supervisors support FCCs to implement FC intervention with fidelity.

CHAPTER	OVERVIEW
6	**ELIGIBILITY & REFERRAL: DETERMINING ELIGIBILITY CRITERIA; IMPLEMENTING THE REFERRAL PROCESS** Chapter 6 describes the Arizona FC eligibility criteria, necessary information to be analyzed by DCS, the process for DCS decision-making and information sharing with FC, and the process for making referrals. It also explains referral documentation requirements. Arizona's Family Connections program serves families assessed by DCS to have unsafe children or children at risk of future abuse or neglect. Arizona's FC program serves families with children in out-of-home care seeking to reunify with a parent, and families with children remaining in the home following a DCS Family Functioning Assessment.
7	**OUTREACH & ENGAGEMENT: ENGAGING FAMILIES AS PARTNERS; DEVELOPING HELPING ALLIANCES WITH FAMILIES** Engagement strategies seek to genuinely connect with families in understanding how the FC intervention may benefit them. This chapter provides an overview of the FC approach for building partnerships with families. When referrals are received from an Investigations Specialist, transition of the family during the intake meeting is considered. When families are receiving In-Home or Ongoing DCS Services, FC and DCS are partners in intervention and begin collaborative, complimentary work with families from the day of the FC referral. The family partnership and helping alliance is the vehicle through which change within families occurs. This chapter provides information on how to communicate empathy, respect, and authenticity with families, and describes steps for preparing for and conducting the first visit with families. Tips for using active listening skills to develop the helping relationship are also provided.
8	**EMERGENCY & CONCRETE SERVICES: ASSESSING AND RESPONDING TO FAMILIES' CONCRETE AND EMERGENCY NEEDS** Chapter 8 provides an overview of how FC assesses for and responds to concrete and emergency needs. A core component of Family Connections includes addressing concrete needs often associated with living in poverty that affect the quality of care provided to children. These may also directly relate to the impending danger and/or barriers to in-home safety planning. When applicable, FC works with families to address conditions necessary for reunification of their children. Families are assisted to locate and/or obtain, concrete services from informal or formal sources at any point needed to meet the basic needs of their children. Assessment of need begins with the first visit and is part of each subsequent visit. In addition, FC assesses for and responds to three types of emergencies: (1) identification of possible child abuse or neglect; (2) psychosocial risk including concrete needs that may need to be addressed immediately; and, (3) psychiatric crisis of a parent/caregiver or child, including the threat of harm to self and/or others.

CHAPTER	OVERVIEW
9	**COMPREHENSIVE FAMILY ASSESSMENT: CONDUCTING THE COMPREHENSIVE FAMILY ASSESSMENT** The FC approach to the family assessment recognizes that assessment is both a process and a product that drives service planning. This chapter outlines the three phases of assessment and identifies specific skills to be employed during the process. The chapter further provides an outline of the content areas for assessment, sources of assessment information, including results from standardized clinical instruments, and how to translate risk, family protective factors, dangers, and caregiver protective capacities into intervention outcomes. All FC services are directed to helping families achieve at least one core outcome from the following: (1) Parenting Attitudes & Behaviors; (2) Family Functioning; (3) Social Support; (4) Family Resources; (5) Managing Parenting Stress; and (6) Child Well-Being related to overall functioning and development. Additional screening instruments help identify possible truama exposure and/or depressive symptoms which may relate to, and impact, the core outcomes. Family members, the impacts trauma has had on parents/caregivers, and how it may relate to child behaviors. Information collection during the CFA includes recognizing possible symptoms of trauma.
10	**DEVELOPING OUTCOME-DRIVEN SERVICE PLANS WITH UBSMART GOALS** FC is guided by tailored interventions based on time-limited, individualized service plans. Service plans facilitate goal and outcome achievement to reduce the risk of child abuse and neglect and prevent out-of-home care. This chapter describes the steps and elements of creating meaningful, collaborative, realistic service plans with families based on findings from the comprehensive family assessment and the selection of specific outcomes. Families collaborate in the development of UBSMART (Understandable, Behaviorally Stated, Specific, Measurable, Achievable, Relevant, Timely) goals. These goals match specific FC outcomes, the identified behavioral change statements from DCS, and are used in selecting specific intervention strategies and services.
11	**CHANGE-FOCUSED INERVENTION: DELIVERING CHANGE-FOCUSED INTERVENTION, INCLUDING ADVOCATING AND FACILITATING SERVICES BY OTHERS** FC Consultants work directly with families to achieve individualized outcomes and UBSMART goals. This is ideally done through face-to-face, purposeful change-focused intervention occurring at a minimum of one hour weekly. Exact frequency is determined by the needs of the family. Additional contact with the family may occur between visits, including by phone, text, or video conference. The goal of change-focused intervention— to help families within communities meet the basic needs of their children— entails providing a mix and intensity of services appropriate to each family's need. This chapter provides examples of interventions FC staff may directly provide or locate for families in the community. This chapter also introduces trauma-informed approaches which are used during change-focused intervention. These include realizing, recognizing, responding, and resisting re-traumatization (Substance Abuse and Mental Health Services Administration, 2014). Change-focused intervention aligns with the seven essential elements of a trauma-informed child welfare system (National Child Traumatic Stress Network, 2020).

CHAPTER	OVERVIEW
12	**EVALUATION OF CHANGE: EVALUATING CHANGE AND PROGRESS** Ongoing consideration and determination of change is a key element of FC. During all interactions with the family, staff review progress on goals, discuss this progress with family members, and target change focused intervention strategies to support goal attainment. While ongoing assessment of progress is important, a formal reassessment is conducted 90 days following the development of the service plan. The reassessment is partly based on findings from a re-administration of the AZ FC standardized assessment instruments. This supports an objective determination of progress related to the behaviors and conditions that have been the target of change strategies, as well as an assessment of the degree of achievement of UBSMART goals. This chapter describes the elements and expectations for evaluating change and progress. This chapter also discusses how the FC Consultants and families work together to determine if the UBSMART goals have been achieved. If not, the FC Consultant and family work together to develop new or revised goals and interventions. When In-Home or Ongoing DCS services are also being provided to the family, collaborative review occurs between FC, DCS and the family. The EOC occurs along with, and provides information for, the DCS Family Functioning Assessment-Progress Update.
13	**SERVICE CLOSURE: DETERMINING WHEN SERVICES TO FAMILIES MAY END; CONDUCTING THE ENDING PROCESS*** This chapter discusses how to make appropriate service closure decisions, implement a positive process of ending with families, ensure families have necessary plans/resources for future use without FC oversight, and document service closure. It discusses the importance of the FC Consultant facilitating ongoing conversation with families that FC is a time-limited intervention with ongoing check-ins on progress toward meeting goals and outcomes in the specified service duration. FC service closure decisions are independent of DCS case closure decisions, but the circumstances of the FC service closure may impact DCS intervention.
14	**STAFF DEVELOPMENT** This chapter discusses what qualifications a FC Consultant and FC Supervisor shall have. It discusses what initial and ongoing training the FC Staff shall participate in. This chapter also describes the role of the FC Supervisor and the skills and techniques a Supervisor should utilize. Lastly, this chapter discusses reports of suspected abuse, neglect or safety threats and the FC Staff's role when there are concerns of such.
References	This section provides references for all citations.
Appendices	Some documents are included at the end of each chapter as exhibits.

** The original name for this component in the Family Connections program model is Service Termination; however, it is called Service Closure in Arizona Family Connections.*

CHAPTER 2: HISTORY OF FAMILY CONNECTIONS, SYNTHESIS OF RESEARCH

The Family Connections program was developed in 1996 through collaboration between the University of Maryland Schools of Social Work and Medicine through support from the USDHHS National Center on Child Abuse and Neglect (now named the Office on Child Abuse and Neglect) with matching dollars provided by the Annie E. Casey Foundation. The study on recurrences and a literature review on child maltreatment interventions led to the development of a theory of change and logic model.

A prevention science lens for addressing risk and protective factors (DePanfilis, 2009) in families at risk of child maltreatment was used to construct the components of intervention operationalized in the first intervention manual (DePanfilis, Glazer-Semmel, Farr, & Ferretto, 1999). In addition, key approaches demonstrated in the early 1980s and the skills needed for successfully engaging families as collaborative partners were integrated into the conceptualization of the intervention (DePanfilis, 1982; 1984). Table 2.1 describes some of the early projects that contributed to conceptualization of this intervention.

TABLE 2-1. BACKGROUND LEADING TO THE DEVELOPMENT OF FAMILY CONNECTIONS

YEAR	MILESTONE
1979	Three-year demonstration to test methods of encouraging families to self-refer to Child Protective Services – US Department of Health & Human Services, National Center on Child Abuse & Neglect.
1981	Three-year demonstration to test methods for improving the quality of child protective services – US Department of Health & Human Services, National Center on Child Abuse & Neglect.
1982-1984	Multiple evaluations of child welfare practice, sponsored by the American Humane Association helped to craft an understanding about what works and what could work better to support families to adequately care for their children.
1985-1990	Contributed to the development of a child welfare practice model – The Child At Risk Field Decision-Making System and the first Safety Evaluation System – with ACTION for Child Protection. Supporting implementation & testing of intervention in multiple states. This model focused on characteristics of protective caregivers and differentiated impending danger from incidents of maltreatment, and would evolve into the SAFE model.

Family Connections was developed following a study of the epidemiology of child maltreatment recurrences (DePanfilis & Zuravin, 1999a, 1999b, 2001, 2002) that examined patterns and predictors of child maltreatment recurrence for 1207 families who were followed prospectively over five years after a substantiated report of child maltreatment. Findings from the study were used to develop the FC intervention with the intent to reach families at risk of maltreatment early to support them to avoid the likelihood of maltreatment in the future.

CHAPTER	OVERVIEW
1991-1995	Implementation of studies of child maltreatment known by CPS, including a five-year prospective study of the epidemiology of child maltreatment recurrences funded by the US Department of Health & Human Services, National Center on Child Abuse & Neglect. Findings pointed to understanding what contributed to preventing recurrences.
1996	Literature review on the role of social support with maltreating families (DePanfilis, 1996) and reviews of child maltreatment interventions.

Since the first demonstration project (DePanfilis & Dubowitz, 2005), Family Connections has been replicated in large and small, urban and rural communities across the country and delivered by community agencies as well as public child welfare systems. Key milestones of this history are depicted in 2.2 beginning with the first demonstration project in 1996.

TABLE 2.2 – HISTORY OF FAMILY CONNECTIONS

YEAR	MILESTONE
1996-2002	Five-year demonstration – US Department of Health & Human Services, National Center on Child Abuse & Neglect
1999-2000	Testing FC adaptation targeting reunification when children placed in foster care – Baltimore City Department of Social Services
1999-2002	Family Connections' family strengthening initiative – US DHHS, Substance Abuse & Mental Health Services Administration (SAMHSA)
2003-2009	Selected as "demonstrated effective program" by US DHHS, Office on Child Abuse & Neglect; federal replication funding for 8 sites (CA-2, MD, MI, TN, TX-2, WV); Adaptation with kinship caregivers in Maryland
2007	SAMHSA award to develop Family Informed Trauma Treatment (FITT) Center; Trauma-Adapted Family Connections (TA-FC) developed
2008-2009	Rated as a promising practice – CA Evidence-Based Clearinghouse for Child Welfare & the Pew Charitable Trust report; Special Issue of Protecting Children; JBA preliminary cross-site findings presented
2010-2012	Replications in CO, MD, NM, NJ, TX, NV, Los Angeles; development of SAFE-FC; New York City Administration of Child Services selects Family Connections as an evidence-based model for conversion of preventive services
2011	James Bell Associates Cross Site Evaluation Released
2013-2015	Implementation of FC through two collaborative partnerships: (1) NYC – nine preventive service programs in the Bronx, Manhattan, and Brooklyn and (2) Florida – two Community Based Care (CBC) partners – Kids Central and Partnership for Strong Families; Expanded replications in Texas
2015 -2016	Studies on implementation, Reflection on what supports are essential for implementation

CHAPTER	OVERVIEW
2017 – 2020	Expansion of Quality Improvement capacity by replicating sites; Converting the Computer Assisted Self Interview (CASI) to Qualtrics in NYC, permitting increased tracking of fidelity and measuring change over time in risk and protective factors
2020	NYC awards ten year contracts to ten programs across seven contracted agencies to continue delivery of FC. Arizona collaborates with Action for Child Protection, Inc. to prepare for statewide implementation of Family Connections in July 2021. A priority is trauma-informed practices.

FAMILY CONNECTIONS RESEARCH

What do we know about the efficacy of Family Connections? There has been extensive research documenting that families who receive the core components of Family Connections are successful in reducing risk factors and enhancing protective factors associated with child maltreatment. These findings have been published in reports and peer reviewed journals and presented at national and international conferences. The highlights are summarized here in question answer format.

WHAT RISK AND PROTECTIVE FACTORS HAVE BEEN DEMONSTRATED TO CHANGE OVER TIME?

Families in the original demonstration were found to increase protective factors (parenting attitudes, parenting competence, social support) and decrease risk factors (parental depressive symptoms, parenting stress, life stress) from Intake until closure and these changes were still evident six months after case closure (DePanfilis & Dubowitz, 2005). Results of the James Bell Associates (2011) cross site evaluation on eight replicating sites found enhancement in protective factors (social support and parenting attitudes) and decreases in risk factors (parental depressive symptoms, parenting stress, risk factors related to family functioning) from Intake until closure. Most changes were also noted at the six-month follow-up. All of these changes over time were statistically significant.

WHAT OUTCOMES HAVE BEEN DEMONSTRATED TO CHANGE OVER TIME?

Child Safety (observation)	Child Behavior	Child Safety (CPS reports)
The original demonstration project found significant improvement in child safety (observation of physical and psychological care of children) and parental self-report of child behavior between intake and case closure. The observational assessment of child safety could not be implemented at the follow-up because it depended on the worker having been in the home.	In the original demonstration, child behavior (externalizing and internalizing) was found to improve between baseline and case closure and these changes were sustained at the six-month follow-up. In the cross-site evaluation, change over time was noted for externalizing behavior but not internalizing behavior (James Bell Associates, 2011). Secondary analysis comparing boys and girls (Lindsey, Hayward, and DePanfilis, 2010) found that boys appeared to experience a larger decrease in internalizing and externalizing behaviors over time than girls.	Families served in the demonstration project were matched with CPS reports and compared prior to intervention and at six months following intervention. Approximately 56.5% of families had received reports of child maltreatment and 38.3% had been substantiated prior to receiving FC intervention. At six months following intervention, 11% had reports of child maltreatment and 7% had substantiated incidents. It should be noted that some of these reports were made close to the beginning of the FC intervention meaning that at the same time a family was referred to Family Connections, they may have also been reported to CPS.

Even though all sites were required to match their cases with CPS data, at the time the cross-site evaluation was completed, only two of the eight sites had submitted these data. For the 243 families from these two sites, 4.6% were subjects of a CPS investigation within six months following case closure and less than 1% had a substantiated incident. Because of these small numbers, the cross-site analysis could not compare treatment and control groups on CPS reports.

HOW HAS LENGTH OF SERVICE AFFECTED RISK AND PROTECTIVE FACTORS AND OUTCOMES?

The original demonstration randomly assigned families to FC intervention for three or nine months. Results showed that for all risk and protective factors, the three-month group achieved the same statistically significant change as families assigned to the nine-month group. The nine-month group demonstrated greater improvement over time in improved child behavior.

The cross-site evaluation compared seven of the eight sites that randomly assigned families to shorter versus longer intervention and found the same results. Families served for shorter times achieved the same change as families served for a longer period of time. JBA 2011 concluded, regardless of the duration of FC, families receiving the FC intervention experienced improvements over time across multiple outcome domains. Outcome trajectories for families assigned to three months of FC were not different from families assigned to longer interventions (p. 137).

WHAT LENGTH OF SERVICE IS MOST COST EFFECTIVE?

A cost effectiveness analysis from the original demonstration project (DePanfilis, Dubowitz, & Kunz, 2008) determined that the three-month intervention was more cost effective than the nine-month intervention in relation to positive changes in risk and protective factors and child safety. However, cost effectiveness analysis indicated that the nine-month intervention was more cost effective (CE ratio=$276) than the three-month intervention (CE ratio=$337) in relation to unit changes in the child's behavior between baseline and six months after service closure.

WHAT CONTRIBUTES TO SUCCESSFUL COMPLETION OF THE PROGRAM?

Secondary analysis from the demonstration project (Girvin, DePanfilis, & Daining, 2007) found that families in the three-month intervention were statistically significantly more likely to finish the program. Families who completed were more likely to have larger numbers of children and to report a more positive helping alliance with their workers than families who dropped out before the end of their assigned service period. In addition, families with caregivers with higher depressive symptoms were also much more likely to finish services than families whose caregivers did not report depressive symptoms. The replication study from Tennessee (Theriot, O'Day, & Hatfield, 2009) also looked at differences between families who completed versus not completed intervention. Their results indicated that families assigned to the program for three months compared to nine months were ten times more likely to finish the program even when controlling for other predictors (caregiver and family characteristics).

HOW DOES FIDELITY IMPACT OUTCOMES?

The JBA (2011) cross-site evaluation explored whether programs with higher fidelity, as measured by a multi-dimensional process to observe the degree to which the program was implemented as intended, would also have greater case level improvements in risk and protective factors and outcomes. Results indicated that families experienced greater change over time in parenting stress, parental depressive symptoms, and social support when programs had higher fidelity scores on components of the practice (termed program structure criteria). Higher scores on consistency in use of the philosophical principles was related to greater change by families in social support. Families at sites with higher administrative activities scale scores demonstrated significantly greater reductions in child internalizing behaviors and improvements in parental attitudes.

WHAT DOES QUALITATIVE RESEARCH TELL US ABOUT FAMILY CONNECTIONS?

A study from one of the Los Angeles project sites concluded that FC is easily adapted to cultural groups (Wu, Mimura-Lazare, Petrucci, Kageyama, & Suh, 2009). They demonstrated

success using community-based recruitment strategies to engage families, using staff matched by language and culture, and educating at the community level to gain acceptance and diminish the shame that some families may have experienced by "accepting help."

EMPHASIS ON THE HELPING ALLIANCE

Emphasis on the helping alliance and concerted efforts to reach families sequentially and support them to move through the stages of change increased the likelihood that families would stay involved in intervention. This approach also illustrates how important it is to empower families to solve their own problems and for the program to respond to concrete needs before expecting families to be ready to change parenting behaviors were other key lessons from the Detroit project's success in engaging families to increase safety for children (Stephens, Mills, Williams, Bridge, & Massie, 2009)

USE OF COLLABORATIVE THERAPEUTIC ASSESSMENT

Family Connections requires the use of standardized assessment instruments to tailor intervention and to engage families to observe their success in changing behaviors and conditions which may place their children at risk of maltreatment. One of the Texas projects (Zaid, Earnes, Driver, and LeGendre, 2009) conducted a qualitative study to explore the perception of staff and families to using this process. Reports from staff and families indicated that use of assessment instruments became a platform to more easily discuss difficult issues (e.g., drug use or parenting attitudes) than would have been possible by having an open-ended conversation alone. They also reported the benefit of narrowing the focus of intervention on the most important risk or protective factors identified through instruments. This helped to reduce how overwhelmed families may have felt in their situation. They also concluded how powerful it was for caregivers to observe the changes in behaviors and conditions by comparing scores before and at the end of intervention.

WALKING THE TALK

Grandparent caregivers in the Maryland replication (Sharpe, DePanfilis, Strieder, & Gregory, 2009) reported the benefit of Family Connections for building support and services, skill building, and helping to create affect and behavior changes (Sharpe, DePanfilis, Strieder, & Gregory, 2009). Grandparents reported great benefit from being connected to other grandparents raising their grandchildren. They also reported having much more energy to work on their interaction with their grandchildren after the program first helped them with resources to take care of basic needs. They also reported greater confidence in their parenting skills and improved family functioning.

CHAPTER 3: PREVENTION SCIENCE, FC LOGIC MODEL & IMPLEMENTATION SCIENCE

This chapter provides an overview of Prevention Science, the FC logic model, and implementation science. These concepts are foundational to the FC intervention and its implementation.

PREVENTION SCIENCE

The principles of prevention science (Mrazek & Haggerty, 1994; Schinke, et al., 1986) suggest that child maltreatment preventive programs should reduce risk factors and promote protective factors (DePanfilis, 2009; DePanfilis & Dubowitz, 2005; English, Bangdiwala, & Runyan, 2005). This is especially important for selective prevention programs (Mrazek & Haggerty, 1994) targeting families whose children are identified with risks of child abuse and neglect.

RISK FACTORS

Risk factors are characteristics which elevate the probability of an undesirable outcome. Examples include substance abuse, parental depressive symptoms, and everyday stress (Masten & Wright, 1998). Interventions aim to reduce the presence of specific risk factors in the life of an individual or family.

PROTECTIVE FACTORS

Protective factors are characteristics promoting resilience or moderating the effect of risk factors such as positive parenting attitudes, parenting competence, and social support (Masten & Wright, 1998). Therefore, preventive intervention is designed to help families develop or promote existing protective factors to offset or reduce the effect of risk factors. For example, helping a parent strengthen a relationship with someone trusted to be there for her through thick or thin would be an example of an intervention to promote social support as a protective factor.

It is widely accepted among professionals that a complex set of risk and protective factors are associated with the occurrence of child abuse and neglect (Brown, Cohen, Johnson, & Salzinger, 1998). Because Family Connections uses an ecological framework (see Chapter 4) to understand the meaning of these factors in the lives of children and families, our comprehensive family assessments consider risk and protective factors about the child, family, and environment. Family Connections was developed through a prevention science lens since it followed the stages of prevention science to first explore the nature of the problem, identify risk and protective factors that contributed to the problem, and construct intervention components to directly respond to these factors (DePanfilis, 2009). Since each family is unique, we do not assume that all risk and protective factors will be relevant for all families – instead we individually assess so that we can tailor our intervention responses to the unique risk and protective factors experienced by each family.

Prevention Science guides the core components of the FC intervention to reduce child abuse and neglect risk factors and increase protective factors.

The logic model details the theoretical connection among the identified family needs, FC objectives, critical program activities, and expected outcomes.

Implementation science research informs what it takes to implement FC effectively.

CHILD WELFARE INTERVENTION

Family Connections has also been successfully delivered to families in which children have been identified to be unsafe. Arizona's Safety Assessment Family Evaluation (SAFE) model defines unsafe children as those who are exposed to present or impending danger threats and whose parents/caregivers lack sufficient capacity to protect them from those threats. At the time families will be referred to Family Connections, there would have been sufficient information collection via the Family Functioning Assessment (FFA) to determine if children are in impending danger.

IMPENDING DANGER

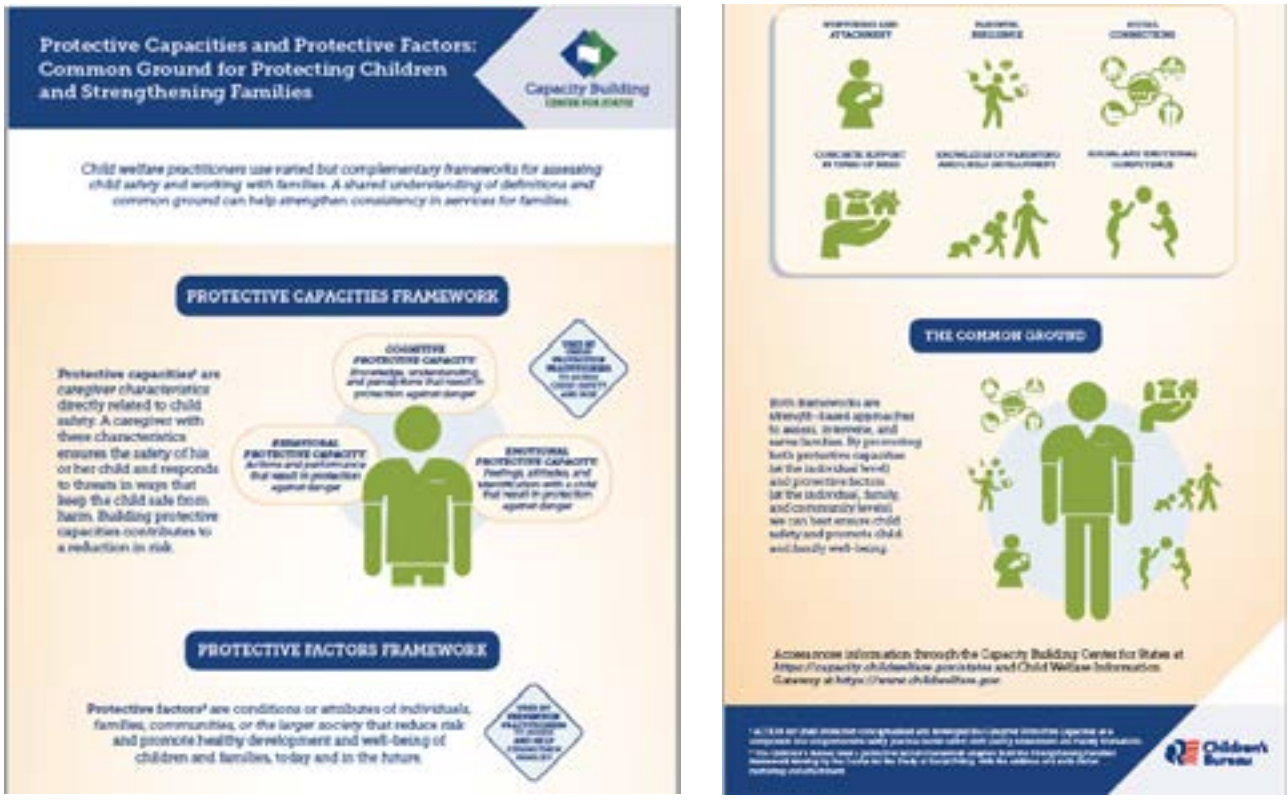
Impending danger refers to clearly observable, imminent conditions that are unmanaged in the family without DCS intervention and will result in serious harm or effects to vulnerable children. DCS must implement a safety plan to manage impending danger. Impending danger is differentiated from incidents of maltreatment or immediate present danger to children. Understanding impending danger requires more in-depth knowledge of the family to understand what is occurring on a daily basis, and anticipate harm in the near future.

PARENT/CAREGIVER PROTECTIVE CAPACITIES

Parent/caregiver protective capacities are the behavioral, emotional, and cognitive characteristics of individuals who protect children. When protective capacities are diminished, they contribute to risk conditions that can be understood via the Protective Factors Framework. When children are not safe in their homes, significantly diminished protective capacities are the underlying conditions that must change to eliminate impending danger.

Figure 3-1, from the Capacity Building Center for States, illustrates the relationship between protective factors and protective capacities, both of which must be understood to ensure effective and individually-tailored FC interventions.

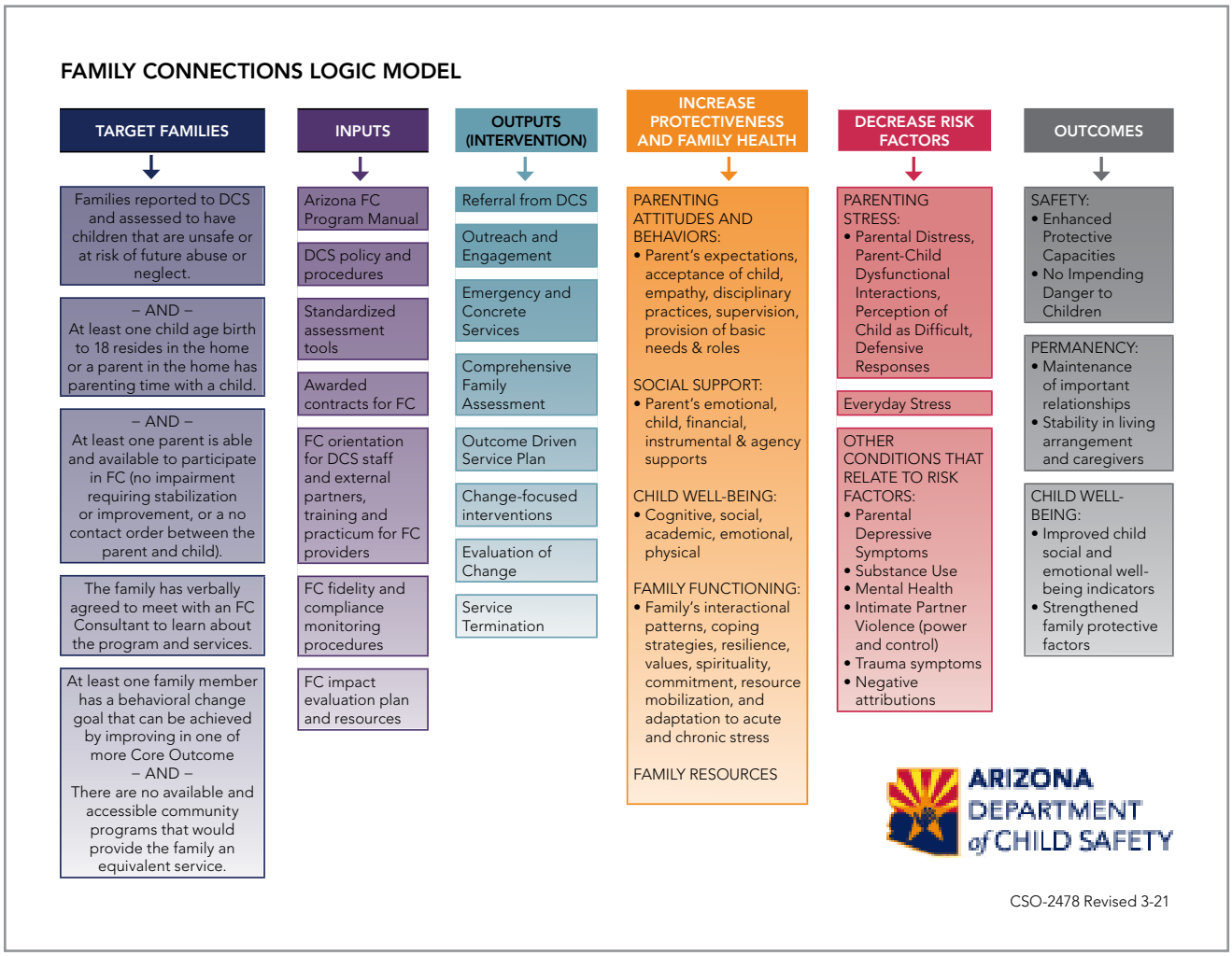
FIGURE 3-1. PROTECTIVE CAPACITIES AND PROTECTIVE FACTORS



ARIZONA FAMILY CONNECTIONS LOGIC MODEL

A logic model is a visual representation of how an intervention is expected to work, the need it aims to address, and how its objectives and activities flow together to reach its desired outcomes. Logic models can be a helpful communication tool to share with staff, providers, families, and other stakeholders. The Arizona Family Connections logic model begins with identifying families who are anticipated to benefit from the intervention based on the understanding of protective factors, protective capacities, and impending danger. The logic model further outlines collaboration with formal and informal community organization, attention to emergency and concrete needs, and provision of individualized, strengths-based intervention and social support. These activities will increase protectiveness and family functioning and decrease risk factors, resulting in child safety, permanency, and child well-being (DePanfilis & Dubowitz, 2005). Figure 3-2 depicts the FC logic model.

FIGURE 3-2. ARIZONA FAMILY CONNECTIONS LOGIC MODEL



IMPLEMENTATION SCIENCE

While the attention to and number of evidence-based programs over the past decade have increased, their use in practice has been weak (Fixsen, Blase, Metz, & Van Dyke, 2013). Many researchers have begun focusing on the factors that lead to successful implementation of evidence-based programs in real world settings (Meyers, Durlak, & Wandersman, 2012). The theory is that both the actual intervention and how it is implemented are important for achieving the desired outcomes.

> *Implementation is a specified set of activities designed to put into practice an activity or program of known dimensions. According to this definition, implementation processes are purposeful and are described in sufficient detail such that independent observers can detect the presence and strength of the specific set of activities related to implementation. In addition, the activity or program being implemented is described in sufficient detail so that independent observers can detect its presence and strength (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005, p. 5).*

The National Implementation Research Network's (NIRN) implementation science framework (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005) offers a strategic, purposeful approach to managing change, fulfilling intervention objectives, carrying out program activities, and increasing the success of the new intervention. Used by child welfare systems (Kaye, DePanfilis, Bright, & Fisher, 2012) as well as in the fields of education and juvenile justice, the framework has guided FC's implementation in Arizona. Specifically, implementation in Arizona has followed the framework's implementation stages, drivers, and teams to guide development of implementation work plans, activities, and ways of organizing. This section describes how the AZ FC has applied the principles of implementation science in its implementation of Family Connections.

IMPLEMENTATION STAGES

Implementation is a process, not a one-time event. Implementation happens over time (it typically takes 2-4 years for the new practice or intervention to become routine or institutionalized) and NIRN identifies four main stages of implementation, with sustainability being part of every stage. The stages usually do not move forward in a tidy, linear progression; rather, work in one stage might overlap with work in another stage or activities thought to be "done" might need revisiting. The stages are shown and described in Figure 3-2 along with a summary of the primary activities that have occurred or are planned to occur in each to implement FC in Arizona.

FIGURE 3-3. STAGES OF IMPLEMENTATION

EXPLORATION AND ADOPTION

During exploration, organizations identify the need for the intervention, consider the "goodness of fit" of intervention alternatives to match their target population and problem. A decision to proceed (i.e., to adopt a particular intervention or model) is made based on exploration activities.

In 2018, the Family First Prevention Services Act (FFPSA) was signed. FFPSA provides states with incentives and supports to implement programs designed to prevent removals of children. Exploration began in October 2018 and continued through the selection of the Family Connections program in April 2020. Exploration began with a survey of providers to obtain an inventory of existing programs, and administrative data analysis to identify target populations by demographic characteristics and risk factors. With assistance from subject matter expert consultants from the Capacity Building Center for States (CFS), the Department reviewed hundreds of evidence-based parent skill based programs. Thirty-two programs were selected for more extensive consideration. A complete compilation of programs for consideration was developed, along with fit and feasibility criteria for screening the programs. These criteria included: fit with Arizona's target populations, alignment with the DCS practice framework and values, staff qualifications, ability to create independent Arizona training capacity, ease of operational implementation, ability to monitor fidelity and outcomes, and evidence base. Thoughtful consideration was given to the needs of priority populations identified through the administrative data analysis, including Native American families, African American families, and families experiencing domestic violence. A symposium attended by over 100 stakeholders was held in December 2019, and was followed by a Request for Information to obtain community input into program selection. In April 2020, Family Connections was selected as one of two parent skill based programs that will be implemented in Arizona in July 2021.

INSTALLATION

Installation occurs after a decision to proceed with a particular intervention or model is made and resources are allocated to support it. Practical activities occur in this stage to prepare the staff and organization for the new intervention, such as developing implementation plans, preparing supervisors and staff for change, training staff, developing communication and feedback mechanisms, and considering strategies to align organizational structures to support implementation.

Installation activities began in May 2020 and will continue through June 2021. DCS formed an implementation team to provide input into the adaptation of the FC program for Arizona, communication planning, and operational decisions (such as designing the referral process). The implementation team included the project's executive sponsor; DCS

program development staff; Family Connections technical assistance providers; Center for States consultants; and subject matter expert representation from the provider community, DCS field operations, procurement, and fidelity and compliance monitoring. Inclusion of the stakeholders in program installation occurred through a series of meetings with the provider community, hosted by the Arizona Council of Human Service Providers; education and planning meetings with the Juvenile Courts and Administrative Office of the Courts; and collaboration with stakeholders from African American communities, Native American communities, and domestic violence advocacy agencies. Some of Arizona's installation activities are: development of a logic model; development of a theory of change; selection of standardized assessment instruments; identification of Arizona Family Connections outcomes based on the protective factors framework and caregiver protective capacities; development of referral, intake, and other procedures; creation of an Arizona FC program manual; system readiness assessment; DCS and provider training; and development of fidelity assessment plans, tools and instruments.

INITIAL IMPLEMENTATION

This stage occurs as the new intervention is put into practice. Initial Implementation is the most challenging stage, as a new intervention can feel awkward for staff and can challenge an existing system. A critical element is the use of continuous improvement strategies and feedback mechanisms to gather information on implementation and barriers to service, identify solutions, and use data to guide decision-making. It is vital to develop strategies to attend to Initial Implementation challenges, as many attempts at new innovations seriously falter during this stage.

Initial Implementation will begin in July 2021. The FC communication plan includes pathways for bi-directional communication between internal and external stakeholders and the implementation team. Fidelity monitoring will be instituted during this stage, along with quality and outcome focused coaching. Training will begin in April 2021 with the Hybrid Learning Program. The core learning program is organized into e-Learning modules, followed by in-person instruction. Full completion involves working through each e-learning module and reading all chapters of the program manual. The instructor led in-person training is designed for staff to practice core Family Connections Components based on their full preparation in the e-learning modules. When Family Connections providers begin to accept referrals, each supervisor will complete a practicum to demonstrate knowledge and ability to apply the core components of FC with real families in Arizona.

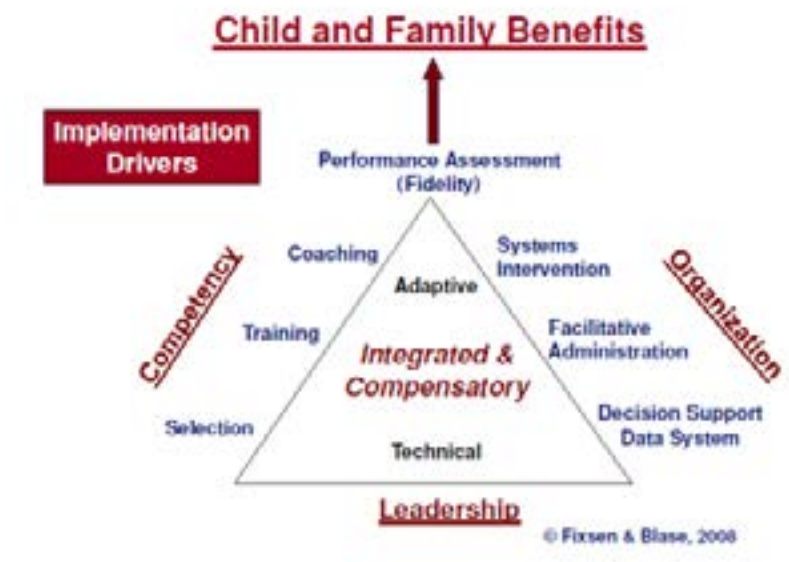
FULL IMPLEMENTATION

Organizations reach Full Implementation once the practice becomes integrated into the organization; staff feel confident in using the practice with every family; supervisors continually support and coach staff; stakeholders are adapted to the practice; procedures and processes of the intervention are routine; and practice change is observable. In Full Implementation, implementation components are sustained, and the intervention outcomes for families are realized. Full Implementation is usually achieved 2-4 years after Initial Implementation.

IMPLEMENTATION DRIVERS

The Implementation Drivers are core activities identified by NIRN's synthesis of implementation literature (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). There are three types of Drivers: Competency, Organization, and Leadership. The drivers are depicted in the triangle in Figure 3-3. Each driver is described along with its specific application in the Arizona FC implementation process.

FIGURE 3-4. NATIONAL IMPLEMENTATION RESEARCH NETWORK'S IMPLEMENTATION DRIVERS



COMPETENCY DRIVERS

Competency Drivers are implementation activities that develop, improve, and sustain one's ability to implement an intervention with fidelity and benefits to children and families. There are four Competency Drivers: Selection, Training, Coaching and Supervision, and Performance Assessment.

- **Selection** – Focuses on strategies for identifying specific personnel characteristics to assess at time of hire as well as recruitment, interviewing, and redeployment strategies that promote thoughtful selection of qualified staff (Metz & Bartley, 2012).
- **Training** – While training alone does not result in sustained practice change, it is essential for introducing new practices and supporting practitioners to try new skills in a safe, supportive environment. Training is an important part of implementation as it introduces the theory and underlying values of a program, uses adult learning theory, and allows staff to explore questions related to a specific model - in this case, Family Connections.
- **Coaching and Supervision** – Coaching and supervision are essential to building staff competency and confidence to use the intervention with all families. Coaching and supervision should be systematic, use multiple sources of data to provide feedback, and feedback from coaching and supervisory sessions should be provided to guide improvements to other drivers. All supervisors in Family Connections use coaching processes and skills. Supervisors attend Community of Practice sessions on a monthly basis to develop and practice supervision and coaching within the Family Connections Program. Supervisory coaching is provided individually and in groups on a weekly basis to all staff.
- **Performance Assessment (Fidelity)** – Fidelity is the end result of effective implementation components. When the Leadership, Competency, and Organization Drivers are working well, sufficient performance assessment measures should be reached. Performance assessment measures are used to not only provide feedback to staff on the strengths of their practice and opportunities for improvement, but also to inform feedback on the functioning of the other drivers. For Family Connections, performance is assessed via fidelity assessments conducted on a regular basis by DCS Fidelity and Compliance Services. Formal fidelity assessments are also implemented by the Family Connections technical assistance providers.

Organization Drivers are the components of implementation that create and sustain hospitable organizational and systems environments for effective services. There are three organization drivers: decision support data system, facilitative administration, and systems intervention.

- **Decision Support Data System** – Supports the ongoing use of data to guide decision-making at every level of the system, from frontline workers and supervisors through managers and administrators. Data are used to guide discussion around implementation or practice challenges and assessment of improvements. It is important for data to be reliable, reported frequently, and supported in use in daily practice (Metz, & Bartley, 2012).
- **Facilitative Administration** – Refers to the efforts and attention of the agency's administration to address implementation barriers and create an administratively hospitable environment for staff. It includes activities such as making sound internal policy decisions, procedural changes, and funding allocations to facilitate implementation. It also involves creating processes for feeding information to the right decision-makers who can take action to improve internal structures.
- **Systems Intervention** – This driver encompasses strategies to work with external systems and both internal and external stakeholders to sustain the financial, organizational and human resources necessary to the ongoing practice. Often leadership takes the responsibility to identify and attend to external system level barriers and facilitators. While these aspects of implementation can be unwieldy, it is necessary to identify and maintain focus on these issues as implementation proceeds through the stages. FC implementation includes service provider active contract management meetings where data is reviewed to identify areas of strength and need in capacity, process, quality and outcomes; and community of practice meetings for collaborative practitioner learning.
- **Leadership Driver -** This driver acknowledges that there are different leadership strategies for different challenges. It is based on Heifetz and Laurie's (1997) identification of two types of challenges: technical and adaptive. Technical challenges are those with high level of agreement about the challenge and high levels of certainty on the solution. Adaptive challenges are those where problems are not clear and solutions are elusive. It is vital for leaders to correctly identify whether the challenge is adaptive, technical, or contains elements of both before solutions are conceived of and carried out.

Increased safety, well-being and stability of children and families

Reduction in out-of-home placement and repeat maltreatment

Presenting issues at time of referral and other case management issues addressed effectively

Reduced risk factors

Developed protective factors

TABLE 3-1. EXAMPLES OF TECHNICAL AND ADAPTIVE CHALLENGES

TECHNICAL CHALLENGES	ADAPTIVE
Selecting the communication method	Communicating tailored messages to stakeholders
Writing policy based on law	Implementing the policy
Issuing memorandum of understanding for interagency collaboration	Collaborating with interagency stakeholders
Providing language translation services	Practicing with cultural competence
Making logistical arrangements for parents to attend family team service planning conferences	Engaging parents to participate in service planning

IMPLEMENTATION TEAMS

To effectively implement a program or intervention, organizational capacity has to be put into place to support and sustain the work. NIRN identifies Implementation Teams as one way to organize internal capacity to support the ongoing work required by evidence-based programs (Metz & Bartley, 2012). Implementation Teams provide a focused and accountable structure to increase the likelihood that the program or intervention will be sustained over time.

Implementation Teams are a "core group of individuals who are representative of the stakeholders and the 'system' and who are charged with guiding the overall implementation from exploration through full implementation" (National Implementation Research Network, 2010) Implementation Teams focus on (Metz & Bartley, 2012):

1. Increasing "buy-in" and readiness
2. Installing and sustaining the implementation infrastructure
3. Assessing fidelity and outcomes
4. Building linkages with external systems
5. Problem-solving and sustainability

Leaders meet monthly to collaboratively support implementation of Family Connections in Arizona.

CHAPTER 4: THEORETICAL BASE

People are individually and uniquely created with different experiences, thoughts, and perceptions which influence their behaviors and outlook on life. Families are complex entities that perpetually influence individual members' well-being within the family system. A change in one individual's behavior affects the system as a whole.

Encouraging positive change in families, such as increased family functioning, is complicated and must consider each individual's needs and strengths. Furthermore, an individual's integration, influence, culture, and community systems must also be taken into account for the best results associated with such change. The FC practice framework expects FC Consultants to regard these considerations as integral underpinnings of the practice and to view each individual in the context of family, community, and culture.

This chapter describes the theoretical base for Family Connections. It is important that FC Consultants and supervisors understand the social work theories underlying the FC practice model and the purposeful alignment with these theories at each level of FC implementation and practice.

ECOLOGICAL DEVELOPMENTAL FRAMEWORK

Family Connections uses multiple social work theories, in addition to trauma-informed practices, to guide the understanding of families' needs and to drive specific intervention strategies. FC operates from an ecological developmental framework that views child abuse and neglect within an at-risk familial system associated with protective factors interacting across four levels: (1) the individual or ontogenic level, (2) the family microsystems, (3) the exosystem, and (4) the social macro system (Belsky, 1980).

The Ecological Developmental Framework, first formulated in Bronfenbrenner's Theory of Social Ecology (1979), is described in Table 4-1.

LEVELS OF INTERACTION	
Ontogenic (Individual)	• Individual characteristics like personality, age, gender, education, health, skills, and talents. • Changing developmental stages of family members (infant, toddler, adolescence, young adult, etc.)
Family Microsystems (Familial)	• Family environment • Parenting styles and past experiences of each family member that influence the family system • Family interactions and rules
Exosystem (Communal)	• Community • Parental workplace • School and peer groups • Formal and informal social supports • Services available to family • Family income • Employment and job availability
Social Macrosystem (Cultural)	• Cultural values and beliefs

TABLE 4-1. ECOLOGICAL DEVELOPMENTAL FRAMEWORK

To be most effective, FC intervention should be directed at these multiple levels—which interact with and influence each other, affect family functioning, and impact child safety and well-being—and focus on the specific needs of each family and each family member. In addition, FC draws from several other social work theories and models including: (1) psychosocial theory; (2) problem-solving theory; (3) life model theory; (4) crisis theory;

(5) systems theory; (6) role theory; (7) cognitive behavior theory; (8) cognitive theory; (9) empowerment approach; (11) attachment theory; (12) trauma theory; and, (13) trans-theoretical model of change. Each is summarized below.

PSYCHOSOCIAL THEORY

Psychosocial theory recognizes the influences of biological factors, internal psychological and emotional processes, external social and physical conditions, and the interplay among these (Robinson & Kaplan, 2011, p. 387). A basic premise of the psychosocial approach drawn from this theory is that of person-in-situation (Martinez-Brawley & Zorita, 2017). It also recognizes the developmental evolution of the individual occurs within a social context. For example, FC Consultant's use psychosocial theory when helping families reduce problems arising from disequilibrium between families and their environments. In particular, FC assessments are geared toward understanding the "person-in-situation" so that meaningful service plans are developed specific to the unique needs of each family to reduce risk of abuse and neglect and/or eliminate impending danger, considering how the family functions within its larger social and environmental context.

PROBLEM-SOLVING THEORY

Problem-solving theory, originally conceptualized by Perlman (1957) and more recently articulated by Shier (2017), involves helping individuals through a problem-solving process to first define their problems and needs and then to mutually develop goals, resources, and plans to implement strategies that will address them. An important assumption of problem-solving theory is that life's problems do not represent weakness or failure on the part of families, but rather are the outcome of a natural process of human growth and change. It is further assumed that if problems can be carefully defined, the capacity to solve them can also be developed.

In Family Connections, problem-solving theory is used to mutually define family needs, conduct a family assessment, develop a service plan, and implement action steps to accomplish outcomes and goals, evaluate progress, and eventually reach decisions about service closure. The collaborative nature of these is further evidenced when there is an in-home or ongoing DCS Specialist involved due to conditions that rise to the level of impending danger or heightened risk to the child(ren). Parents/caregivers who are overwhelmed by their experiences often need additional support and encouragement to effectively problem solve to begin to address the safety threats or risks in their family. FC Consultants help families address each of the obstacles in the change process through development of a collaborative relationship that motivates and supports individuals' thinking and feeling processes. Problem-solving theory can help families describe and "put words to" the underlying problem, allowing them to then focus on developing solutions and action steps to increase their protective factors and enhance their protective capacities.

LIFE MODEL THEORY

Life Model theory helps us understand that individuals and families experience unique developmental pathways. Over the life course, people strive to improve the level of fit between their expectations and existing environmental supports, in order to buffer against stressors and facilitate greater access to desired resources (Gitterman, 2017). When people feel positive in their ability to fulfill their needs and aspirations and when they view resources as available, both they and their immediate environments enter into a reciprocal relationship that creates a sustained condition of adaptedness (Gitterman, 2017). For example, children left with the task of parenting younger siblings because of the death of a parent may have negative feelings and perceptions of "being out of sync" with peers as they feel they are missing out on typical childhood experiences. In FC, Life Model theory is used to consider difficult life transitions, traumatic life events, environmental pressures, dysfunctional interpersonal processes, and the degree to which the environment is supportive through both formal and informal systems.

CRISIS THEORY

Crisis theory suggests that stressful life events can precipitate a state of crisis for parents/caregivers as a result of being overwhelmed. A particular situation may be experienced by

some as a crisis, but not by others – even within the same family system. For others, the traumatic event or crisis may become a significant risk factor for other problems.

Because Family Connections targets families who are at risk of child abuse or neglect or have unsafe children, it is likely that many families will be in crisis when service is initiated. Crisis theory in FC is applied when families are provided with immediate emotional, informational, and/or concrete aid. Some families may need immediate relief before they will be able to fully participate in services. Still other families may periodically experience crises at later stages of the FC intervention. The goal is to help families function in difficult situations in a comfortable, growth-enhancing way by reducing stress and restoring, at a minimum, the previous functional level (Regehr, 2011). When crises occur, it is important to apply nine principles of crisis intervention (Ell, 1996):

1. Aid is provided as quickly as possible, often through outreach to families
2. Crisis interventions are time-limited and brief
3. The practitioner role is active
4. Symptom reduction is a primary goal
5. Practical information and tangible support are provided
6. Social support is mobilized
7. Expression of feelings, symptoms, and worries is encouraged
8. Effective coping is supported to restore a sense of competency as early as possible
9. Cognitive issues about reality testing and confronting the experience are addressed

SYSTEMS THEORY

Systems theory provides a conceptual framework shifting attention away from a cause-effect relationship between two variables and instead views people and their situations as an interrelated whole (Bowers & Bowers, 2017). Systems theory studies reciprocal relationships among individuals, groups, organizations, and communities and mutually inter-influencing factors in the environment. Behavior change is conceptualized to occur by examining interacting components. This suggests we need to study the entire system to understand the dynamic interactions, transactions, and organizational patterns critical to the functioning of both the individual and situation. This theoretical framework partly explains why FC Consultants work with families in their communities and why their networks of support become part of the outcome driven service plan and intervention process.

Further, since FC Consultant's work with each family as the family members define it, the principles of systems theory should be applied (Andrae, 2011, p. 246), including:

1. The family system represents a subsystem of the larger community.
2. The whole is greater than the sum of its parts.
3. Changing one part of the system will lead to changes in others parts of the system.
4. Families organize and develop over time. Families are always changing, and, over the life span, family members assume different roles.
5. Families are generally open systems in that they receive information and exchange it with each other and with people outside the family. Families vary in their degree of being open and closed, which may vary over time and according to circumstances.
6. Individual dysfunction is often reflective of an active emotional system. A symptom in one family member is often a way of deflecting tension away from another part of the system and hence represents a relationship problem.

There are four essential domains of environmental interactions for individuals and families, including the micro-, meso-, exo-, and macro- levels. For example, for a child, the micro-system is the actual setting in which the child experiences and creates reality. At first, the micro-system is quite small: the home environment. However, as the child develops, the micro-system includes a broader base of activities in which the child plays, works, and learns to love others.

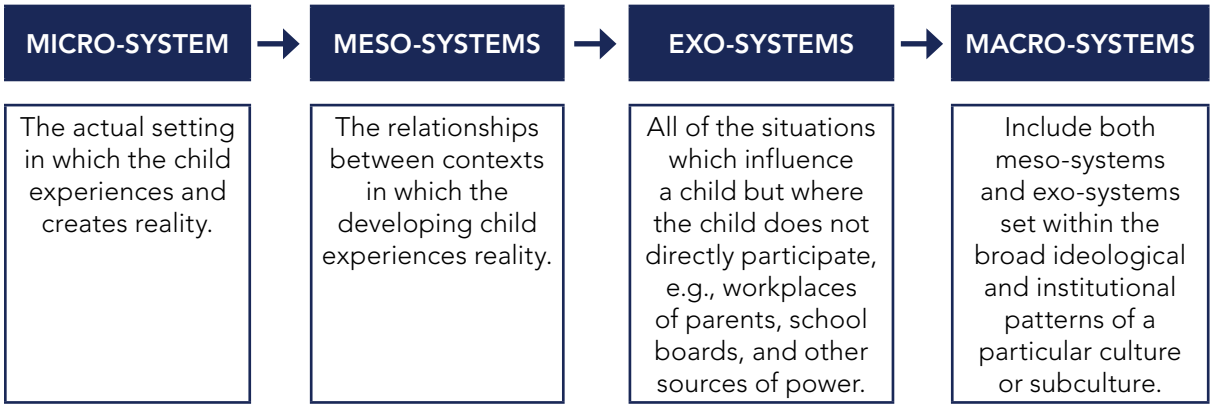
In contrast, meso-systems are the relationships between contexts in which the developing person experiences reality. The richness of meso-systems for the child is measured by the size

(quantity) and depth (quality) of connections (Garbarino & Eckenrode, 1997). For example, the connection between home and school constitutes an important meso-system. Growing up in a home in which family members do not value the benefit of schooling and the usefulness of books and reading, nor stimulate children to participate in learning, can jeopardize the child's academic development. However, when all of these links are strong, the odds favor the development of academic competence(Garbarino & Eckenrode, 1997).

Exo-systems are all of the situations influencing a child but in which the child does not directly participate, e.g., workplaces of parents, school boards, and other sources of power(Garbarino & Eckenrode, 1997).

Macro-systems include both meso-systems and exo-systems that are set within the broad ideological and institutional patterns of a particular culture or subculture (Garbarino & Eckenrode, 1997). The interactions of these systems are illustrated in Figure 4-1.

FIGURE 4-1. ENVIRONMENTAL INTERACTIONS



Family systems are governed by rules, for the most part unstated, which have typically been developed and modified through trial and error over time. Functions of individual family members are inextricably connected and a degree of reciprocity is essential in maintaining relationships in a system. Family systems are open or closed depending on the degree to which they are organized and interact with the outside environment.

Each family system has boundaries separating it from the outside or from non-family members. Family systems are dynamic and must maintain their continuity while tolerating change. However, systems always strive to maintain a stable equilibrium. A positive change in one member of the system can have a destabilizing effect and may be perceived as a threat by other members of the family. The system must be helped to frame the change as positive and desirable.

ROLE THEORY

Role theory is used in social work practice from a sociological understanding of how much of our functioning is shaped by modifiable role patterns developed throughout life (Kimberley & Osmond, 2017). Role theory helps us understand how a person's perceptions of role affect behavior and interactions with other family members. For example, individuals who experienced maltreatment may bring behaviors and expectations to the family situation because it is their understanding and experience of the role they are in rather than their choice. Some parents who are challenged to adequately care for their children are influenced by their inability to accept a parenting role. Frustration and stress can occur when roles are not well defined or the person does not have adequate resources to fulfill their role. This is especially important to remember since many of the reasons that some parents/caregivers have difficulties meeting the basic needs of their children are not due to personal problems, but due to a lack of access to adequate resources that will enable them to fulfill their caregiving roles.

COGNITIVE BEHAVIOR THEORY

Behavior theory assumes all behavior is learned and can be both defined and changed. Individuals learn that when they alter their behavior, they will receive a different response. Behavior theory suggests that looking at what happens before or after a behavior and

changing one reaction or response, may change the outcome and consequences. Through reinforcement, behaviors are shaped (Thomlison & Thomlison, 2017). Built on three waves of behavioral theory, this approach holds that with active participation in intervention, behavior can be modified through a wide range of tested techniques (Thomlison & Thomlison, 2017). Cognitive behavior theory posits the idea that if you can change the way you think, you can change the way you feel.

Since families come to FC with a range of presenting needs and challenges, some of them will be best addressed through cognitive behavioral techniques. In particular, the treatment of social, emotional, and behavioral problems of children, adolescents, and adults fit well with cognitive behavior therapy (CBT). Specific issues that may lend themselves to cognitive behavioral strategies include child behavior at home and school, parent/child interaction, stress management, social skills, addictions, developmental disabilities, depression, couple problems, or family violence. Cognitive behavioral interventions can foster feelings of competence and control and can instill hope.

COGNITIVE THEORY

A cognitive approach to social work practice is based upon the idea our thoughts affect our emotions and then our behavior. As a result, it is suggested that if you can influence thinking patterns leading to dysfunctional patterns, then you can help individuals experience different emotions that in turn affect behavior. For example, if a child is crying because he is teething, yet your thought pattern is that the child is deliberately crying because he does not love you and wants to punish you, you might feel less nurturing and comforting toward the child. Cognitive theorists and cognitive social work models of intervention believe good social work treatment includes considerable effort directed toward helping the individual identify, challenge, and change thinking patterns that result in dysfunctional forms of emotion, behavior, and problem solving (Lantz, 1996).

Emerging from sociology, cognitive theory helps us to understand how an individual, group, family, community, or organization thinks about a social reality and how such thoughts influence behavior (Chatterjee & Brown, 2017).

FC Consultants may choose to use cognitive interventions in any situation in which the comprehensive family assessment suggests the problem is at least partially the result of thought processes. Cognitive strategies may be particularly relevant when parents/caregivers have experienced deprivation in their own childhood. Described by Polansky, Chalmers, Williams, & Buttenwieser (1981) as "apathy-futility syndrome", or as "psychological complexity" by Pianta, Egeland, & Erickson (1989), neglectful caregiving may be related to a failure of parents/caregivers to have received nurturing when they were children. Cognitive interventions may help such individuals change dysfunctional self-perceptions incorporated as a result of early experiences of neglect and abuse and break the intergenerational cycle of maltreatment (Egeland & Erickson, 1990).

EMPOWERMENT APPROACH

The empowerment approach focuses on empowering people as individuals, families, groups, and communities to develop potential and assets (Lee & Hudson, 2017). The empowerment approach asserts that people in poverty and oppressed groups seldom have a goodness of fit with their environments. Empowerment involves assisting individuals to develop a more positive sense of self, helping them achieve an understanding of their social and political realities, and facilitating their cultivation of resources and strategies to attain personal and collective societal goals. Empowering families is basic to the Family Connections approach. Our goal is to carry out interventions in a way that enables family members to acquire a sense of control over their lives because of their efforts to meet their needs (Dunst, Trivette, & Deal 1988). To accomplish this, we assume the role of working "with" the family, not "for" the family. This requires working hand-in-hand with individuals and families to promote their sense of self-efficacy as they strive for independence.

ATTACHMENT THEORY

Attachment theory, developed by John Bowlby (1982), focuses on the form, quality, and strength of human attachments made in early life and their effect on development and pro-social behaviors (Page, 2017). Attachment theory as applied to Family Connections

focuses on parental/caregiver attachment to their children and how the historical styles of relating to others, experienced by the individual, influence the capacity to form secure attachments with their own children (Erickson, Egeland, Simon, & Rose, 2002; Egeland, 2007; Sroufe, Egeland, Carlson, & Collins, 2005). Attachment theory informs work with both children and parents/caregivers. Early attachments with primary caregivers form the basis for later adult and caregiver-child relationships. When these attachments are severed, inconsistent, or affected by trauma or maltreatment, the capacity to build adult relationships and caregiving skills may be impaired.

Despite the potentially deleterious effect of early psychosocial deprivation on humans, many maltreated children show resilience and are able to build positive working models and securely attached relationships. The ability to form a coherent understanding and narrative of early childhood experiences has been related to successful adult attachment relationships and parenting. For example, in one study, adults who reported negative attachment relationships in childhood but were able to later form secure attachments in adulthood showed similar parenting ability to those with continuous positive experiences throughout the life course (Roisman, Padron, Sroufe, & Egeland, 2002).

TRAUMA THEORY AND TRAUMA-INFORMED CARE

Trauma is a common experience in the United States and knows no boundaries with regard to age, socioeconomic status, gender, race, or ethnicity. Trauma may occur as a result of a deeply distressing or disturbing event, the experiences the individual has due to the event, and/or the long-term effects the event has on the individual. Individual perception of the event largely determines whether or not trauma is experienced. Not all distressing or disturbing events result in trauma, as particular events may be experienced or perceived as traumatic by one individual, but not by another (Substance Abuse and Mental Health Services Administration, 2014). The perception of trauma has much to do with the individual's functioning level prior to the event and the person's capacity to recover quickly from difficult situations. When a person Perceives an experience as traumatic, it can negatively affect physical, social, mental, cognitive, and emotional functioning. (Trauma and Violence, 2019). The impact of trauma can cause a variety of physical and mental health issues, including substance use and depression, creating a long-lasting impact on an individual's life.

Integrating an awareness of trauma into child welfare service delivery is critical in supporting the achievement of positive outcomes for children and families. The integration of trauma -awareness and related best practices in service delivery is known as trauma-informed care. Trauma-informed care provides "a framework that involves understanding, recognizing, and responding to the effects of all types of trauma. It emphasizes physical and psychological and emotional safety for staff and providers, with the goal of helping staff rebuild a sense of control and empowerment" (The Trauma Informed Care Project, 2020). This framework is put into action through demonstrations of empathy and compassion, through curiosity and listening, and by accessing skills that elicit these important narratives.

Trauma-informed care includes developing a deeper understanding of the individuals and families being served, with special attention to how trauma has impacted both historical and present day behaviors. It is being attuned to individuals' perceptions of their traumatic experience and making active efforts to avoid re-traumatization. Trauma-informed care is also the action of providing trauma-specific interventions and resources, guided by the wants and needs of the person or family being served. Lastly, trauma-informed care emphasizes the well-being of FC staff and the importance of self-care, including the development of positive coping strategies that can be accessed when their own traumatic histories have been triggered.

TRAUMATIC EVENTS

Traumatic events and perceptions of events differ between adults and children; children process trauma differently due to differing levels of cognitive, emotional, and social development. A traumatic event for an adult is defined as a shocking, scary, or dangerous experience that can affect an individual emotionally and physically (Coping with Traumatic Events, 2020). Potential traumatic events for children or adults may include any of the following:

- Physical, sexual, or psychological abuse and neglect

- Natural disasters
- Terrorism
- Racism
- Domestic Violence
- Community Violence
- Death of a primary caregiver or loved one
- Separation from a primary caregiver
- Substance use disorder
- Serious car accidents
- Life-threatening accidents
- Serious illness
- Family experience of trauma (i.e., historical)

Adults who experience a traumatic event may or may not present with trauma symptoms depending on their ability to cope with the event. This may be, in part, because adults who access social or other support systems and are able to verbally process feelings about the event are generally able to decrease the severity of the trauma and the overall impact of the trauma on their lives.

For children, trauma is defined as "a frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity. Witnessing a traumatic event that threatens life or physical security of a loved one can also be traumatic." (Peterson, 2018) Unlike adults, children often have difficulty processing traumatic events and may show trauma symptoms almost immediately. Because children internalize and process information differently than adults, there are specific types of traumatic events that are unique to them. One such example of a traumatic event that is specific to children is traumatic separation. A child's psychological attachment and relationship with the primary caregiver greatly impacts the child's sense of self, ability to trust, and ability to feel safe. When a child is suddenly separated from the primary caregiver, such as due to a removal from the home, the deportation of a caregiver, or the death of a caregiver, it may be overwhelming and traumatic for the child. Separation from a parent may cause posttraumatic responses in a child, including nightmares, appetite changes, self-blame, self-destructive thoughts and actions, somatic symptoms, and changes in the child's behaviors (National Child Traumatic Stress Network, 2018).

While there are numerous types of traumatic events an individual may experience, exposure to trauma is categorized as follows:

- Acute, or simple, trauma is the result of an individual experiencing a single dangerous or stressful event. For example, an individual may suffer from acute trauma after experiencing a car accident, or witnessing a violent fight.
- Chronic trauma occurs when an individual experiences multiple traumatic situations. This may happen, for example, to an individual in an abusive relationship or when an individual experiences one trauma after another.
- Complex trauma is similar to chronic trauma as an individual has experienced repeated instances of the same type of trauma over a period of time or experienced multiple types of trauma. (Van der Kolk, McFarlane, & Weisaeth, 1996). In addition, complex trauma is generally caused during childhood by a child's primary caregiver or another trusted individual in a child's life. Complex trauma impacts several areas of a child's functioning and development. This may present in their ability to trust caregivers, and in identifying, expressing, and managing emotions.

All trauma exposures and experiences can create life-long difficulties that impact both the individual and the family unit.

SPECIFIC TRAUMAS

Specific traumas cover a broad range of traumatic events that impact generations of families,

cultures, religions, and races. These traumas include historical, intergenerational, and racial traumas and are defined as follows:

- **Historical trauma** impacts large populations and the effects of the trauma have lasting impacts on the generations that follow. Tori DeAngelis defines historical trauma as a "… multigenerational trauma experienced by a specific cultural, racial or ethnic group. It is related to major events that oppressed a particular group of people because of their status as oppressed, such as slavery, the Holocaust, forced migration, and the violent colonization of Native Americans" (2019).
- Coyle defines **intergenerational trauma** as a trauma that affects one family (2014). "While each generation of that family may experience its own form of trauma, the first experience can be traced back decades" (Coyle, 2014). Children who live in homes where they are subjected to maltreatment often experience secondary trauma and are vulnerable to feelings of depression, guilt and anger.
- **Secondary trauma** occurs when an individual is indirectly exposed to trauma personally, or when witnesses a traumatic event, such as domestic violence.
- **Racial trauma** is a form of race-based stress. Racial trauma refers to People of Color and Indigenous individuals' (POCI) responses to dangerous events and real or perceived experiences of racial discrimination (Comas-Díaz, Hall, & Neville, 2019). Racism is a contributing factor to racial traumas and present as interpersonal, systematic, and institutional racism.

FC staff may encounter these specific traumas as they work with diverse family systems, and should use skills such as active listening and open-ended questions to empower the family members to share how they have been impacted by specific trauma.

HOW TRAUMA IMPACTS A PERSON THROUGHOUT LIFE

According to the Center for Disease Control and Prevention (CDCP), Adverse Childhood Experiences (ACEs) are "potentially traumatic events that occur in childhood" (2020). ACEs help determine the long-term impact trauma has on an individual throughout life. About 61% of adults surveyed across 25 states reported that they had experienced at least one type of ACE, and nearly 1 in 6 reported four or more types of ACEs (CDCP, 2020). Examples of ACEs include:

- child Maltreatment (abuse and neglect)
- witnessing violence within the home (domestic violence) or within the community
- incarcerated primary caregiver
- parental mental illness

ACEs have been shown to impact an adult's physical and mental health and increase substance use. Exposure to ACEs increase the risk of the following:

- substance use
- heart and liver disease
- mental illness such as depression
- teen pregnancy
- suicide

Children who continually live in a state of abuse and/or neglect experience an enduring traumatic event that causes toxic stress in their bodies and increases their chances for long-term effects. Child who experience toxic stress due to ACEs have an increased risk forphysical and mental health conditions as they age.

TRANS-THEORETICAL MODEL OF CHANGE

The Trans-Theoretical Model assesses an individual's readiness to act on new behaviors and provides strategies for change to guide the individual through the stages of change (Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992). The degree to

which children, youth, parents/caregivers, and families are ready to change varies over time and has been described as following a pattern that includes:

- Precontemplation: not seeing the need to change
- Contemplation: considering change but also rejecting it
- Preparation: wanting to do something about the problem and may have begun small steps to change
- Action: taking steps to change after deciding change is desired
- Maintenance: maintaining goal achievement
- Termination: sufficient change has occurred and intervention is no longer needed

Although not a specific stage, relapse should also be considered as it involves a return from Action or Maintenance to an earlier stage. Rarely do individuals follow these stages sequentially; rather, they are more likely to be at different stages in addressing different aspects of their behavior. Both the DCS Specialist (when applicable) and the Family Connections Consultant strive to understand how ready individuals and families are to change. Families are engaged in a professional process of assessing their comfort with the status quo and considering the pros/cons of making particular changes. Both DCS and FC Consultant then use techniques to try to instill hope that the situation can be different. Throughout the course of work with the family, there is continual assessment of motivation to change, how change is connected to the individual's core values, and whether their goals are realistic. It is important to remember that family members may be more ready to address some issues than others so they could be at different stages of change related to different identified risks and impending danger threats.

This implementation is a replication of the Family Connections practice model. The program design is family-centered, community-based, preventive, comprehensive, flexible, and employs a set of philosophical practice principles that have evolved from what research has proven works best with vulnerable families (Dunst, Trivette, & Deal, 1988; Hopps, Pinderhughes, & Shankar, 1995; Kinney, Strand, Hagerup, & Bruner, 1994; and Schorr, 1989).

This chapter provides an overview of ten philosophical practice principles that guide FC intervention: (1) community outreach; (2) family assessment and tailored interventions; (3) development of a helping alliance; (4) empowerment approaches; (5) strengths perspective; (6) cultural competence; (7) developmental appropriateness; (8) trauma-informed approaches; (9) outcome-driven service plans; and an (10) emphasis on positive attitudes and qualities of helpers. These principles drive the way we work with families and support Family Connections staff to implement FC intervention with fidelity. A brief summary of how each of these principles supports our work follows.

The overarching purpose of Family Connections intervention with families is to reduce the likelihood of future abuse and neglect to children. As such, Family Connections intervention within Arizona may occur with families whose children are not currently unsafe, but who have been identified to be at risk of future abuse or neglect and/or subsequent DCS referral. Family Connections intervention may also occur in families whose children are unsafe in their families; in impending danger. This latter category involves family conditions that have crossed from risk to imminent danger of serious harm.

IMPORTANCE OF OUTREACH AND COMMUNITY

Families with children whose basic needs are at risk of being unmet are typically poor and lack adequate financial support and access to resources (Gaudin, 1993; Smale, 1995). Further, these families are more likely to be socially isolated, experience loneliness, and lack social support (DePanfilis, 1996). Finally, the available literature shows that traditional, in-office, one-to-one counseling by professionals has not been proven effective in reducing the risk of child maltreatment (Cohn & Daro, 1987).

Family Connections believes it is essential to engage, support, and provide services to families within their homes, neighborhoods, and communities. As the FC Consultant gains knowledge of the family's neighborhood or community, they are in a better position to understand the context of protective capacities, risk factors and protective factors. Working with each family in its natural setting allows FC staff to do a more accurate family assessment and develop a more meaningful and achievable outcome driven service plan.

A central focus of the FC intervention is to use each family's strengths and community resources to achieve mutually agreed upon goals. Community supports may include schools, churches, child care services, legal aid, health centers, other social service providers, relatives, and friends. As community partners are identified, the FC goal is to help the family develop and manage beneficial relationships to meet its ongoing and long-term needs. In addition to including community partners in the assessment and service planning processes, these connections are established to ultimately benefit the community as a whole.

IMPORTANCE OF FAMILY ASSESSMENT AND TAILORED INTERVENTION

Effective intervention to reduce the risk of child maltreatment and/or address underlying conditions that made children unsafe is based on a comprehensive, individualized, collaborative assessment of the family. The assessment considers the types of maltreatment that may occur without our intervention due to impending danger; and/or, the specific contributing risk factors at the individual, family, neighborhood, and community levels.

When available, this individualized assessment is undertaken in conjunction with the DCS Specialist (if applicable) and with other service providers to form a comprehensive picture of the individual, interpersonal, and societal pressures on the family members - individually and as a group. This holistic approach takes both individual competencies and environment into consideration (Whittaker, Schinke, & Gilchrist, 1986) and views the environment as both a source of and solution to families' problems (Bronfenbrenner, 1979; Garbarino, 1982).

For both practice accountability and empirical usefulness, the FCC incorporates the use of standardized clinical assessment measures included in a Computer Administered Self Interview (CA-Self Interview) to guide the assessment of parent and family needs contributing to impending danger or risk of abuse or neglect. These identified needs are then translated into specific intervention outcomes which form the basis of time-limited, individualized family service plans. This process involves tailoring services to the unique strengths and needs of each family. When the family has an open DCS in-home or ongoing services case, the DCS Specialist and FCC collaborate so that FC services compliment and support progress toward the behavior change statements in the DCS case plan. Information from the FCC about the parent/caregiver's work and progress within the FC program is considered in the DCS Specialist's ongoing assessment of safety, risk, parent/caregiver protective capacities, and family protective factors.

Family Connections intervention includes assertive outreach and advocacy and is designed to mobilize concrete formal and informal helping resources.

Family Connections Consultants work with each family to develop an individualized family assessment that guides identification of individualized tailored interventions which will reduce risk of future abuse and neglect, and ameliorate impending danger when children are unsafe. Each family is considered an expert about its family and is treated with dignity and respect. Each family is encouraged to invite other providers involved with the family to participate in the assessment, allowing the FCC to get a more comprehensive view of the family in its community. The assessment considers the family as a whole and each family member as an individual.

Because each family is unique and families who are at risk or imminent danger of child abuse or neglect are heterogeneous, no particular method of intervention will lead to desirable outcomes for even a majority of families (National Research Council, 1993; Wolfe, 1993). Further, because of the many different types of family systems, it is important that intervention be geared to the family's own definition of family and to culturally based differences and strengths (Lloyd & Sallee, 1994). Mainstream efforts with families in the past have focused too exclusively on mothers and have not explored the roles of fathers and other primary caregivers.

IMPORTANCE OF DEVELOPING A HELPING ALLIANCE AND PARTNERSHIP WITH THE FAMILY

Many families with impending danger or at risk for child abuse or neglect may not have had positive experiences with formal systems. However, an essential component of many effective programs is the creation of a helping alliance and partnership with the family (Dore & Alexander, 1996; Kenemore, 1993).

This requirement is sometimes challenging because some parents/caregivers, whose children are in impending danger or at risk of abuse or neglect may have difficulty forming and sustaining mutually supportive interpersonal relationships (Dore & Alexander, 1996; Gaudin & Polansky, 1986). One of the essential challenges for FC Consultants is to form positive connections and partnerships with families so that they will have an opportunity to tackle the difficult challenges in their lives (McCurdy, Hurvis, & Clark, 1996). Successful engagement with families, who may be resistant to intervention, requires an ability to feel and demonstrate empathy with caregivers (Siu & Hogan, 1989) despite their initial resistance to intervention.

Building relationships with parents/caregivers models conflict resolution and how parents/caregivers can build harmonious relationships which nurture the development of vulnerable family members (Bowlby, 1988). Crittenden (1996) suggests that when the FCC sensitively attends to the affective communication of family members, a pattern of feedback loops leading to mutual accommodation and assimilation is established. These dialogues acknowledge and support caregiver strengths and provide family members with a secure base for developing communicative skills (Bowlby, 1988). Through this process, FC Consultants can create interventions tailor-made to each family's needs and competencies (Crittenden, 1996).

Research has shown that effective engagement can be facilitated through evidence-based engagement practices that are designed to help families identify and overcome obstacles through participation in services (McKay, et al., 2004; Lindsey, Korr, Broitman, Bone, Green, &

Leaf, 2006). The helping alliance begins to be established with the first face-to-face meeting with the family. Engagement strategies have been shown to increase continued participation in services and help develop a strong therapeutic relationship that addresses the goals the family deems most important (McKay, et al 2004). To be effective over time, the intervention must help families develop more sustaining relationships with others. If intervention is neighborhood based, then these relationships will have a greater chance of enduring after intervention ends.

For families who also have an in-home or ongoing DCS Specialist assigned, the FC Consultant is a unique position to support the family's work with DCS. While building a trusting helping relationship with the family, the FC Consultant must also be diligent to not allow triangulation to occur. Regular communication between FC and DCS must ensure clear mutual understanding and agreement of why DCS is involved in the family. As such, the FC Consultant may help the parent/caregiver(s) understand the reason for DCS involvement and facilitate a strong working relationship between the family and DCS.

IMPORTANCE OF EMPOWERMENT BASED-PRACTICE

Empowerment is both a theory and a practice. It is also a process as well as an outcome (Lee & Hudson, 2017). To decrease risk and impending danger of child abuse and neglect, interventions must help families learn to effectively manage the multiple stresses and challenges in their families and neighborhoods. Ultimately, families should be empowered to resolve their own problems and avoid dependence on the social service system (Lloyd & Sallee, 1994).

Empowerment denotes a partnership between the practitioner and the family and involves the development and use of capacities of the individual, family, organization, and community (Fraser & Galinsky, 1997).

Drawing on these capacities helps families fully realize their own abilities and goals (Cowger, 1994; Guitierrez, 1990; Guitierrez, GlenMaye, & DeLois, 1995; Simon, 1994). The role of the helper becomes one of partner, guide, mediator, advocate, coach, and enabler.

Family Connections empowers family members to acquire a sense of control over their lives as a result of their efforts to meet their own needs.

Family Connections provides the opportunity to build on a family's existing competencies to respond to crises and stress, to meet needs, and to promote, enhance, and strengthen the functioning of the family system

IMPORTANCE OF EMPHASIZING STRENGTHS

Strengths-based practice involves a shift from approaches that emphasize problems, deficits, and pathology to one that fosters a positive partnership with the family. The focus on assessment is on the complex interplay of risks and strengths (protective factors), that may also coincide with impending danger related to individual family members, the family as a unit, and the broader neighborhood and environment. This is not to suggest staff avoid addressing problems or needs, but step back and put them into the larger context of family and community, while considering strengths to help improve the family's functioning. The focus of FC intervention is not on the correction of a problem through deficit thinking. It is on recognizing the conditions within the family and community that may be contributing to the problem and helping the family to identify strengths and resources within it and the community to meet its needs.

Another way to conceptualize this approach is that even in families in which children are unsafe, most impending danger is not active every minute of every day. Seeking to understand what is happening when the danger is not active will help to identify the family's strengths and periods of protective parenting.

IMPORTANCE OF CULTURALLY COMPETENT INTERVENTION

Risk and protective factors for child maltreatment, along with how impending danger manifests in families, may differ according to race and ethnicity. Furthermore, it is well established that families of color, and especially African American families, are disproportionately represented in the child welfare system (Leashore, Chipungu, & Everett, 1991; Chibnell, et al., 2003). Often these families are poor, poorly educated, and disadvantaged in the economic mainstream of the larger society (Jackson & Brisett-Chapman,

1997; Chibnell, et al., 2003). It is also well documented that children from African American, Hispanic, and non-Caucasian racial and ethnic backgrounds are subject to direct and indirect effects of discrimination and oppression, which increases their risk for many kinds of problems (Fraser & Galinsky, 1997). DCS and contracted Family Connections providers must collaborate in their assessment of families, and challenge themselves to identify and self-reflect upon any possible bias.

Culture is a set of beliefs, attitudes, values, and standards of behavior that are passed from one generation to the next. It includes language, worldview, dress, food, communication styles, notions of wellness, healing, spirituality, child-rearing, and self-identity (Abney, 2000). Human beings create culture, and each group develops its own over time. Culture is dynamic and ever changing. It changes as the conditions of people change and as their interaction with larger society changes. Every culture has a set of assumptions made up of beliefs that are so accepted by the group that they do not need to be stated, questioned, or defended. Cultural competency is the ability to understand, to the best of one's ability, the worldview of culturally different family members and adapt our practice accordingly. To best meet the needs of culturally diverse families, FC staff must use empathy, notice differences, and reflect on the uniqueness of each family (Wu, et. al., 2009).

DEVELOPMENTAL APPROPRIATENESS OF INTERVENTIONS

Children whose basic physical and emotional needs have been unmet may suffer significant developmental delays. Interventions may need to focus on developmental remediation, (e.g., therapeutic child care), while at the same time address attachment relationships between caregivers and children. Parents/caregivers may bring a host of developmental issues to the family, such as unresolved losses, abuse, or deprivation during childhood, and/or may have difficulty assuming parental roles. Described by Polansky, Chalmers, Williams, & Buttenwieser (1981) as "apathy-futility syndrome" or "psychological complexity" by Pianta, Egeland, & Erickson (1989), maltreating caregiving may be related to parents/caregivers having themselves experienced inadequate nurturing in their own childhood. Cognitive interventions can help such caregivers change dysfunctional self-perceptions incorporated as a result of early experiences of abuse/neglect and break the intergenerational cycle of maltreatment (Egeland & Erickson, 1990).

Family Connections strives to prepare staff to engage in culturally competent practice so that they may understand the worldview of the families, accept and respect cultural differences, and empower families to create intervention goals that are congruent with their culture.

Families may be suffering stress due to their developmental stage as a system (e.g., blended, young) or due to conflict in roles when families are comprised of caregivers across generations (e.g., grandparents, parents, children, grandchildren, and great-grandchildren). For example, our society is increasingly seeing grandparents raising their grandchildren due to neglect by the parents. These newly constituted families often lack security due to informal arrangements and inadequate resources (financial and physical) to provide adequately for children.

Further, the life cycle stages through which families evolve (Carter & McGoldrick 1988) are interrupted, and caregivers who thought that their child rearing days were concluded are unexpectedly unable to look forward to fewer demands during their later years. An essential FC practice principle is that our interventions target the specific developmental needs of children, caregivers, and the family as a system.

For families also assigned a DCS Specialist, collaborative information sharing will assist both the DCS and FC Consultant in understanding underlying causes of risk conditions and/or safety threats. This understanding will increase the likelihood of effective intervention throughout the FC intervention components and in the change-focused work of DCS.

OUTCOME DRIVEN INTERVENTION

John Schuerman, a former Professor at the University Of Chicago School of Social Services Administration, suggests that the future of the social work profession will depend on the ability to specify and measure the outcomes of social work practice (Mullen & Magnabosco, 1997). Similarly, Shanti Khinduka, the former Dean of the George Warren Brown School of Social Work at Washington University, suggests that measuring the results of interventions

is an essential component of social work practice today (Mullen & Magnabosco, 1997). Over twenty years after these statements, there is a general consensus that social workers must be able to collaborate with families to mutually define outcomes; develop UBSMART goals and activities to achieve outcomes; and define adequate measures for evaluating the degree to which families are successful at achieving outcomes. It is essential FC programs clearly measure the results of their work in order to determine what is working well and what needs to be developed or improved to benefit families.

Family Connections Consultants consider the developmental level of children, caregivers, and the family as a system in their assessments and intervention strategies.

If fidelity of service delivery is achieved, the Arizona DCS leadership team believes that child and family outcomes will also be achieved, including: (1) prevent child abuse and neglect; (2) strengthen parents' ability to keep their children safe, healthy and well cared for; (3) serve families in their own neighborhoods; (4) reduce the likelihood children are placed into out-of-home care; (5) reduce the likelihood there is a new report to DCS; (6) reduce the length of out-of-home care stays for children, reunifying them with their families more quickly; and (7) reduce the likelihood the reunified children re-enter out-of-home care. These outcomes contribute to long-term child safety (preventing child maltreatment), permanency & stability (preventing placement outside of the family home) and child well-being.

As noted in the AZ FC logic model (see Chapter 3), FC work with families targets interventions toward one or more core intermediate FC outcomes: parenting attitudes and behaviors, family functioning, social support, family resources, parenting stress, and child well-being. Trauma-informed approaches are incorporated to achieve these outcomes with families who have experienced, and whose functioning has been impacted by, trauma.

POSITIVE ATTITUDES AND QUALITIES OF HELPERS

To be effective delivering FC intervention, staff must possess specific qualities and skills including: concern for others; feel a commitment and obligation to the families they serve; communicate acceptance and expectation in their work with families; convey empathy and genuineness in all interactions with children, youth, parents, and families; demonstrate comfort with authority and power; and, accept and focus on the purpose of FC intervention.

Selecting staff with core helping skills and building competency in FC practice through facilitated learning and supervisory coaching is a strategic implementation expectation of FC. In particular, the learning and coaching approach, including weekly individual and group supervision, is expected to support staff to develop and strengthen effective ways of helping including:

1. a skillful use of self;
2. flexible and caring attitudes with children, youth, and families;
3. an interest in and ability to engage children, youth, parents, and families and form meaningful professional relationships with families;
4. a profound belief in a family's ability to change;
5. empowerment skills to support family member behaviors that improve the use of personal power, foster self-esteem, take care of personal problems, and set and pursue personal goals;
6. tolerance and acceptance of race, ethnicity, and gender and serve as a role model for respect and tolerance of diversity;
7. skills that involve the family in planning and in every stage of the Family Connections process; and,
8. the ability to advocate for families to obtain needed resources from community organizations.

Family Connections promotes the development of positive attitudes and qualities and effective ways of helping by selecting staff with these qualities and skills and providing coaching and supervision to build and sustain a professional approach to FC practice.

CHAPTER 6: ELIGIBILITY & REFERRALS

This chapter provides an overview of the eligibility criteria and service referral process, with an emphasis on which families are to be referred to Family Connections (FC) by the DCS Specialist. For FC to have the greatest chance of success in serving families, DCS will identify families who may benefit from this intervention based on the reason for DCS involvement and identify particular family characteristics that will help the receiving FC agency match the family to the best suited FC Consultant (FCC). Contracted FC agencies may have staff with additional qualifications to provide supplemental interventions (i.e. Nurturing Parenting Program) or with additional professional experiences to support more effective work with certain populations (i.e. knowledge and skill to deliver services to families impacted by mental illness or domestic violence.).

If families referred to FC are not good candidates to be successful,

there are a number of possible negative outcomes:

- Valuable FC resources are taken from families who would benefit from the intervention.
- There is increased likelihood of families dropping out of the program.
- There are unclear intervention focus and unclear outcomes.
- There is promotion of families' dependence rather than independence.
- The lack of success could lead to the family having feelings of hopelessness.

Family Connections was designed and tested to help families reduce risk factors associated with child abuse and neglect and to strengthen protective factors that will help families meet the basic needs of their children and keep them safe. FC has been successfully adapted for families whose children are unsafe (impending danger) to increase child safety, improve child well-being and improve family stability and permanency.

The purpose of Arizona Family Connections is to prevent future abuse and neglect and address risk factors and dangers that may lead to out-of-home care. To achieve this purpose, the FC referral process must accurately identify families who can benefit from FC intervention.

When DCS Specialists refer families to FC, they will have information from the Family Functioning Assessment (FFA-Investigations and/or FFA-Ongoing) about the six domains of family functioning. Using the FC service request, the DCS Specialist shall describe how the family meets all eligibility criteria.

The DCS Specialist and Supervisor shall discuss the family's service needs during a clinical supervision conference, including whether the family could benefit from the FC program and whether there are available community services that would be able to adequately meet the family's needs.

This chapter reviews the Arizona FC eligibility criteria, required information analysis, and documentation expectations. This chapter also includes information about the FC service request.

DCS ENGAGEMENT OF FAMILIES DURING THE FC REFERRAL PROCESS

The DCS Specialist shall describe the purpose, process, and services available through Family Connections; and ask the family about their history of service provision and perception about service benefit or lack thereof. In addition, the DCS Specialist shall begin to identify barriers that would interfere with participation and develop strategies to mediate these barriers.

FAMILY CONNECTIONS ELIGIBILITY CRITERIA

Family Connections can serve:

- families DCS case will close following investigation;
- families receiving in-home case management with no impending danger and no risk of emergency removal of a child if services are not effective;
- families receiving SENSE services;
- families receiving in-home case management with impending danger and safety plan, or risk of emergency removal of a child if services are not effective;

- families receiving ongoing case management with a child in out-of-home care

Families may be referred to Family Connections when all of the following criteria are met:

- The FFA-Investigation has been completed, with sufficient information collection to make an impending danger decision.
- At least one child age birth to 18 resides in the home; or a parent in the home has parenting time (visitation) with a child.
- At least one parent is able and available to participate in FC, and does not currently have any of the following restrictions on participation:
  - No contact order between the parent/caregiver and the child
  - Impairment requiring stabilization or improvement before the parent could benefit from FC (i.e. active psychosis, physical illness requiring hospitalization or residential care, pervasive substance use impacting reality orientation)
  - Institutionalized or incarcerated
- The DCS Specialist and family have discussed the family's strengths and needs, and the family has verbally agreed to meet with a Family Connections Consultant (FCC) to learn about the program and services.
- The DCS Specialist and DCS Supervisor have concluded one or more family members has a behavioral change goal that can be achieved by improving in one or more FC Core Outcomes, and there are no available and accessible community programs that would provide the family an equivalent service.

Families who only need concrete supports, where the lack of these supports is not creating a safety threat and risk of out-of-home care, shall be assisted by DCS to locate community resources and shall not be referred to FC.

FAMILY CONNECTIONS SERVICE LEVELS

FC services shall be provided at one of the following service levels:

Level One: The FC Consultant shall meet with the parent/ caregiver an in-person one (1) time per week, for a minimum of one hour, over a maximum of 150 days (five months) and conduct additional virtual, or telephone contact as required by the family to meet behavior change goals.

Level Two: The FC Consultant shall meet with the parent caregiver in-person two (2) times per week, for a minimum of one hour,over a maximum of 150 days (five months) and conduct additional virtual, or telephone contact as required by the family to meet behavior change goals.

The FC service level shall be determined by DCS and communicated to the Contractor through the referral process. The initial FC service level shall be determined by DCS case type, as follows.

FC Level 1:

- Families whose DCS case will close following the investigation (no DCS oversight)
- In-Home case with children assessed as safe (no safety plan managing dangers)
- Out-of-home/ongoing case with all children residing outside of the home and it is not expected for a child to reunify with the parent during the service authorization period

FC Level 2 (may only be requested and approved by the Supervisor when any of the following is true):

- In-home case with children assessed as unsafe due to impending danger (safety plan managing dangers)
- Out-of-home/ongoing case with one or more children residing in the home of the parent receiving services
- Out-of-home/ongoing case and a child in OOH care is expected to reunify with the parent receiving services within the service authorization period

FC Level 2 - SENSE Case (infant remains in the home with a parent and has an open in-home DCS case)

The FC service level for continuation authorizations will be determined by the FC Evaluation of Change [exhibit 12.1], family need, and consideration of other services in which the family is participating. The FC service level for continuation authorizations shall be determined and approved by DCS.

FAMILY CONNECTIONS REFERRAL PROCESS

The DCS Specialist shall submit a Family Connections Service Request to the Centralized Referral Unit for assignment of a Family Connections agency.

The DCS Specialist shall ensure that the following documents are associated with the Family Connections Service Request in the DCS Child Welfare Case Management System:

- completed most recent FFA-Investigation (Assessment), FFA – Ongoing, or FFA – Progress Update;
- completed safety plan if child is unsafe with a safety plan to manage dangers;
- Infant Care Plan (SENSE only);
- current court report (if applicable);
- Team Decision Making meeting summary (if applicable);
- current case plan (if referring for FC after FFA – Ongoing completed and available); and
- any other supporting information.

RE-REFERRAL FOR SERVICES

A Family Connections re-referral may be submitted at any time after the family's previous Family Connections service authorization referral has closed, if the family currently meets the Family Connections eligibility criteria.

The following are examples that indicate when a re-referral may be warranted:

- The prior referral closed because the family did not engage or refused services, and the family is now communicating readiness to participate, is court ordered to do so, or barriers to participation have been removed.
- The prior referral closed because the family could not be located, and the family's location is now known.

The DCS Specialist shall obtain DCS Supervisor approval for a re-referral prior to submitting a Service Request.

The DCS Specialist shall complete and submit a new Family Connection Service Request through the DCS Child Welfare Case Management System, following the procedures for an initial service request.

If a family is re-referred for the FC program within three months of the previous FC case closure, the family will be re-assigned to the same agency.

- If the DCS Specialist believes that re-referral to the same agency and/or FC Consultant is not appropriate, the DCS Specialist will notify the referral unit prior to referral assignment.
- If a family is re-referred for the FC program more than three months after the previous referral closed, the family may be assigned to the same agency or a new agency.

RECEIVING REFERRALS

Family Connections programs shall accept all service requests assigned by the DCS Centralized Referral Units. Family Connections agencies shall ensure staff are monitoring communication from the DCS Child Welfare Case Management system for pending service approvals. Family Connections agencies shall have staff available to receive and assign referrals Monday through Friday, 8:00 a.m. – 5:00 p.m., except on legal holidays recognized by the State of Arizona.

The Family Connections supervisor shall contact the assigned DCS Specialist if there are concerns with the requested service or with the referral questions, in order to develop the best strategy for service(s).

Upon referral receipt and prior to initial outreach with the family, the assigned Family Connections Consultant shall:

- participate in supervision consultation with the FC supervisor; and
- contact DCS to initiate information sharing and collaboration.

The in-person initial outreach meeting and intake meeting shall occur in the family home, unless the family requests another location or there are concerns for the safety of professionals entering the home.

The FCC shall refer to and apply the Code of Ethics of the National Association of Social Workers (NASW) (2017) when working with families. The NASW Code of Ethics describes the core values and ethical principles and standards that should guide social work practice, including FC practice. The FC model particularly reflects the following core values: the individual's dignity and worth, the importance of human relationships, and the integrity of social work professionals.

The Family Connections Providers shall be aware that culture and language may influence the behaviors of individuals who are seeking health, habilitative, or rehabilitative care and their attitudes toward speech, language, and hearing services and providers. Similarly, the delivery of services is impacted by the values and experiences of the provider. Providing competent care is providing service that is respectful of, and responsive to, an individual's values, preferences, and language.

The Family Connections Providers shall ensure that all services, procedures, and forms provided are culturally relevant, linguistically appropriate and gender responsive (including Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ).

The Family Connections Providers shall ensure cross-cultural communication support with the involvement of culturally competent staff in all levels of service delivery.

The FCC shall utilize strengths-based engagement techniques during the initial outreach meeting and/or intake meeting, including the use of open-ended questions, affirmations, reflections, and summarization (OARS).

The FCC shall utilize and communicate empathy, respect, and authenticity during the in-person initial outreach and intake meetings.

CHAPTER 7: OUTREACH & ENGAGEMENT: BEGINNING THE FAMILY PARTNERSHIP

WHY IS OUTREACH & ENGAGEMENT IMPORTANT? KEY ELEMENTS OF BUILDING A WORKING RELATIONSHIP WITH FAMILIES

Successful intervention relies on the quality of the interpersonal relationship (also known as the "helping alliance" or working relationship) between the Family Connections Consultant (FCC) and family members (DePanfilis, 2000). Forming positive connections with families will support the FCC's ability to help families overcome challenges and reach goals. The success of Family Connections depends on the ability of the FCC to engage and work with the family to identify underlying conditions that contribute to risk or safety threats, develop goals, and work toward goal attainment. The family's trust of and rapport with the FCC is paramount to this work. This chapter reviews the critical steps, skills, and elements of effectively reaching out to and engaging families in a working relationship. It focuses on the first face-to-face visit between the family and FCC, which is crucial to establishing a positive, constructive foundation for the ongoing working relationship.

INITIAL OUTREACH WITH THE FAMILY

The goals of initial outreach are to develop a positive helping alliance by reaching out and engaging with families, communicating concern, overcoming past experiences and other barriers to service, and conveying a comfortable and accepting presence. Initial outreach shall be conducted by the Family Connections Consultant (FCC).

- The FCC shall confirm the family's contact information through the DCS Child Welfare Case Management System before conducting initial outreach.
- The FCC shall contact the family via telephone to schedule the in-person initial outreach meeting, making reasonable efforts to hold the in-person meeting within one business day of referral receipt. A telephone call to schedule the in-person meeting shall not be considered the initial outreach meeting*. If telephone contact is unsuccessful, the FCC shall make an unannounced in-person visit to the home within one business day of referral receipt. If in-person initial outreach attempts are unsuccessful within one day of referral receipt, the FCC shall continue with initial outreach as outlined below:
    - Over the following three business days or until an appointment is scheduled, the FCC shall make a minimum of one telephone call attempt per day, and three in-person outreach attempts at alternate times of day or evening.
    - The FCC shall prepare a contact letter, in a plain envelope, to be left at the home if the parent/caregiver(s) are not home, following each in-person outreach attempt; informing the parent caregiver(s) of the FCC's attempts to contact the family. The letter shall include information about the FC program, the provider's office address, a contact person, and contact information for the FCC.
    - If a family is homeless or transient, this does not automatically preclude the family from participating in Family Connections. The FCC shall make reasonable efforts to engage the family regardless of their living arrangement. Reasonable efforts may include, but are not limited to: providing the parent/caregiver(s) with bus tickets, scheduling meetings in locations the family can readily get to, and/or making arrangements to communicate through a third party if the parent/caregiver does not have a cell phone.
    - The FCC shall notify the assigned or referring DCS Specialist or DCS Supervisor when these efforts to contact the family have been completed and remain unsuccessful, or within one business day of the family declining services. The provider may request DCS assistance to contact and engage the family at any time.

** The name "initial outreach meeting" is specific to Arizona Family Connections. In the original Family Connections program, the first meeting between the Family Connections staff and the family is called the initial visit.*

- If a family does not have an open DCS case and was referred to the FC program as part of Aftercare Planning and Services and the family declines the FC program during initial outreach, follow procedures outlined in Parent/Caregiver Declines the FC Program.
- If the FCC makes contact with the family during initial contact, the FCC shall document all of the initial outreach events in the Weekly Progress Report. If the FCC is unable to make contact or engage the family in the FC program, the FCC shall document all initial outreach attempts with the family in the Service Closure Summary: Section A. Services shall not be closed without prior approval from DCS (if the family remains open with DCS oversight) or FC Supervisor (If a family does not have an open DCS case and was referred to the FC program as part of Aftercare Planning and Services).
- The FCC shall facilitate the initial in-person outreach meeting with the family within one business day of referral receipt and complete the following:
  - connect with and engage the family by establishing therapeutic rapport;
  - explore the family's understanding of why they were referred to FC;
  - describe the FCC and DCS Specialist roles (if applicable);
  - emphasize the family strengths and needs;
  - discuss the FCC's responsibility to report any suspected incident of child abuse or neglect to DCS or disclosure/observation of suicidal or homicidal intention;
  - review and obtain written consent utilizing the Department's Release of Information (ROI) form;
  - introduce how FC works with families, including use of computerized assessment and screening tools, weekly home visits, and development of outcomes and goals that target change;
  - when referred as a SENSE case, the FCC shall introduce how FC works with families, including working in collaborative partnership with the home visitor, SENSE Registered Nurse (RN), and substance use treatment provider;
  - explore issues of risk and/or safety in the context of the DCS referral;
  - identify concrete, practical issues to be immediately addressed;
  - to obtain commitment to work together, answer questions the family may have and summarize the process for working together;
  - provide contact information for the FCC and the FC Supervisor; and
  - schedule the next meeting between the family and the FCC, including what the family can expect prior to the next home visit, which may include work toward assessing and meeting immediate, concrete needs.

Arizona Family Connections (FC) is focused on preventing child abuse and neglect and addressing threats to child safety that create risk for out-of-home care or DCS referral. A crucial ingredient to achieving these goals is building effective partnerships with families. This process begins during the first contacts with families.

INTAKE MEETING*

The intake meeting is an opportunity to encourage and motivate the family to participate in Family Connections services, ensure a timely hand-off to FC (cases that do not have an open DCS case and were referred to the FC program as part of Aftercare Planning and Services) or coordinate services (for cases that will remain open and have ongoing or in-home DCS case management), and reach a shared understanding of the reason for DCS and FC involvement.

The FCC shall conduct the intake meeting with the family within five business days of referral receipt. To prepare for the intake meeting, the FCC shall:

** The name of the Intake Meeting is specific to Arizona Family Connections. Arizona DCS commonly uses the term "Intake" in such a way. While the original Family Connections program does not require a joint visit with the family by a referring CPS caseworker and FC staff, these sort of meetings are commonly called a joint home visit or transition meeting in other FC replications.*

- communicate with the family to identify potential times for the intake meeting, while considering the family's schedule and preferences, noting that the intake meeting shall be a minimum of one-hour;
- review all available DCS documentation about impending danger threat(s) and/or risks present in the family, protective capacities, protective factors, the behavioral changes identified by DCS, Conditions for Return (when applicable), and the anticipated focus of intervention;
- review information about the family's cultural background provided on the FC service request or contained within other DCS documentation; and,
- anticipate responding to any emergency needs the family identifies and prepare to devote additional time to the family if needed.

The FCC shall facilitate the intake in the parent/caregiver's home, unless the parent/caregiver requests another location or there are safety concerns for professionals entering the home. The FCC shall obtain approval from the DCS Specialist, via telephone call or e-mail, for exceptions to the intake meeting occurring in the home. The approval communication and date will be documented within the Weekly Progress Report. Exceptions shall be based on the needs of the family or due to a scheduled meeting, such as a TDM or CFT at which the intake meeting will take place.

During the intake meeting, the FCC shall confirm the family is informed of, and understands:

- whether the DCS case will close or remain open;
- if the DCS case will close, the case closure process and continued role of the FCC with the family and expected length of service;
- if the DCS case will close, that the DCS Specialist shall assist the family to develop an Aftercare Plan (CSO-1349A);
- if the DCS case will remain open, that the DCS Specialist and the FCC will both meet in-person with the parent or family, at times together but most often separately, and the expected frequency of contact by the DCS Specialist and FCC;
- if referred for SENSE services, that within the first thirty (30) days of service a SENSE RN will outreach and engage the family to schedule a home visit;
- the reason for DCS involvement with the family, and the behavioral change goals if these have been established;
- if the child is in out-of-home care, the safety plan and the Conditions for Return, and ways in which the FC program might assist the family to meet the Conditions for Return;
- if DCS already has a case plan established at the time of the family's referral to FC the contents of the case plan;
- that the FCC is not a DCS employee, but will communicate with the DCS Specialist and share information about the parent's/family's attendance, participation, and progress reaching the identified goals; and
- the FCC's and DCS Specialist's roles and what the family can expect throughout the FC program.

A description about engagement related to the in-person initial outreach and intake meetings is provided in Additional Information-Engagement at Each Phase.

MISSED APPOINTMENTS

The FCC shall make reasonable efforts to continually engage the family during the outreach and engagement process to reduce likelihood of missed and/or cancelled appointments. If a regularly scheduled appointment is missed by the family, the FCC shall initiate telephone contact with the family, utilizing all available phone numbers. If telephone contact does not occur, the FCC shall wait at the appointment location for fifteen minutes. If the parent/caregiver is not at home, the FCC shall leave and document the attempted home visit in the Weekly Progress Report.

If the FCC does not receive a response from the parent/caregiver within twelve hours of the missed contact, the FCC shall follow the initial outreach protocol for re-engagement with

the family.

If appointments with the FCC are missed, cancelled and/or rescheduled without reasonable justification, and in-person contact with the family does not occur over the next three business days, the FCC shall contact the DCS Specialist to schedule a meeting within three (3) business days. This meeting shall occur via video conference or telephone and include a discussion of:

- the FCC's efforts to engage the family and the family's response to these efforts;
- reason(s) known as to the family's missed appointment; and
- whether a joint home visit should be scheduled with the family to discuss their continued interest in participating in the FC program, or the FCC should proceed with service closure.

If there is no open DCS case, the FCC shall consult with the FC supervisor and obtain approval before initiating the service closure process.

PARENT/CAREGIVER DECLINES THE FC PROGRAM

A family may decline the FC program at any point during service delivery. If the family has ongoing or in-home DCS case management and the family declines the FC program at initial outreach, the DCS Specialist shall encourage the parent/caregiver to agree to a single meeting to learn about the FC program and meet with the FCC. If the family has agreed to participate in the FC program and later declines the FC program, the FCC shall speak with the family to understand the family's reasons for declining and attempt to re-engage the family in the FC program.

If a family does not have an open DCS case and was referred to the FC program as part of Aftercare Planning and Services and declines the FC program, the FCC shall:

- proceed with the service closure process when there is low risk of future child abuse and neglect and no concern for impending danger; or,
- If there is reason to believe there is present danger, impending danger, or high risk of future child abuse or neglect without formal intervention, the FCC will report the information to the DCS hotline.

If the family has ongoing or in-home DCS case management and the family declines the FC program, the DCS Specialist shall:

- review the FCC's efforts to engage the family and the family's response to those efforts;
- identify any reason(s) known as to the family's determination to decline the FC program;
- consult with the DCS Supervisor and Unit Consultant to identify assessments or services to be provided to the family;
- reassess the level of oversight required by DCS and/or court;
- if a child remaining in-home has been determined unsafe, reassess the in-home safety analysis to determine if criteria for an in-home safety plan continues to be met;
- engage the family in making any changes to the safety plan; and inform the family of any changes to agency or court oversight; and
- when applicable, discuss options for adjustment to the current DCS case plan and referral to other DCS contracted services and assist the family to access community resources and/or change-focused interventions in the absence of the FC program.

Upon determination by DCS, the FCC, and FC Supervisor that the services shall close, the FCC shall proceed with the service closure process.

RELEASES OF INFORMATION

Information sharing between agencies can reduce duplication of services to FC clients. During the intake meeting, the FCC shall discuss and inform the parent/caregiver about confidentiality issues, and obtain written consent from each parent/caregiver utilizing the Authorization To Release Information (ROI) for parent(s)/caregiver(s) who verbally express agreement to participate in the FC program. The ROI shall allow the FCC to speak with family members and other state and/or provider agencies to gather information for the CFA or FC

service plan.

As permitted and identified in the ROI, the FCC may gather information from family members and non-DCS professionals that is relevant to the CFA or FC service plan, and that is not currently available from the family or DCS. The FCC shall inform and obtain the agreement from each parent/caregiver before contacting a family member or non-DCS professional at another state or provider agency. Other state and/or provider agencies may include substance use disorder treatment providers, home visitor providers, behavioral health programs, Nurturing Parenting Program (NPP), supervised parenting time providers, drug testing labs, probation/parole officers, primary care physicians, childcare providers, early intervention programs, DDD, and juvenile justice. After each parent/caregiver signs the form, the FC provider shall provide a copy of the ROI to the DCS Specialist and maintain the signed consent for release of information in the parent/caregiver's file.

As permitted and identified in the ROI, the FCC may gather information from family members and non-DCS professionals that is relevant to the CFA or FC service plan, and that is not currently available from the family or DCS.

ADDITIONAL INFORMATION – COMMUNICATION SKILLS FOR ENGAGEMENT

There are several skills that the FCC uses to ensure a successful, productive visit. These skills can be practiced or enhanced during supervision and peer-to-peer learning through demonstrations, role-plays, observations, and other means.

COMMUNICATING EMPATHY

Put simply, empathy is the act of understanding, experiencing, and responding to the emotional state of another person. There are two dimensions of empathy. First, the FCC must accurately and sensitively identify individuals' inner feelings. Second, the FCC must accurately reflect or respond to the child's or parent's emotions so that they feel understood and validated. Possessing and using a rich vocabulary of affective words and phrases, which reflect feelings in a way the parent/caregiver can relate to and understand, is a skill the FCC should strive to develop. Essentially, to be an effective helper you must be able to picture yourself as the recipient of another's help (Stephens, Mills, Williams, Bridge, & Massie (2009). Doing so conveys understanding. Example:

FCC: A few minutes ago, you said that you have good days and bad days with the kids and sometimes you "need a break". I think every parent has felt that way at some point or another – it just isn't easy being a parent, especially doing it alone.

COMMUNICATING RESPECT

A key component of social work practice and a core value of FC is to communicate respect for children and parents. We should view every human being as unique and inherently valuable. To convey this, the FCC should show respect for the personhood of all family members, regardless of their views, actions, or circumstances. In addition, the FCC must respect the family's right to self-determination—meaning, their fundamental right to make their own decisions – even if the FCC does not understand or agree with the parent/caregiver's decisions.

The FCC can communicate respect for families by operationalizing four core values of the social work profession (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2017):

- All human beings deserve access to the resources that they need to deal with life's problems and to develop their potential for responding appropriately to life's problems.
- All human beings have intrinsic worth and dignity.
- Each individual person's uniqueness is of value.
- Given appropriate resources, human beings are capable of growth and change, and should be supported to make choices to solve their problems and direct their own lives.

KEY POINT: The FCC uses skills to communicate respect: LISTENING and OBSERVING. Carefully and slowly review the key information you want to communicate during the first visit. Use Reflective Listening skills to check in and respond to the individual's verbal and non-verbal behavior, seeking frequent feedback from families to gain their perspective about what you explain about your role.

COMMUNICATING AUTHENTICITY

Authenticity refers to a sharing of self by behaving in a natural, sincere, spontaneous, real, open, and non-defensive manner. It involves relating to others personally in a non-contrived way. It is a skill and trait that can help foster a productive, trusting working relationship. Being authentic helps family members perceive the FCC as interested, honest, neutral, caring, and relatable. Authenticity does not mean that the FCC has the right to say whatever he/she is thinking or feeling (Cournoyer, 2017). Rather, it is a way to support family members and work toward mutually agreed upon goals. Hepworth, et al., (2017) suggest that in responding authentically to individuals and families, the FCC expresses his/her own feelings and ideas as clearly being their own. Example:

FCC: Wow! I can't imagine how you must feel right now. As I listened to you describe everything that has happened in the last two weeks, I could almost see your pain. Your eyes are downcast, your shoulders are slumped, yet at the same time you look very tense. I want to help you feel some relief from some of these feelings. I don't have a magic wand but maybe if we break things down together, we can come up with some things you can try to feel better.

To communicate with authenticity, FCCs have to express themselves in ways that seem "real." Sometimes, it is appropriate for the FCC to self-disclose. The social work profession reflects distinct differences of opinion about when and how much self-disclosure is appropriate in the context of professional helping relationships. However, FC believes that the conscious and intentional revelation of information about oneself through both verbal and nonverbal behaviors can encourage family members to reciprocate with trust and openness. In any event, self-disclosure should be done judiciously and should not include sharing personal problems or shifting the focus from the family's situation to one's own. The self-disclosure should end with a question to transition the conversation back to the parent/caregiver so that it is used as a tool to engage and convey empathy for the parent/caregiver's experience.

In addition, the FCC is urged to discuss instances of self-disclosure with the FC supervisor. An example of careful and intentional use of self-disclosure follows:

A mother shares that she is very angry with her husband for not doing his share around the house and adding to the mess she must clean up.

FCC: When a family member doesn't chip in, it's very frustrating and could make anyone angry. My kids constantly leave dirty laundry and dishes lying around. It's like I'm their maid! When this happens over and over again, I get resentful. What feelings does it bring up for you when your husband isn't doing his share around the house?

USING ACTIVE LISTENING SKILLS

Active listening combines talking and listening skills that enable individuals to feel understood and demonstrate that the FCC has accurately heard and understood what the family member has communicated. In addition, it provides a means through which family members are encouraged to express themselves. It is important for the FCC to reflect understanding or interpretation of what individuals have communicated. The FCC responses should mirror information provided by family members. In general, if feelings are expressed, the active listening response should convey the feelings at an equivalent intensity (Cournoyer, 2017).

The skill of active listening is used when the FCC closely observes family members and carefully listens to what is said. After listening, the FCC reflects back what the person expressed. When the FCC confirms understanding with the family member, it can increase

the person's positive regard for the FCC and the professional relationship. Active listening also decreases the likelihood that the FCC misunderstands, distorts, or misrepresents what family members are trying to convey.

Some examples of phrases that can be used when reflecting back include, "What I think I hear you saying is…" and "It sounds like…."

There are some pitfalls associated with active listening that the FCC should take care to avoid. They include mimicking or repeating verbatim what the person said, misconstruing family members' comments or behaviors, and focusing only on a part of what was communicated rather than attending to what the message as a whole was conveying (Cournoyer, 2017).

ADDITIONAL INFORMATION – ENGAGEMENT AT EACH PHASE

FIRST VISIT (IN-PERSON INITIAL OUTREACH)

The FCC's first visit with a family will have several phases, which are detailed below: beginning and seeking introductions; describing the initial purpose, outlining the FCC's role, the role of the DCS Specialist (if applicable), and the role of each family member; discussing policy and ethical factors; and, seeking feedback (Cournoyer, 2017). Following these phases will help the FCC communicate respect and begin to develop the helping alliance with families. In addition, there are specific skills, which can be used to conduct the first visit and ensure its success. These will be described after the phases.

PREPARING FOR THE FIRST MEETING WITH THE FAMILY

The first visit is purposeful and preparing for it is crucial. Preparation will help foster a helping alliance between the FC Consultant and the family and will allow the FCC to be better positioned to understand the family situation. The FCC should conduct any necessary research to learn about aspects of the family's culture with which the FCC may be inexperienced or naïve. Even when FCCs have worked with families of similar ethnic, racial or cultural backgrounds, they cannot assume all families are the same. They must be prepared to learn about how this family's identification, experiences, values, and practices. Supervision should occur to discuss culturally sensitive and relevant engagement and information collection strategies.

This is beneficial to both FC and families because: (1) family members will not have to repeat information they previously provided to DCS; (2) triangulation or undermining can be prevented; and, (3) it allows more efficient use of time, helping families feel that what they have said is heard and remembered. This is especially true if the family has an immediate concrete need, such as an emergency need for food or clothing, and the FCC is able to immediately work to address the need.

KEY POINT: "Preparing for social work interactions can increase the likelihood of establishing a positive worker-client relationship and hearing what the client has to say" (Schulman 2012, p. 68).

Preparing to meet families involves using the skill of centering or tuning in (Schulman, 2012). A major skill in the preliminary phase of FC work is the development of the FCC's empathy for the family and their circumstances. It involves getting in touch with potential feelings and concerns that the individual may bring to the helping encounter.

The key to centering or tuning in is finding a way to manage one's personal feelings so they do not interfere with one's work with families and to do so without having to minimize or deny the feelings and issues (Cournoyer, 2017). A key purpose of this activity is to help the FCC anticipate the individual's indirect communications so that the FCC can help family members manage their feelings, especially during these initial meetings. This process entails addressing any personal factors that may affect the FCC's ability to provide quality services to families. Personal factors could be assumptions, thoughts, emotions, biases, doubts, or gut feelings that could interfere with the FCC's provision of services and supports to the family. Questions

that might be asked during the centering/tuning in process include:

- How am I feeling about the situation of this family? Do I feel empathy toward the children and parents' circumstances or do I want to blame or otherwise judge them for their situation? Do I have mixed feelings?
- Are there issues about this situation, which I may be uncomfortable about because of my own personal history, experience, bias, or values?
- Is it possible the parent or child might hold a worldview or a cultural point of view that differs from mine? If so, what do I need to understand about this viewpoint in order to be sensitive and responsive to the all-family members?
- What do I know about this family's neighborhood or housing circumstances? Am I nervous or scared to go there by myself?
- Based on what I know about the history of this family (e.g., experience with DCS or other community agencies), what concerns or fears might I anticipate the family will be feeling which may affect how open the family is to my offer of help?
- Is it likely family members will have feelings of being "coerced" to accept help and confused about their decision to participate in FC?
- What can I do to ready myself and help me feel more comfortable with having the first visit?

PHASES OF THE FIRST VISIT

1. Beginning and Seeking Introductions - At the beginning of any first visit, the FCC should identify to the family by name, position, and agency. As an example, the FCC might say:

FCC: Hello Ms. Brown (offer a handshake), I am_____, a consultant staff from [Insert Agency Name]. I understand you and your DCS Specialist discussed the referral to Family Connections. I work with families to help address and resolve conditions in their families which have either made their children unsafe, or been identified as a risk factor. And your name is Ms. Danielle Brown. Is that right? Am I pronouncing your name correctly? How would you like me to address you?

   Non-verbal communications, such as facial expressions, eye contact, posture, and type of handshake, can greatly impact an individual's perception of the first contact with the FCC. The content of dialogue also plays a pivotal role. The FCC might consider making a few informal comments about the weather or other non-threatening topics to help set parents and other family members at ease and break the ice. However, the FCC must be sensitive to individual and cultural factors. For example, some individuals may perceive informality as premature or rude. In addition, over-doing the "small talk" might frustrate individuals who have urgent needs (Cournoyer, 2017).

   It is important to closely attend to how each family member wants to be addressed. Because it reflects a courteous and respectful tone, this process of clarifying names and titles can increase the likelihood that the working relationship starts on a positive note.

2. Describing the Initial Purpose - Following introductions, the FCC should clearly describe a tentative purpose for the visit. If family members do not understand the visit's purpose or do not begin to get a general idea about how they and the FCC will work together, they are likely to feel even more uncertain, anxious, and ambivalent about a process that may already be stressful (Cournoyer, 2017). Asking for and accepting help are not easy. In particular, sharing personal information with a stranger is very difficult. It is the FCC's responsibility to help family members feel as comfortable as possible during the initial visit. One way to do this is to ask family members what they want to get out of, or expect from, the visit. Doing so signifies to the family that FC is about them making choices and voicing their own preferences and priorities. An example of this approach follows:

FCC: The purpose of today's visit is for us to meet each other and for you to decide if you would like to participate in Family Connections. It is my understanding you gave the DCS Specialist permission to send a referral to Family Connections on your behalf, so I could come and talk with you more about the program. I want to hear from you directly about what is working in your family and in what ways Family Connections might be able to help with things that you would like to change. This is a brochure about our program and how we work with families. If you have any expectations of the program, or me, I would like to hear them. I also want to work out a schedule of meetings with you (and other members of your family) over the next several weeks so that together we can plan how we will work together. As we get to know each other over the next several weeks, we will set specific outcomes and goals that you would like to achieve through our work together. What questions do you have about my visit today?

KEY POINT: It is very important that we focus on the purpose of our first visit but at the same time remember that our purpose is to listen and make an initial connection to begin the working relationship. We are not there to "sell" or "market" the services we have to offer. That suggests that we know what a family needs before we have spent the time to get to know them, their strengths, and their needs. This way of working may take some adjustment from our usual way of work but also might be quite different to a family's past experiences where they may have perceived that they have been "told" what services they must attend. This could mean we have to spend a little time talking about the way we will work together, more so than listing the services we may provide.

3. Defining Roles: The FCC, the DCS Specialist, and Family Members- During the beginning stages of a professional helping relationship, family members often experience considerable uncertainty and anxiety about what is expected of them. Initially, family members may be concerned about the conditions that led to a report being made to DCS and possibly led to their transfer for In-Home or Ongoing Services. Many are also worried that they may not know how to improve the situation or resolve the problem. In addition, individuals are often uncertain about how they may best help the FCC to help them. High rates of disengagement or withdrawal from a program are often due to ambiguity about what they are supposed to do. The FCC may increase engagement by eliciting parent's and children's expectations and clarifying discrepancies between expectations and what realistically can be offered along with clarifying the expected length of intervention.

   When the family is transferred for in-home or ongoing DCS case management due to impending danger, it is important that the FCC hear the family's perception of continued DCS involvement. In order to know where the parent/caregiver is coming from, the FCC must listen to the family's understanding of, and degree of agreement with, why the children were found to be unsafe or at risk of abuse or neglect (specific impending danger threats). The DCS Specialist can provide any needed information or clarification so all parties are clear as to the reason the family had been transferred for in-home or ongoing DCS case management, and that working with the family to identify what needs to change for the child(ren) to be safe will be the overarching goal of DCS and FC work. When families with safe children are referred to FC and in-home DCS case management due to risk issues, work will focus on reducing specific risk factors.

   It is also important families understand that the FCC considers the FC working relationship to be a partnership based on collaboration. Therefore, in the first few weeks of working together, the FCC and families will define together how FC will support them to make changes to behaviors or conditions that affect the risk of abuse or neglect or the impending danger to the children in their family. This is facilitated by parents/caregivers answering questions via a computer assisted self-interview (CA-Self Interview) about what is going well in their family and what areas are not going as well.

   Whether the family was referred to FC for risk or for safety threats, the FCC and the parent/caregiver will use the FC service plan to define outcomes and goals, identify

outside formal services to be provided or arranged, and the roles for the FCC and family members for accomplishing tasks that will help families achieve their outcomes and goals.

4. Discussing Policy and Ethical Factors - During the first visit, the FCC must discuss relevant legal, policy, and ethical issues (Cournoyer, 2017). If done in a non-threatening and non-authoritarian manner, this openness can help establish an authentic and honest relationship. In general, this will include informing parents/caregivers:
   - of the FCC's responsibility to report any suspected incident of child abuse or neglect to DCS (FC staff should follow agency protocols for making a report – see Chapter 8);
   - when and how information will be shared with other parties, which includes advising parents/caregivers that all information will be documented and available to DCS;
   - if the DCS case will remain open, that the DCS Specialist and the FCC will both meet in-person with the parent or family, at times together but most often separately, and the expected frequency of contact by the DCS Specialist and FCC; and
   - when the FCC needs permission to share information, such as with other service providers, and the exception that permission to share information is not required when individuals disclose or the FCC observes a risk of harm to self or others, such as suicidal or homicidal intention, or suspected child abuse or neglect.

   The NASW Code of Ethics describes the core values and ethical principles and standards that should guide social work practice, including FC practice. The FC model particularly reflects the following core values: the individual's dignity and worth, the importance of human relationships, and the integrity of social work professionals. These principles can be practiced by other professionals, even if they do not carry the professional title of Licensed Social Worker.

5. Seeking Feedback – The FCC should ask parents/caregivers if there was anything that was said that they do not understand, or if they have questions or concerns. By soliciting feedback, the FC initiates the process of informed consent (Cournoyer, 2017). Seeking feedback also reinforces that the FC relationship will be mutual and reciprocal. Some general ways to seek feedback include asking, "How does that sound to you?" or "What questions or comments do you have?" (Cournoyer, 2017; McKay, McCadam, & Gonzales, 1996). Often individuals ask questions that give the FCC the opportunity to respond in greater detail to their concerns. Most importantly, parents/caregivers will usually feel respected and informed when the FCC seeks their feedback.

Several research studies have revealed that when a family and the FCC have different expectations that are not acknowledged, there is a higher likelihood of dropout from the program or intervention (Norcross, 2011; Swift & Callahan, 2011).

ADDITIONAL INFORMATION – MOTIVATED PARTICIPATION

Decline Services

Some families will decide that the FC program is not the right match for their needs. DCS and FC will collaborate to reach out to families, engage them in discussion of what the program has to offer, and encourage them to work together to set and achieve goals. The DCS Specialist will strongly encourage families to at least meet with the FCC for an initial meeting, to learn more about the program and determine if they are willing to commit to participation.

The FCC never "pressures" or "sells" families to accept services; respecting the family's right to self-determination. A family may, at any time, request the FCC cease attempts to contact them. If this request comes during a telephone or in-person conversation, the FCC should acknowledge the family's decision and encourage the family to communicate if the family's situation changes. If this request comes in writing (by email, fax or letter), no further attempt at contact will be made and the FCC will close the services.

If the family has an open DCS case the FCC will notify the assigned DCS Specialist via email and telephone of the family's decision to decline the FC program within one business day of the FCC receiving this information from the family.

Disengagement from the FC Program

There may be times a parent/caregiver decides to disengage from the FC program. The parent/caregiver may tell this to the DCS Specialist, the FCC, or a Supervisor. Whichever professional is told this information shall attempt to speak with the family in order to understand their reason for discontinued participation and see if the family can be re-engaged.

If a family does not have an open DCS case and was referred to the FC program as part of Aftercare Planning and Services, the FCC shall attempt to speak with the family in order to understand their reason for disengagement and see if the family can be re-engaged. If this is unsuccessful, the FCC shall do the following:

1. proceed with the service closure process when there is low risk of future child abuse and neglect and no concern for impending danger; or,
2. if there is reason to believe there is present danger, impending danger, or high risk of future child abuse or neglect without formal intervention, the FCC will report the information to the DCS hotline.

Missed Appointments

Most, if not all, FC contacts with the family are scheduled. There are many reasons a family may miss appointments with the FCC and this may be a pattern for some families. While this may be frustrating, it is important for the FCC to continue to put forth a high level of effort to keep the family engaged in the FC program.

If it is determined a joint home visit should be scheduled to re-engage the parent/caregiver(s) and assess for continued FC involvement, the DCS Specialist will schedule the joint visit with the family and FCC. If it is determined the FCC should initiate service closure, the DCS Specialist will immediately become responsible for the delivery, oversight and/or referrals for change-focused interventions and for any necessary treatment service referrals. The DCS Specialist will notify the family that Family Connections has been discontinued due to lack of response by the parent/caregiver(s).

Reasonable Efforts to Engage Families

It is important that the FCC and the family mutually schedule a time and place to meet. FC discourages an unannounced first visit because some families may experience it as an intrusion or an invasion of their privacy. This is a difficult "first impression" to overcome, so it is important to avoid it in the first place. The family should choose the location of the first visit, with the priority being their home. If the family refuses to meet in their home, this meeting may occur in the FC agency office, the DCS office, or at another community location, which provides appropriate privacy. The FCC will notify the family that the first visit should last approximately one hour, and take measures to allow time and flexibility to remain longer in case the family extends the initial visit beyond an hour. This is important because it demonstrates to families that the FCC will give them the time they need and not rush them. At the same time, the FCC needs to be sensitive and ensure that they do not overstay their welcome. It is important to read the family's verbal and nonverbal cues during this first encounter and adjust the amount of time spent with them accordingly.

Parents have a right to self-determination and may choose if, when, and how they engage with DCS and service providers to address the conditions that make their child(ren) unsafe or pose risk of abuse or neglect. For parents to make an informed choice about participating in the FC program, the DCS Specialist will provide, in language the parent can understand:

- information about the FC program, its structure and its anticipated benefits, which include:
    - family-specific assessment and planning to help accomplish DCS case plan goals and the reason for DCS involvement;
    - advocacy, referral and support in securing resources to meet concrete, emergency, and behavioral health needs;
    - individualized change-focused interventions, provided in the home, to support parents/caregivers to address conditions that need to change for children to be reunified with an in-home safety plan (CFR's) and conditions making children unsafe (diminished protective capacities/impending danger threats); and

- DCS's options and potential concerns if the family does not accept the FC program.

As long as reunification remains the permanency goal, the DCS Specialist will make reasonable efforts to engage the parents/caregivers in service participation. During monthly contacts with each parent, the DCS Specialist will use strategies to attempt to raise parent/caregiver' self-awareness and contemplation of their choices and the consequences of those choices. The DCS Specialist will use interviewing skills to gain information and understanding of the parent/caregiver's perspective, to determine what Stage of Change they are in as it relates to each impending danger threat. [Reference Chapter 3: Section 2]. If the family continues to meet FC eligibility criteria aside from agreement to meet with an FC Consultant, the DCS Specialist will continue to make reasonable efforts to engage families in the FC program, explaining the FC program during monthly contacts.

Overcoming Barriers to Engagement

Evidence-based engagement strategies ensure that initial meetings with family members, whether over the phone or face-to-face, find a balance between gathering the information necessary to complete required assessments and documentation; and meeting family's needs as the helping alliance is developed. Two important steps for fostering engagement include identifying "concrete, practical issues that can be immediately addressed" and developing plans "to overcome barriers to ongoing involvement with the agency" (McKay et al., 2004).

The FCC should come to the first visit with background information provided by DCS on potential needs and barriers, which can be explored during the visit. These may include concrete needs, such as lack of time, transportation, and financial resources. During the first visit, the FCC should use problem-solving skills to help the family determine the most pressing concrete needs and explore ways to immediately begin to address the concerns. This demonstrates to the family that the FCC is committed to helping it meet its needs as defined by the family, not just DCS or the FCC, in order to overcome any immediate crises. One of the FC core components is a continued recognition of the primacy of concrete needs throughout the provision of services. Helping families address their most urgent concrete concerns demonstrates the FCC's openness to the family deciding and prioritizing what is important to it and enables the family to move onto addressing other concerns that are no less important but may feel less urgent or less concrete. Chapter 8 discusses how to respond to families' concrete and emergency needs.

When a family has identified emergency or concrete needs at the onset of FC work, the FCC must be prepared to devote more time to that family. The requirements for Outreach & Engagement must still be achieved while working with the family to attempt to meet their immediate needs.

The FCC should also seek information on less tangible barriers to engagement, such as the possibility the family has previously had negative experiences with other helping professionals. The parents/caregivers' attitudes and beliefs about receiving assistance may reduce their engagement with the FCC. Examples of negative experiences might include experiences of racism or discrimination, or personal trauma, which results in guardedness in opening up and trusting others. These might create barriers to engagement as they may make it difficult for parents/caregivers to trust the FCC and other service providers (McKay, McCadam, & Gonzalez, 1996). Exploring these issues during the first visit sets a tone that the FCC is open to acknowledging the family's history and perspective and is sensitive to the family's concern, skepticism, or other doubts about participating in the FC program.

Throughout services, the FCC may experience challenges with engaging families and their perspective of the FC program.

- Family Perspective on Receipt of Services
  There may be many difficulties, both real and perceived, which challenge family members' ability and willingness to connect to providers or services. These include, but are not necessarily limited to, the following:
  - Individuals do not want someone else managing their lives or telling them what to do.
  - Individuals may not want to directly acknowledge their inabilities to meet their individual or family needs.
  - Individuals do not want to make personal issues into public ones by sharing them with "still another helper."

- Individuals may not have the cognitive and/or emotional resources to reach out and ask for help.
- Individuals may be afraid that entering a new system will result in them being labeled.
- Individuals may be afraid of the unknown (providers or systems).
- Individuals may be afraid of the proposed interventions.
- Individuals may be afraid of the results of the proposed interventions.
- In addition, there are individual feelings and/or behaviors that may be accurately or inaccurately labeled as resistance. These include, but are not limited to, the following:
- Individuals do not agree with the problem identification that is precipitating the referral.
- Individuals do not see the identified problem as a priority for work at this time.
- Individuals do not want to commit personal resources (time, emotion, energy, finances) to FC.
- The identified community resource is difficult or inconvenient to access.
- Individuals do not "like" the helper who is making the recommendation.
- Individuals do not understand the service that is being recommended or appreciate the impact that receiving the service would likely have for them or their families.
- Individuals know, through experiences or hearsay, someone who has had a bad experience with the community provider or agency.

SO WHAT DOES THE FCC DO TO HELP FAMILIES BECOME MORE RECEPTIVE TO SERVICES?

Acknowledge that reaching out for and connecting with services is not an easy process and:

1. **Encourage family members to identify barriers, both functional and emotional, which can be addressed through mutual problem solving.**
2. **Help individuals to identify similar feelings that have been successfully overcome, and can be generalized to this situation.**
3. **Self disclose – the staff can share an experience that they have had entering a new system, describing both the challenges and opportunities that the experience provided.**
4. **Encourage family members to discuss feelings with friends or family who will be understanding and supportive, and who may have had a similar experience.**
5. **Utilize role rehearsal and role reversal exercises to help individuals reduce their anticipatory anxiety and increase their skills.**
6. **Provide "in-vivo" support – In other words, offer to accompany family members to their first (or first few) appointment(s).**

SO WHAT DO FCCs DO TO ADDRESS SYSTEMIC CHALLENGES EXPERIENCED BY COMMUNITY AGENCIES?

1. **Expect the process of referral and connection to be challenging yet manageable.**
2. **Call ahead to obtain a detailed and realistic expectation of what it will take to facilitate the family's connection to the service.**
3. **Keep the family goals and best interests in mind in all transactions with an agency. Staff should be guided by professional standards and behaviors and the desired outcomes for the family.**
4. **Be the squeaky wheel. Most providers have quite a "to do" list. Gentle inquiries regarding the status of family members within the other agency system may help.**
5. **Whenever possible, identify multiple or alternate resources to meet the family member's needs.**
6. **Develop relationships with key people in agencies with which you will most often work. Try to identify a contact person at the agency and develop a working relationship. Appreciate the role that s/he is assuming and support rather than antagonize.**
7. **Expand knowledge of available resources. If one provider is unavailable, ask if s/he knows other resources that could be helpful. Talk with peers and colleagues. Use the online databases. Ask families themselves.**
8. **When all else fails, staff should be sure that they have carefully and accurately documented all efforts. If staff members believe that a family member has not been well served, a supervisor should be consulted. If FC services cannot locate a resource because it does not exist, careful documentation of need may support future efforts to develop the resource.**

THE FCC'S PERSPECTIVE ON SERVICE FACILITATION AND ADVOCACY

It is always important FCCs remain aware of their own thoughts and feelings, which may be contributing to the behaviors they display and the ways in which they engage families. The following feelings and realities may become especially significant as staff engage families in the service facilitation process:

- The FCC may have difficulty letting go or sharing the professional control.
- The FCC may have concerns about the quality of the new service or provider.
- The FCC may feel frustrated by family members' behaviors, in general, or by their responses to the referral process, in particular.
- The FCC may feel overwhelmed by the paperwork that is required to facilitate the referral.
- There may be a lack of needed resources, which results in a detrimental delay, a poorly matched service, or no service at all.
- For service referral that occurs at the end of FC involvement, the FCC may have many feelings about saying "good-bye" to families, from sadness to ambivalence.

SO WHAT DO FCCs DO TO MANAGE THEIR OWN FEELINGS AND THOUGHTS?

1. FCCs need to stay in touch with their own feelings and thoughts! These are neither right nor wrong – it's how the FCC handles them and what they do with them that can be more or less desirable in their professional capacity.
2. Self-disclose, as appropriate. If unsure about whether or how to self-disclose, FCCs should consult with their supervisor.
3. FCCs must be honest with themselves and their families – If a family member's behaviors are confusing or frustrating to staff, they must use their clinical skills to effectively confront him/her.
4. Advocate for the development of needed services to meet identified needs, such as affordable housing, utilities, special education, health care, and other needs. Staff can join a professional or community group that supports meeting the needs of children and families. They can also participate on local and state committees to advocate for systemic change

CHAPTER 8: ASSESSING & RESPONDING TO CONCRETE AND EMERGENCY NEEDS

WHY IS THIS IMPORTANT?

We know it is hard to consider changing behaviors and conditions if a family has insufficient resources to meet the day-to-day basic needs of the children. Maslow (1943) was one of the first to propose that physical and safety needs must be addressed before individuals can be motivated to address more complex needs. A core component of Family Connections includes assessing and addressing concrete needs often associated with living in poverty, affecting the quality of care provided to children. The provision of concrete services and resources can mitigate dangers and meet Conditions for Return.

Many FC families experience crises related to food, clothing, finances, and/or shelter that impact child safety and increase risk of child abuse or neglect. The ecological framework of intervention that guides FC practices requires the FCC to quickly help families respond to these situations.

The basic and emergency needs of families must be addressed to foster successful engagement and participation in services.

CONCRETE SERVICES

The FCC and the family use the Family Resource Scale (FRS, Dunst & Leet, 1987), and Support Functions Scale (SFS) (Dunst, Trivette, & Deal, 1988) in coordination with other information and observations to identify concrete needs requiring an emergency response. FC-involved families may feel overwhelmed and unable to express or prioritize their needs – assessment scales can help families reflect more specifically on their needs.

The FCC shall assist the family to obtain concrete services when a concrete need is a barrier to the parent's readiness to engage in FC or other services, or would meet a Condition for Return. Concrete services include, but are not limited to, childcare, utility assistance, rent assistance, clothing/uniform vouchers, food boxes and nutrition, household furniture and supplies, cell phone minutes, homemaking/housekeeping, housing services, cleaning and repair service when the household is unsafe or unsanitary.

- Homemaking/Housekeeping refers to any activity required to maintain the household. Examples include but are not limited to: cleaning, sweeping, mopping, cooking, doing dishes, doing laundry, shopping for food or other basic supplies, installing child proof locks, organizing a medicine cabinet so it is out of a child's reach, changing a smoke/CO detector battery, etc.
- Housing Services refers to any activity required to ensure the safety and security of the home structure. The FCC may function as an advocate, helper, or teammate to the parent/caregiver in assisting to obtain housing services. Examples include but are not limited to: arrange for repairs or sub-standard conditions or code violations, prevent/address exploitation from landlords or other tenants, locate suitable alternative housing, secure public assistance to ensure housing is maintained.

Maslow's Hierarchy of Needs:

1. Physiological Needs: Food, Water, Shelter, Sleep, Air
2. Safety Needs: Protection, Security, Health, Employment, Freedom from Fear
3. Belongingness & Love Needs: Intimate Relationships, Friends, Affection, Sense of Connection
4. Esteem Needs: Respect, Prestige, Feeling of Accomplishment, Dignity, Recognition
5. Self-Actualization: Achieving One's Full Potential

Adapted from: https://www.simplypsychology.org/maslow.html

During the first several contacts, the FCC shall assess the following areas and assists the parent/caregiver to obtain related concrete resources to address any areas that are inadequate.

- Smoke detectors
- Condition of the windows: Are the windows intact, or broken or missing
- Adequacy of the sleeping arrangements, furniture and bedding:

    - including Safe Sleep practices if there are any child(ren) under 12 months
- Clutter, garbage and/or waste in the home and if/how garbage, including human and pet waste, is disposed of
- Adequacy of storage for clothing and other items
- Each of the following to conclude if they pose any hazard, especially to young children:
    - peeling paint, including lead paint
    - frayed electrical cords or long extension cords
    - long hanging cords from window blinds or curtains
    - presence of vermin or insects
- Adequacy of food in the home, including safe storage of perishable food
- Where and how toxic and/or hazardous cleaning supplies or objects are stored
- The family's source of each of the following utilities, the adequacy and reliability of each, including any problems such as gas leaks or water damage:
    - heating and cooling
    - plumbing
    - electricity
    - water
- Storage of any guns or other weapons in the home

FC Emergency Flex Funds, not to exceed $300 per referred family in a six (6) month service period may be used to purchase needed items or resources that will address the concrete needs of a family that relate to meeting the child's basic needs, child safety and/or Conditions for Return, when these resources are not available through other sources, including community resources, or in-kind donations from community collaborators.

The FC provider shall obtain prior approval to use emergency funds from ADCS (as designated by ADCS) using the FC Emergency Funds Authorization form. Cases without DCS Oversight, shall obtain prior approval to use emergency funds from the ADCS Fidelity & Compliance Services (FCS) or as designated by ADCS. The FC provider will be reimbursed for the actual cost of the purchase, not to exceed $300 per six (6) month period for each referred family. Expenses, including copies of receipts, shall be submitted for reimbursement to DCS via the monthly billing. The FC provider shall maintain in the family record original receipts for all concrete supportive services paid through the FC contract.

EMERGENCY NEEDS

Emergency needs include, but are not limited to, identification of possible child abuse or neglect, and psychiatric crisis of a parent/caregiver or child, including threats to harm self and/or others.

- FC providers shall maintain a current list of suicide and crisis line contact information available to families within their geographical area.
- If a parent/caregiver expresses an immediate need to access crisis services for a mental health or substance abuse condition (e.g. detoxification facility), the FCC shall immediately assist the parent/caregiver to obtain the service and ensure the parent has the necessary crisis services or other support to be safe before leaving the home or ending the contact with the parent/caregiver. The FCC does not need to wait until the Comprehensive Family Assessment is completed or the case plan is developed with the DCS Specialist.
- If the family has an open DCS case with ongoing or in-home case management, the FCC must notify the assigned DCS Specialist within one business day if the FCC assisted the parent/caregiver to obtain emergency mental health or substance use disorder stabilization (detoxification) services. The DCS Specialist shall determine whether a service request for Arizona Families FIRST services is needed, and make the request if appropriate. If a family does not have an open DCS case and was referred for the FC program as part of aftercare planning, and if there is reason to believe there is present

danger, impending danger, or high risk of future child abuse or neglect without formal intervention, the FCC will report the information to the DCS hotline.

- The FCC shall have knowledge of and information about available resources through state and federal government agencies and community agencies that serve the family's geographical area; including eligibility criteria, and application processes. The FCC shall assist the family with applications and advocate for the provision of needed services.
- The FC provider agency shall maintain resource guides, literature, and ongoing staff training so the FCC is able to provide parents/caregivers with information about children's mental health and related services, including but not limited to: trauma and the emotional impact of abuse/neglect on children; the range of behaviors traumatized children may express, what the behaviors mean and how to appropriately intervene; common children's mental health issues and treatments; the importance of mental health screening and early intervention; and, psychotropic medications and how they are used as part of an overall mental health treatment plan.
- The FCC shall provide parents/caregivers education about adult mental health (including maternal post-partum depression) and its impact on children. As needed, the FCC shall provide parents/caregivers ongoing education about the importance of being meaningfully engaged in their children's mental health treatment, including participating in family treatment as recommended.
- When a parent/caregiver or child needs an emergency behavioral health assessment or immediate treatment services, the FCC shall complete the Benefits Screening Tool CSO-2399, or other tool designated by DCS, with the parent/caregiver within the first thirty (30) days of services. This tools is used to determine eligibility for funding by Title XIX/XXI, the Substance Abuse Block Grant (SABG), private insurance, Indian Health Services, or Veteran's Administration. Once the tools is completed the FC shall:
    - Refer parents/caregivers who are currently eligible and enrolled for Title XIX or Title XXI services to the appropriate agency.
    - Assist parents/caregivers not currently enrolled, but who may be eligible for Title XIX- or Title XXI funding, with the application process to determine Arizona Health Care Cost Containment System (AHCCCS) eligibility if the parent/caregiver requests or needs assistance. This shall include providing access to, or assistance with, the HEALTH-e-ARIZONA online application system in areas of the state in which use of this system is mandatory.
    - If barriers exist to establishing Title XIX or XXI eligibility, the FCC Provider shall make reasonable efforts to overcome the barriers by proactively seeking solutions, including assisting the client with obtaining documentation of proof of citizenship, assisting with the application process, and working with the Family Assistance Administration to facilitate the application process.
    - If reasonable efforts to access needed behavioral health services are unsuccessful and there is an open DCS case, discuss the family's need with the assigned DCS Specialist who will determine if the parent/caregiver meets the criteria for referral to DCS contracted psychological or counseling services.

DOCUMENTING EMERGENCY AND CONCRETE SERVICES

During the first 30 days of the FC program, the FCC shall document the FCC's initial assessment of, and response to, any emergency or concrete needs, including:

- information gathered from observations, interviews and DCS records relevant to assessing for emergency and concrete needs;
- any needs identified and discussed with the family; and
- a specific plan developed with the family to assist them in addressing the needs, which may include referrals, conducting research, or assisting the family in scheduling and attending appointments.

The FCC shall document ongoing assessment and identification of emergency and concrete needs in contact notes and weekly reports to DCS.

THREAT OF HARM TO SELF OR OTHERS

The FCC must take any verbal or behavioral expression of threats of harm to self or others by a parent/caregiver or child, such as suicidal or homicidal ideation, very seriously. These expressions can present in a wide variety of ways, and describing all of them is beyond the scope of this manual. However, the below indicators can guide critical thinking about possible threats of harm and the extent to which an immediate emergency response is required.

CONCERNING SIGNS

1. **Expressions of wanting to die or to kill someone – Regardless of the affect that accompanies the words, you must assume that the threat is a real one.**
2. **Expressions of wanting to give up, go away, not feel so bad anymore, escape for good – These may be no more than very real and reasonable messages that the client needs a temporary respite or some other support, or they may indicate a much more serious threat.**
3. **Expressions of sadness or depression – Different people use different words in different ways at different times. You must always be careful not to assign a particular meaning to the words, but rather to enable your client to assign the meaning to his/her own words.**
4. **Significant changes in regular behavior patterns – Eating, sleeping and relationship patterns are typical dimensions that merit further exploration.**
5. **Ordering or organizing personal and professional "business" – Sometimes, people who are contemplating suicide will divest themselves of possessions and/or organize their life in such a way that they believe will make it easier/neater for others when they are gone.**
6. **Significant changes in observable behaviors – Affect, appearance and connectedness as observed by you during the clinical transaction, or as reported by significant others or other providers.**
7. **Verbal expressions of wanting to harm another – These may be accompanied by feelings of anger, hurt, betrayal, extreme frustration, vengeance or they may be expressed in a calm, controlled manner.**

HELPFUL CONSIDERATIONS

1. **What do parent/caregiver or child(ren) mean when they say that they are feeling bad/sad/depressed? What do they feel, what do they think and what do they do when they have these feelings? How often and for how long at a time do they feel this way? When was the last time? What did they do to resolve it, or do they still feel this way?**
2. **Was there another time or times in their life when they felt this way? How long ago, and how long did it last? What did they do? What happened?**
3. **Has there been any change (more or less) in their eating, sleeping or relationship patterns? Have they lost/gained a significant amount of weight? Are they having trouble falling asleep, do they wake in the middle of the night, or do they wake very early in the morning, and is this a change for them? Have they lost touch with friends/family that had been close?**
4. **When they are feeling sad, do they ever feel like giving up for good or hurting themselves or another to escape? If yes, when? What did they think about doing? Did they have a specific plan to harm themselves or another? Did they have the means to carry out the plan? Did they attempt to harm themselves or another? What happened? Did they tell anyone else or try to be rescued? What was the response?**

CHAPTER 9: CONDUCTING THE COMPREHENSIVE FAMILY ASSESSMENT

One of the core philosophical principles of FC emphasizes the importance of individualized comprehensive family assessment. This chapter outlines the family assessment process and the identification of FC Core outcomes as the target for developing customized and meaningful service plans (See Chapter 10) and change-focused intervention (See Chapter 11). For families who are experiencing depressive symptoms, or who have experienced trauma, analysis should occur as to how the family's functioning and identified Core Outcome(s) are impacted by depression and/or trauma exposure. Each FC Core outcome is closely related to diminished protective capacities and/or risk factors identified via the Protective Factors Framework. When DCS is remaining involved with families, the work of FC should complement and support DCS to address the identified risks and/or safety threats impacting the safety and well-being of the child(ren). This chapter serves as a foundation of key aspects of family assessment reinforced in training and supported by supervision and coaching.

Differences between Risk & Safety Assessment and the FC CFA:

- Assessment of risk via the Protective Factors Framework is to understand what conditions or behaviors may increase the risk of abuse or neglect.
- Assessment of safety is to determine whether there is a need to control safety threats.
- The FC CFA is to understand the focus of change-focused intervention by the Family Connections Consultant.

WHY IS COMPREHENSIVE ASSESSMENT IMPORTANT?

Effective intervention to reduce the risk of child maltreatment and/or eliminate danger to children should be based on a comprehensive, individualized assessment of the family. Assessment is the process of gathering information about the individual's or family's current circumstances; determining what is contributing to the strengths, challenges, and needs; and using this understanding to inform service planning and intervention. Truama-informed approaches support building an understanding of how responses to trauma, relative to the family's cultural context, manifest within the family system and impact interactions between its members. A core principle of FC is that assessment is done with the family and not to the family; the family and FC staff work together to understand the family's situation.

COMPUTER ASSISTED SELF INTERVIEW (CA-SELF INTERVIEW)

Using a laptop, tablet, or other computer device, the FCC will administer the CA-Self Interview, which is a compilation of validated standardized assessment and screening tools that relate to the identified FC Core outcomes. The FCC shall initiate the CA-Self Interview process during the second or third visit with the family, noting that the CA-Self Interview may continue beyond the second or third visit based on the needs of the family. The FCC shall conduct the CA-Self Interview in the home, in a quiet and calm place with each parent/caregiver. The FCC shall utilize the CA-Self Interview as a mechanism for follow-up discussion with the family related to the FC Core outcomes and incorporate results within the CFA Summary. The CA-Self Interview Assessments are administered and scored via two different sites; Qualtrics and Assessing Parenting. The "Family Profile" that is referenced below and throughout the Program Manual refers to a family's printed assessment instrument results, combined from Qualtrics and from Assessing Parenting.

Protocol for administering and interpreting the results of the CA-Self Interview Family Profile are outlined in Exhibit 9.1.

The FCC shall utilize the relevant self-interview and screening tools, to determine a need for potential further assessment by a qualified and relevant professional:

- Support Functions Scale (SFS)
- Family Functioning Style Scale (FFSS)
- Family Resource Scale (FRS)
- Adult-Adolescent Parenting Inventory (AAPI-2) – Revised 2010
- Parenting Attitudes about Raising Teens Inventory (PARTI)
- Nurturing Skills Competency Scales 3.0 Short Version (NSCS)

- Parenting Stress Index – Short Form (PSI-SF)
- Edinburgh Post-Partum Depression Scale (EPDS)
- Life Events Checklist (LEC-5)

The EPDS will be used for women who are up to 12 months post-partum.

A brief description about each of the assessment and screening tools administered to families is provided in Exhibit 9.2.

COMPREHENSIVE FAMILY ASSESSMENT (CFA)

The CFA is not a one-time-only event or the result of a structured interview. The CFA process is critical because it drives service planning and the selection of interventions and services. The FCC shall conduct the CFA process beginning at initial outreach with the family, and continuing over the first 30 days.

The CFA is both a process and product. The FCC shall conduct the CFA process following three phases: (1) introductory/engagement meetings; (2) assessment meetings with the family unit and individual family members (to include conducting the CA-Self Interview); and (3) analysis and collaboration between the FCC, families and DCS Specialist (when applicable). Through information collection and analysis, the CFA process uses trauma-informed approaches to assist the family and FCC to collaboratively identify the following:

- the diminished CPCs related to the impending danger threat(s);
- the most important risk and protective factors affecting the family's functioning;
- how protective capacities and protective factors affect the day-to-day care of children;
- ways to build on family's strengths and meet their needs;
- child and family outcomes to empower and strengthen the family to meet the basic needs of the children

Expectations of each of the phases and skills to be utilized can be found in Additional Information - CFA process.

The Weekly Progress Report shall function as the communication between the FCC and DCS Specialist. The FCC shall document all contacts with the family during the CFA via the Weekly Progress Report. The FCC shall document any phone calls and/or emails that occur between the FCC and DCS Specialist within the Weekly Progress Report. The FC provider shall upload the Weekly Progress Report to the DCS Child Welfare Case Management System by 5:00 p.m. on the Friday following the week services were provided. The Weekly Progress Report must include a summary of:

- the identified FC Core Outcome(s), related UBSMART goals and the progress or lack of progress for each;
- the week's activities, family's participation and reaction to services, describing plans to overcome any barriers to services or progress;
- any additional needs of the family and plans to address them, and what each participant will do prior to the next contact;
- the emergency and concrete needs identified and the activity or plans to address those needs;
- assistance to help the family meet Conditions for Return, when applicable; and
- the parents' stage of change related to each Core Outcome.

Upon completion of the CFA process, the FCC shall summarize the results and findings within the CFA Summary [Exhibit 9.3]. The CFA Summary shall include information gathered from the family, family members, and/or non-DCS professionals, and the results of the CA-Self Interview Family Profile and NPP Assessments. The CFA Summary shall include:

- reason(s) for referral;
- dates and summary of contacts with family and collateral sources of information;
- documents/reports received and reviewed for the CFA;

- assessment instrument results related to the FC Core Outcomes;
- other family conditions related to the adult functioning of the parents/caregivers;
- summary of family strengths and needs;
- core outcomes to be the target of change strategies; and
- readiness for change.

A complete outline of the assessment summary is included in Exhibit 9.3.

The FCC shall review with the family the CFA Summary and identified areas of needed change or growth, and discuss selection of intervention outcomes that connect to identified risk factors and/or protective factors. The results of the CFA should directly inform the selection of intervention outcomes and the development of the service plan with UBSMART goals (see Chapter 10).

ASSESSMENT COORDINATION MEETING - INITIAL

The FCC shall complete the CFA process within 30 days of referral receipt, and shall finalize the service plan within 45 days of referral receipt. The assessment coordination meeting shall occur after the CFA Summary is complete and while the FC service plan is being created.

The FCC shall schedule the assessment coordination meeting with the DCS Specialist via video conference or in-person.

The DCS Specialist and FCC shall conduct an assessment coordination meeting to share information gathered during the FFA(s) and FC CFA, and the results of those assessments; resolve discrepancies between the assessments; and reach consensus on the behavioral change statements that will be discussed with the family members at the DCS case plan staffing and other family and service team meetings. This meeting allows both professionals to ensure their messaging to the family is congruent and they are prepared to help the family identify change-focused intervention strategies that relate to reasons for DCS involvement.

If the referral to FC occurs after a DCS plan has been established, the assessment coordination meeting shall occur after the FCC has gathered information during the CFA process and has compiled the results of the CA-Self Interview Family Profile and NPP Assessments. At the assessment coordination meeting, the DCS Specialist will determine if a case plan staffing is needed to modify the case plan so the behavioral change statements and identified services match and include those in the FC service plan.

During the assessment coordination meeting, the FCC and DCS Specialist shall discuss:

- the results of the CA-Self Interview Family Profile, including the FC Core outcomes indicated for change-focused intervention;
- the most recent FFA – Investigation, Ongoing, or Progress Review, and/or Protective Factors assessment results, including the identified safety threats, diminished CPCs related to the impending danger threat(s), and family protective factors and risks for future abuse or neglect;
- any additional information that may influence (support or refute) the results of either the CA-Self Interview Family Profile, FFA, or Protective Factors assessment, behavioral change statements, or service plan;
- any discrepancies between the two assessments, including a plan to resolve those discrepancies;
- the diminished CPCs that will be the basis of behavioral change statements in the family's DCS case plan;
- one or more FC Core outcomes that are supported by the CA-Self Interview results and related to the diminished CPCs or family protective factors;
- how the FC change-focused interventions will incorporate trauma-informed approaches, and if formal trauma-related treatment services appear necessary;
- services through other agencies/ programs to offer the family that are: (1) specifically targeted to what needs to change for the children to be safe in the family or reduce risk of future abuse or neglect; (2) culturally relevant to the family; and (3) available to the family in their community - this may include, but is not limited to, the Nurturing Parenting Program (NPP), Arizona Families FIRST (AFF), or Behavioral Health Services;

- if the family is receiving non-FC program through DCS (such as Arizona Families FIRST), information about the frequency and duration of services so that the FCC is aware of expectations placed on the family;
- if the child is in out-of-home care, information on the safety plan and the Conditions for Return, and ways in which the FC program might assist the family to meet the Conditions for Return;
- the FCC's observations or other information that may support or refute that the current safety plan is sufficient, feasible and sustainable;
- if the child is in out-of-home care, information about the parenting time plan, the child's living arrangement, and any restrictions on contact between the child and any member of the family.

At the conclusion of the assessment coordination meeting, the FCC and DCS Specialist shall jointly contact the family to schedule the case plan staffing at a time when the required participants can attend, if the case plan staffing is not already scheduled.

If the family is unable to be contacted while both professionals are meeting for the assessment coordination meeting, the DCSS schedules the case plan staffing, seeking to include the family and the FCC. The case plan staffing is discussed in Chapter 10.

The Arizona FC Core outcome definitions and assessment measures, along with their related protective factors (for families with safe children) and protective capacities (for families with unsafe children with a safety plan) are incorporated in Figure 9.3.

ADDITIONAL INFORMATION – CFA PROCESS

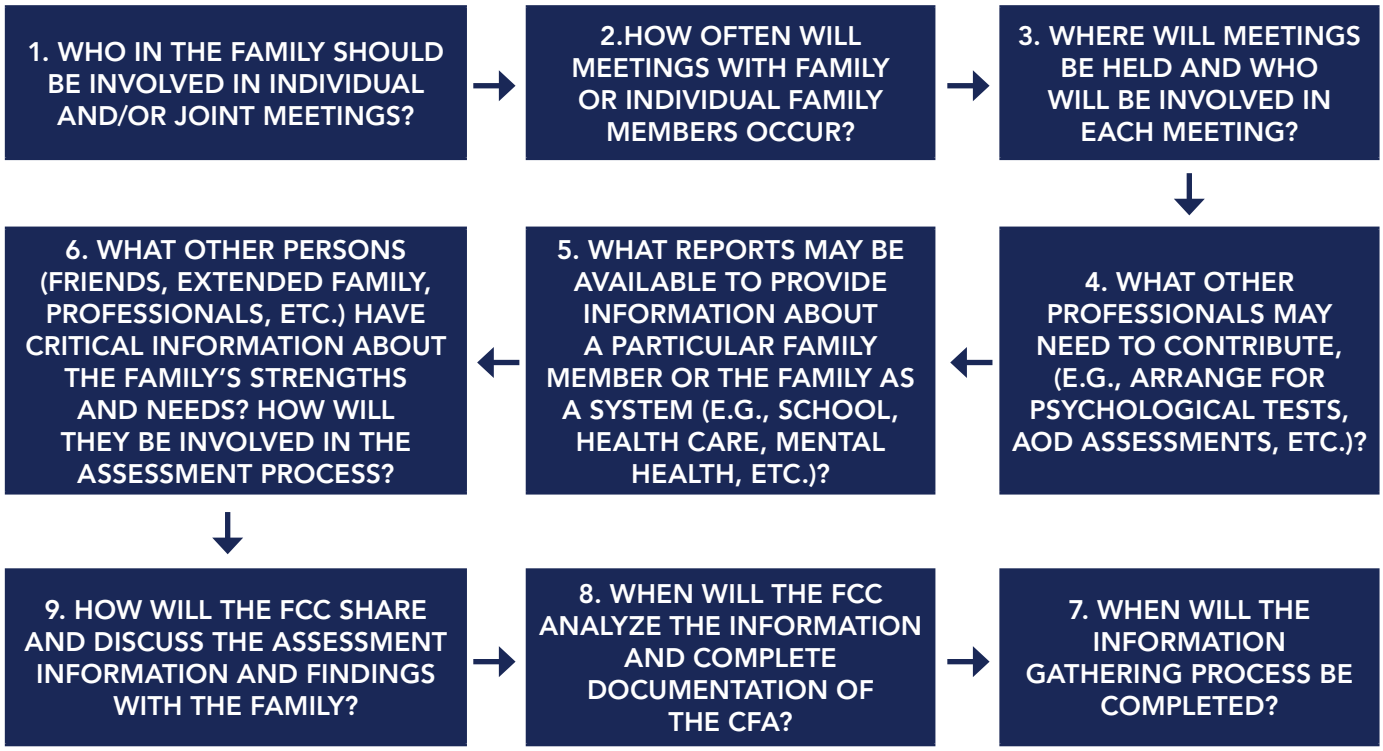
Figure 9.1: Key Activities of the FC Family Assessment

PLANNING THE CFA

After the first visit with a family and before the next scheduled visit, which is the CFA introductory meeting, the FCC will meet with the supervisor to plan for conducting the CFA with the family.

In general, it takes about four weeks to "get to know" families enough to gather sufficient information and draw accurate conclusions. If the family has ongoing or in-home DCS case management, the FFA-Exploration will be occurring at the same time. Frequent communication and information sharing should occur between the DCS Specialist and FCC. This will allow for transparency in the working relationship with the family and mutual understanding of what is learned about the risk of maltreatment and/or danger to the child(ren). The FCC can ensure the activities on the FC service plan will support necessary changes related to protective factors and/or protective capacities.

The following issues are considered when developing the plan to complete the CFA:



Sources of Assessment Information

During the family assessment process, information is gathered and considered from multiple sources. While the sources will vary somewhat from family to family, following are the most common (adapted from (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2010):

FIGURE 9.3: SOURCES OF ASSESSMENT INFORMATION

1. **Information documented on the FC Service Request. These items are further explored in conversations with families during the assessment process.**
2. **Information contained within the most recent Family Functioning Assessment, and other DCS documents, including any past reports/referrals and services.**
3. **Verbal reports from family members. The family assessment protocol calls for meeting with the family as a group, and for meeting and talking with family members on an individual basis. FCCs are interested in what family members tell them about their strengths and needs and their feelings, views, and thoughts about what they hope to achieve through the FC program. The focus of some of these conversations is prompted by self-reports on standardized assessment instruments.**
4. **The Family Profile is generated from the computerized standardized assessment measures (see further information below). Typically, the assessment instruments are administered on the 2nd or 3rd face-to-face visit to collect information on specific areas of family strengths, needs, and functioning.**
5. **Direct observation of nonverbal behavior. Assessment involves observing the nonverbal behavior of family members, which may be cues of emotional states and reactions such as anger, hurt, embarrassment, or fear. These observations may be within the family or with others outside the family, if available and appropriate.**
6. **Direct observation of the interaction between family members – between adult caregivers, between parents/caregivers and children, and between the family and other household members who may not have a direct caregiving role. If a parent does not reside with the family, there should be at least one interview with the absent parent.**
7. **With the family's knowledge and consent (i.e. via a release of information), the FCC should consider collateral information from relatives, friends, physicians, teachers, employers, and other professionals. Collaterals may have critical information about the needs, strengths, and protective capacities of the family.**
8. **Psychological/mental health evaluation and/or Alcohol or Other Drug (AOD) assessment. When mental health and/or AOD problems of a parent/caregiver or child increase the risk of maltreatment or contribute to the danger threat, it may be necessary for the FCC to enlist pertinent professionals to help with the assessment of the family.**
9. **General health care status of all family members as well as any physical health evaluations of chronic or acute illness experienced by family members. To gather an overall picture of the needs of the family, the FCC should be aware of the physical health status of its members. The FCC should obtain information about their routine health care and, if indicated, help the family obtain needed health care evaluations.**

COMPREHENSIVE ASSESSMENT PHASES

PHASE 1: Introductory Meeting(s)

One of the first meeting(s) the FCC has with families is the intake meeting. This may become part of the CFA introductory meeting, as it may occur within five (5) business days of referral. See Chapter 7 for more information about the intake meeting that occurs with DCS.

The introductory CFA meeting allows for clarification of the purpose of the CFA: to mutually define the ways that families and FC staff will work together to determine the outcomes to be achieved as a result of the FC program. It will be important that the families understand DCS and FC are collaborative partners who want to engage families in the most purposeful possible work to reduce risk of future maltreatment and DCS involvement.

The FCC should use clear language and avoid jargon when introducing and discussing the CFA process. The FCC should consider consulting with supervisors and colleagues on how to explain terms that are commonly used in the FC program, such as "risk factor," "protective factor," "protective capacity," "impending danger," "maltreatment," "outcome,"

"intervention," "standardized instrument," etc. It is important families understand what information is being gathered and why.

Early on, the FCC should also arrange a meeting with the whole family. This helps ensure each family member knows the shared expectations from the beginning, that everyone's participation is valued and viewed as important, and that communication is open. If the family has ongoing or in-home DCS case management, the family should know from their very first meeting that the professionals will openly share information and are partners in working with the family, working toward the same goal of child safety. More information about this can be found in Chapter 8.

An important way to hear the family's voice, engage the family as partners, and begin to gauge the family's stage of change is to ask questions before telling the family information. The FCC should use open-ended questions, without correcting or judging, to gain an initial understanding of families' perceptions of their strengths, needs, current situation, and attitudes about working with the FC program. The FCC should also factor in the family's and parent/caregiver's readiness for change when introducing, explaining, and planning the assessment process. Depending on the stage of change, the FCC should consider using motivational interviewing techniques to engage the parent/caregiver in conversations about the prospect of change (for more information, see the below section on skills).

During the introductory phase, the FCC collaborates with families about the plan for conducting the formal assessments and when the meetings will occur. Sometimes, families may only be able to plan a few days or a week in advance, so scheduling may need to be done incrementally.

PHASE 2: Assessment Meetings and Other Sources of Information

After the introductory phase, the FCC should meet with families and individual family members to further understand family risks and strengths, protective factors or protective capacities, as well as the specific needs to be addressed through intervention. The focus of these meetings is on gathering information about specific aspects of families and their environments, which, without intervention, may lead to maltreatment and contribute to challenges in meeting the children's basic needs. The CA-Self Interview is administered early during this phase.

For risk cases in which DCS had applied the Protective Factors Framework, careful consideration of both risk and protective issues helps families and the FCC "understand the factors associated with the origin, development, and maintenance of any problems, as well as those strengths, attributes, and resources that may later be useful in working toward problem resolution" (Cournoyer, 2017). Cases of impending danger are going to involve the DCS Specialist concurrently completing the FFA-Ongoing, in which they will be exploring with the family which protective capacities must be enhanced for children to be safe. The FCC will use information from the CFA to build a complimentary plan with a range of possible activities to help the family strengthen specific protective capacities related to the impending danger threat(s).

Cournoyer (2017) suggests it is essential to explore all aspects of the family's person-issue-situation and the interconnectedness of those three domains. This involves examination of the current status of the family's presenting problems and their onset, intensity, frequency, and duration. Furthermore, it includes a careful examination of past attempts to resolve, cope with, or avoid problems, as well as the strengths and resources that were used in previous problem-solving efforts. In addition, aspects of the person (i.e., the primary caregiver and other individual family members) must be examined, including individual thinking, feeling, and ability to effectively act on one's own behalf. The circumstances in which the family lives must be examined to understand the social, economic, and cultural factors that might be affecting caregiving and family functioning. This includes stressors as well as familial and community networks and interaction patterns that offer physical, emotional, spiritual, and financial supports. To attain a comprehensive picture of all three domains, it is necessary to consider the family's perceptions of each one in the present, past, and future (Cournoyer, 2017).

PHASE 3: Analysis and Convergence

During the final phase of the assessment process, the FCC analyzes the information collected, arrives at tentative conclusions, discusses them with families, and develops analysis or convergence with families on priority intervention outcomes. This is the point in the assessment process where all information is synthesized to complete the CFA Summary and identify the family's priority strengths and needs. There must be connection to the identified risk factors and/or diminished protective capacities that relate to impending danger.

It is important to carefully weigh all available information to determine the family's greatest needs and to prioritize core outcomes. Selection of outcomes is done with the family. That said, the FCC utilizes supervision to prepare for this meeting. Supervision should include discussion of the assessment results and consider the following:

- Which items are rated the highest (or lowest depending on the instrument scoring on CA-Self Interview measures) and suggest an important area to be addressed to reduce the risk of child maltreatment or the diminished protective capacities causing impending danger?
- How ready are family members to work on the most important risk factors or diminished protective capacities?
- How likely is it that the selected outcomes can be achieved in a ninety-day period or what might be reasonable progress within a ninety-day increment to move the family closer toward enhancement of protective capacities?
- What has the FCC learned about the impact of trauma on the family? How will this be discussed with the family? How does trauma related to the other assessment instrument results and influence the Core outcomes?

The FCC's role is to help the family thoughtfully consider and prioritize possible outcomes. Discussion should occur as to how trauma has impacted the family, the children's functioning, the parent/caregiver's coping and daily routine, interactions between family members, etc.

The FCC should assist families in thinking critically about what they want to change, including weighing the pros and cons of making the change. It is important to acknowledge and discuss any differences in opinion or perception between the parent/caregiver(s) and the FCC, as well as any discrepancies between the family's perceptions and the standardized assessment results. It is important to openly and objectively explore results with parents/caregivers, as their cultural background or interpretation of a question may provide context/meaning to how the family responded and impact the FCC's interpretation of the results. Vetting these differences will increase the likelihood that the right challenges and needs are targeted for intervention, and that the family and FCC have a shared sense of the family's readiness, justification, and motivation for change. Discussion to select core outcomes might require more than one meeting with the family.

It is important to dedicate the time needed to having in-depth discussion and reflection around the family's determination of its greatest needs and to avoid prematurely discussing action steps or services. Premature discussion about formal treatment/change-focused services risks setting the family up for compliance-based work. With that said, if families request and/or have an emergent need for formal services, the FCC will assist them in securing said services immediately at any point during the CFA process. These referrals come with an important discussion with the parent/caregiver(s): outcomes are based on behavioral change directly related to identified risk conditions or safety threats, not on service attendance or completion. The FC program views service planning (which is discussed in Chapter 10) as a distinct activity that must first be grounded in thoughtful prioritization of outcomes and the changes desired by the family.

When there is a DCS Specialist working with the family, the FCC and DCSS will hold an assessment coordination meeting prior to meeting with the family at the case plan staffing. The FCC and DCS Specialist will both attend the case plan staffing in order to develop consensus with families on priority intervention outcomes. This is the point in the assessment process where all information is synthesized to identify the family's priority strengths and needs. There must be connection to the identified risk factors and/or diminished protective capacities that relate to impending danger.

ADDITIONAL INFORMATION: SKILLS USED DURING THE CFA PROCESS

Motivational Interviewing is a technique, which is essentially a conversation about change, particularly behavior change (Miller & Rollnick 2013). Motivational interviewing is a collaborative, goal-oriented method of communication with particular attention to the language of change. It is intended to strengthen personal motivation for, and commitment to, a targeted behavior change by eliciting and exploring an individual's own arguments for and against change. Useful during clinical assessment and treatment, it is also particularly useful for helping families identify and establish goals for change during the assessment process leading to the identification of desired outcomes and development of the FC service plan. This sometimes means we explore a family's ambivalence toward making a specific change in order to facilitate moving toward change. Motivational interviewing requires an empathic, calm, and caring style, shared decision- making, and the ability to avoid arguments while handling resistance skillfully.

There are four strategies of motivational interviewing that are particularly useful in the early stages of change (i.e., pre-contemplation, contemplation, preparation). Represented by the OARS acronym, the strategies are:

FIGURE 9.4: MI STRATEGIES

Open-Ended Questions	Facilitates dialogue; requires more than a simple yes or no; often starts with words like "how," "what," "tell me about," or "describe"; usually goes from general to specific; conveys to families that our "agenda" is about them.
Affirmation	Acknowledges the difficulties the family has experienced; validates the family's experience and feelings; supports and promotes self-efficacy; emphasizes past experiences which demonstrate strength and success to prevent discouragement; must be done sincerely.
Reflective Listening	Demonstrates an interest in what the family has to say and a desire to truly understand how they see things; begins with a way of thinking and incorporates different types of statements including: (1) repeating (simplest); (2) rephrasing (substitutes synonyms); (3) paraphrasing (major restatement); and, (4) reflection of feeling (deepest).
Summarizing	Reinforces what has been said; shows you have been listening carefully and prepares the family to move on; often links together family's feelings of ambivalence and promotes perception of discrepancy.

Exploring Skills include probing, seeking clarification, reflecting content, reflecting feelings, reflecting feeling and meaning, partializing, and going beyond what is said. These skills, considered foundational to information collection and assessment in the social work/ counseling and other professions, are summarized below.

EXAMPLES OF COMMON PROBES

"What do you like best about being a parent?"	"What were your parents like?"	"How did you feel when he/she did that?"

PROBING

Probes are phrased as questions or requests. For example, after families say they feel "stressed out," the FCC might say something like, "Tell me more about that…exactly what has happened this week to contribute to feeling stressed out?" A change-focused example would be "What would you like to be different?"

There are two types of probing questions: open ended and closed ended. A closed ended question yields specific, discrete information. The following are examples: "What's your address?", "When were you born?", and "How many children are you caring for?" Answers to such questions are brief. Sometimes too many closed- ended questions asked one after

another may make families feel like subjects of an interrogation. Therefore, it is usually more productive to mix closed-ended with open-ended questions and active listening responses.

Open-ended questions are phrased in a way that encourages families to elaborate and express themselves more fully. Often they are phrased as "what" questions such as "What is the nature of your concern?" and "What happened next?" "What" questions can be framed as closed- or open-ended and can gather factual and feeling- related responses. "How" questions nearly always yield open responses from families. Examples include: "How did that come to happen?"; "How did he react?" and "Please tell me more, how do you manage those situations?"

SEEKING CLARIFICATION

During an interview, individuals may make statements that are vague, incomplete, or imprecise. Contradictory information may be communicated. The contradiction can be in the form of conflicting statements or other "mixed messages," such as family members saying they are comfortable when their tone of voice or body language appears to demonstrate a level of discomfort. Communication may not be clear because of cultural differences. In any case, it is critical to clarify what is being communicated. This attempt to gain understanding facilitates the development of a sound helping relationship. When unclear about what an individual has expressed, FC staff should attempt to elicit more complete expressions of the meanings of a family member's words or gestures, asking them to be more specific about something they have said. For example, a FC staff member could say, "I'm a little confused. You said _____, but you also said_____."

REFLECTING FEELING AND MEANING

A significant aspect in the helping relationship is offering family members a mirror of themselves, which allows them to develop an enhanced understanding of issues that are important to them and they want to address. Until information or insights are reflected back to them, they may not have been aware of the connection. It is crucial to be disciplined in the reflection of meaning and feelings to individuals and to precisely "give back" only what the individual family members communicated and to not make any changes in what the families have conveyed.

SUGGESTED FORMATS FOR REFLECTING FEELING & MEANING INCLUDE:

You feel ___ because ___.	You feel ___ and ___.	You feel ___ but/yet ___.

PARTIALIZING

Family members often have many complex issues along with many thoughts and feelings, each of which seem to require immediate attention to the them. To be effective, it is necessary to prioritize what needs to be addressed first. This skill may be applied throughout the FC intervention process. For example, it may be useful at the beginning of intervention to sort out issues and prioritize what must be addressed first. It may also be useful when a crisis arises or at other times when circumstances create overwhelming demands.

GOING BEYOND WHAT IS SAID

The FCC works with families to facilitate understanding of the person-issue- situation and help to increase understanding by using skills that explore and clarify family members' thinking and feelings.

The FCC also helps family members organize their thoughts and emotions through skills of partializing and reflecting meaning and feeling. In going beyond what is stated, the FCC extends slightly what an individual actually said. Often there are clues in the general communication, both verbal and nonverbal, suggesting an unspoken theme. This skill should only be used once a strong helping relationship has developed because it is essential to know family members well in order to effectively use this skill.

AN EXAMPLE:

Caregiver: (55 year old grandmother) "I don't know what to do. My daughter left her children with me 6 years ago but she continues to visit and disrupts things, making promises to the children she never keeps. It just upsets the whole house when she comes."	FCC response: "Your daughter left the children and you have had the sole responsibility to care for them. You don't know how to deal with her. You hope someday she'll be able to care for them, but you also know this probably won't happen. You love her but you are also angry with her."

Seeking clarification is an attempt to gain understanding that facilitates the development of a sound helping relationship. In addition, it may promote an opportunity for individuals, who previously may not have had a clear understanding about their own person-issue-situation, to develop a more accurate understanding.

ADDITIONAL INFORMATION: OUTCOME OF THE CFA

Key conclusions of the assessment provide a thorough rationale for an identification of the most important risk and protective factors and the selection of outcomes that will be the target of change-focused interventions.

- *Risk and Protective Factors*. Based on the complete assessment, the summary provides the opportunity to analyze the information that has been collected and draw conclusions about the most important risk and protective factors of individual family members and the family as a system. Each risk and protective factor should have a rationale for identifying these factors. For famliies in which there is impending danger, the DCS Specialist contributes to this analysis by discussing the most important diminished protective capacities that must be enhanced for the child(ren) to be safe; and, the enhanced protective capacities that contribute to positive aspects in the family. This section of the summary provides a connection between the findings of the CFA related to relevant protective capacities. Key results of the CA-Self Interview Family Profile should be highlighted in this section.
- *Core Outcomes to be the Target of Change Strategies*. Based on the assessment, core outcomes are identified that will be targeted for change strategies. This section supports FC staff to select the identified outcomes, in collaboration with the family, and to define these outcomes as they uniquely match each family.

RECOGNIZING THE SYMPTOMS OF TRAUMA

As FCCs work to identify symptoms of trauma within a family, it is important to recognize that trauma can manifest in many ways. For example, though family members may experience the same traumatic event, their individual symptoms of trauma may look very different and have varying impact on functioning. The individual response to the traumatic event is dependent on other experiences prior to the event, such as natural supports and the use of healthy coping skills. When symptoms of trauma are present, they may manifest physically, emotionally, cognitively, and/or behaviorally. These symptoms may be observed immediately or delayed for several days, weeks, or months. According to the Substance Abuse and Mental Health Services Administration (SAMHSA),

> *"Initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect. Most responses are normal in that they affect most individuals and are socially acceptable, psychologically effective, and self-limited. Indicators of more severe responses include continuous distress without periods of relative calm or rest, severe dissociation symptoms, and intense intrusive recollections that continue despite a return to safety. Delayed responses to trauma can include persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety focused on flashbacks, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma, even remotely." (2014)*

FCCs use engagement skills and assessment instruments to help determine if symptoms of trauma are present, and continue to assess while working with the family. During this process, FCCs partner with families to determine if additional interventions are needed, such as psychotherapy provided by a community partner. Some individuals have experienced a traumatic event and may not be ready to discuss it. FCCs should respect the individual's readiness and avoid forcing the conversation during a Family Connections visit.

> In going beyond what is said, the FCC uses their knowledge, experience, and intuition to add to the feelings or meanings actually communicated. What the FCC says must be congruent with the services to help continue the conversation (Cournoyer, 2011).

Physical symptoms are often somatic. Somatic means that the body is processing and expressing emotional distress. When children, in particular, experience trauma, they may have difficulty expressing themselves, and present with somatic symptoms such as stomachaches and headaches. Common physical symptoms include, but are not limited to:

- difficulty sleeping,
- stomachaches,
- headaches,
- easily startled,
- changes in eating patterns,
- difficulty breathing, such as experiencing panic attacks and;
- physical regressions, such as bed wetting.

Emotional symptoms of trauma vary from person to person. After experiencing a traumatic event, some more common reactions are anger, sadness, shame, and fear. Some individuals may feel "numb" or detached from their emotions. Emotional symptoms are influenced by the individual's history, and a person may not be able or willing to express these feelings, especially to others outside the family. Children who have experienced trauma may have difficulty describing how they feel or regulating their emotions, resulting in frequent outbursts and regression in behavior.

Trauma can impact an individual's cognition. The Substance Abuse and Mental Health Services Administration (SAMSHA) explains that "trauma challenges the just-world or core life assumptions that help individuals navigate daily life" (2018). For example, an individual who once felt safe driving on the freeway, but was in a significant accident on the freeway, may now only take side streets. The person's perception of the freeway being a safe place to drive has been impacted by the trauma. Trauma can cause cognitive errors, which is the misinterpretation of a current situation as dangerous because it resembles, even remotely, a previous trauma. The individual may also experience excessive guilt about the trauma and self-blame for the traumatic event occurring.

A common symptom of experiencing a traumatic event, and more specifically associated with posttraumatic stress disorder, are intrusive thoughts and memories. Intrusive thoughts can occur at any time and are associated with the trauma. These are also called triggers and can impact an individual's response both emotionally and behaviorally. A behavioral response to a traumatic event is common and, again, will vary from individual to individual. Behavioral symptoms may include:

- avoidance of triggers, such as the place the traumatic event occurred
- withdrawal from activities the individual enjoyed prior to the traumatic event
- social isolation
- angry outbursts
- poor impulse control
- self-destructive behavior

All of these responses are common after an individual experiences a traumatic event.

ADDITIONAL INFORMATION

FCCs conduct the CFA to understand the nature of the conditions that are contributing to

the risk of maltreatment or impending danger to the child(ren). This analysis allows for later trauma-informed, change-focused interventions tailored to the unique needs of each family.

Many families who will be referred to FC will have experienced trauma. As such, it is important that all services offered to families are trauma-informed. This begins with use of a screening tool (the Life Events Checklist- Revised, or LEC-R) at the time the CA-Self Interview is administered. If the tool, along with conversations with the family, confirms the family has experienced trauma, the FCC will explore the need for referral for trauma-related services. The FCC will ensure they continue to utilize trauma-informed approaches throughout the assessment process, and later change-focused interventions.

EXHIBIT 9.1: PROTOCOL FOR ADMINISTERING & INTERPRETING THE COMPUTER ASSISTED SELF-INTERVIEW (CA-SELF INTERVIEW)

Introduction

The purpose of this section is to provide information about facilitating the Computer Assisted Self Interview (CA-Self Interview). The CA-Self Interview is usually facilitated during the 2nd or 3rd meeting with each parent/caregiver. This section covers the following:

- Explaining the purpose of the CA-Self Interview
- Preparing for facilitating the CA-Self Interview
- Facilitating the CA-Self Interview
- Assessment Instruments within the CA-Self Interview

EXPLAINING THE PURPOSE OF THE CA-SELF INTERVIEW

During engagement interview(s) with families, the FCC explains the process used to work together (see Chapter 7). It is likely some information about the CA-Self Interview will be shared over several sessions; depending on how many times the FCC has met with the family. Consider the information included here as reminders of what/how the FCC will explain the process.

For example, when discussing how the FCC and family will work together, the FCC may say:

FCC: During one of our first meetings, we want you to answer some questions about your family using a computer. We have found that taking a little extra time to answer these questions at the beginning saves time later as you can tell us what is working well in your family and identify things that might be the focus of our work together. Have you ever used a computer for anything like this before, for example when going to the doctor?

Parent/Caregiver: I guess I understand. How long will this take?

FCC: We like to plan about 90 minutes to give us time to show you how the computer works. Answering questions generally takes an average of one hour. It works best when there are few distractions so it helps us to plan a time/place to help you get through this as quickly as possible.

Parent/Caregiver: What happens after I answer these questions?

FCC: I take the computer back to my office and then the next time we get together, we will talk about your answers. You might decide that answering some questions help you think about what is most important to you and we can talk about that next time. It is important that you know that there are no right and wrong answers AND this is NOT A TEST. It is just a way for us to get to know you better.

KEY POINT: Whether the FCC takes the printed version of the Family Profile to discuss with the family should be decided between the FCC and FC supervisor. For some families, seeing the "profile" might be overwhelming and the FCC could decide to present the information in another format or to just discuss the results in

another way. When possible however, many families find actually seeing the results of their answers helpful.

This is especially important ninety days later to discuss changes in behaviors and conditions following the FC program.

PREPARING FOR FACILITATING THE CA-SELF INTERVIEW

The most important preparation before facilitating the CA-Self Interview the first time is to PRACTICE. The FC supervisor can help the FCC set up "practice interviews". The FCC can do this as a role play with the FC supervisor or another FCC so the FCC can practice what the FCC will do when the FCC is actually with clients (see below) and it is also important that the FCC practice answering the questions at least once but preferably more than once. It is very important that the FCC seek consultation from the FC supervisor or someone from the FC agency's IT department so that the FCC does not keep "practice" interviews with "real client interviews".

It is also helpful if the FCC reviews training handouts (and to complete the sections about the instruments in the E-learning program) for each of the assessment instruments before facilitating the CA-Self Interview and especially before meeting with a parent/caregiver about the results.

It is important to be prepared with all the materials the FCC may need while facilitating a CA-Self Interview with a parent/caregiver.

This holistic approach to family assessment considers family and parent/caregiver strengths (Whittaker, Schinke, & Gilchrist, 1986).

The family's environment is viewed as both a source of and a solution to the family's needs (Bronfenbrenner, 1979; Garbarino, 1992).

TO DO PRIOR TO THE INTERVIEW:

- Sign out a laptop or other device (e.g., smartphone, iPad) and make sure the laptop is fully charged (the FCC may not be able to plug it in at the family's home).
- Confirm the appointment and remind the parent/caregiver you may need as much as an hour and a half for this visit.

ADMINISTERING THE CA-SELF INTERVIEW WITH MORE THAN ONE PARENT/CAREGIVER

When the FCC is working with a family with more than one parent/caregiver in the household, the FCC will administer separate CA-Self Interviews with each parent/caregiver in the household, privately. This is necessary because the assessment instruments have not been tested and validated for use with multiple respondents simultaneously. In addition, this allows the FCC to learn about each parent/caregiver's perspective, and develop an understanding of the similarities and differences between their responses. When scheduling and planning for the CA-Self Interview, supervisor consultation may need to occur to address any issues regarding the family's willingness and availability for the CA-Self Interview, any anticipated large differences between each parent's CA-Self Interview results, and the best plan of action to accommodate for any suspected, reported, or proven power and control dynamics in the home that can affect the administration of the CA-Self Interview.

ITEMS TO TAKE:

- laptop
- power cord
- electrical outlet adapter (not all electrical outlets may permit 3 prongs)
- power strip with a long cord - some apartments may not have an available outlet in a location that is convenient for the caregiver to use the laptop.
- technical sections of this section that may be referenced if needed while the FCC is in the home.
- A hard copy of each assessment instrument (in case of technical difficulties).

FACILITATING THE CA-SELF INTERVIEW

The FCC plays an essential role to support parents/caregivers to answer questions about themselves so that the FC program can be individualized and tailor interventions based

on what is working well in the family and what is not working that well. The FCC is the vehicle to enable parents/caregivers to tell us about themselves and their families before intervention and at the ninety-day assessment. If the family has ongoing or in-home DCS case management, the FCC serves as a bridge and a support in helping the parent/caregiver consider what is underlying the identified risk or safety concerns.

As a facilitator of this process, the FCC may have opportunities to use core listening techniques. However, as much as possible, the FCC wants to support parents/caregivers to answer questions on their own without discussion during the process. Avoid advising, offering suggested answers, or providing evaluative comments while the parent/caregiver is answering questions. Research has confirmed that individuals respond more honestly when they can do this on their own, rather than answering how they think others would like them to answer. This will also help to keep the completion of the CA-Self Interview as brief as possible.

The FCC should think of their role to support parents/caregivers to understand the purpose of the CA-Self Interview including reviewing how the information will be used, to help with setting up the technical aspects of using a computer, and to answer clarifying questions as appropriate (see below). Prior to facilitating the completion of the CA-Self Interview, the FCC should seek consultation from the FC supervisor if the FCC has any questions about their role.

KEY POINT: It is essential that the FCC informs parents/caregivers that they can withdraw from completing the CA-Self Interview at any time. The FCC must give them the information they need to make an informed decision and must not use any degree of coercion or influence in the process. The FC supervisor can advise the FCC further about this. It is important parents/caregivers understand DCS will need to create a case plan, and this information will help inform what is in that case plan. DCS and FCC always hope the family is involved in looking at what has led to DCS involvement, what is occurring in the family and what should be included in the case plan. The results of the CA-Self Interview Family Profile will help provide information to make those conclusions.

OVERVIEW OF THE CA-SELF INTERVIEW

FC requires the completion of standardized assessment instruments and screening tools by parents/caregivers during the CFA process to create the FC service plan. The assessment instruments will later be re-administered during the EOC component of FC (ninety days following the development of the FC service plan); see Chapter 12. The screening tools are only administered during the initial CA-Self Interview.

Depending on the unique family situation, there may be more than one EOC and the FC program may be in place for additional increments of ninety days. For families involved due to risk conditions, and without continued DCS involvement, the second CA-Self Interview (the ninety-day EOC) may coincide with, and support, services ending with the family. The contracted FC agency and the DCS Specialist may make the decision to continue services for another ninety-day period of change-focused intervention, and then a third CA-Self Interview will be done prior to service closure.

If the family has ongoing or in-home DCS case management there is likely additional complexity and/or severity of family conditions. In these situations, there likely will be three or more CA-Self Interview administered due to extending the FC program for additional periods of time. Further information can be found in Chapter 12 of this Program Manual, which discusses the EOC.

CA-SELF INTERVIEW DURING THE CFA.

This interview is the first CA-Self Interview the parent/caregiver completes. After a brief introduction to the computer and the CA-Self Interview, the CA-Self Interview proceeds through one section corresponding to each area of assessment.

TRAINING LINK

Your FC handouts in the E-Learning Program include printed versions of each assessment instrument and a summary description about the purpose of each instrument.

Reviewing these resources multiple times should help the FCC feel confident that the FCC can answer questions the parent/caregiver may have prior to, during, and following the time they are answering questions on the computer.

CA-SELF INTERVIEW DURING THE EOC/FFA-PROGRESS UPDATE/SERVICE CLOSURE.

This interview is facilitated as part of the EOC following ninety-days of change-focused FC intervention. If the family has ongoing or in-home DCS case management, this will correspond with, and help inform, the FFA-Progress Update.

For example, if the FC service plan was developed on February 1st, the second CA-Self Interview will be facilitated no later than May 1st. This interview includes one section per area of assessment. These sections correspond to the FC Core outcomes and the FCC will use the results of the CA-Self Interview Family Profile to assess progress of the change-focused intervention and determine if sufficient progress has been made to successfully close the FC program with the family.

INTRODUCING THE CA-SELF INTERVIEW TO THE PARENT/CAREGIVER

Explain to the parent/caregiver(s) that they will answer questions on a computer for about an hour. With the parent/caregiver, select a place where the laptop can be set up so that the FCC can provide hands-on instruction of how the computer assisted interview works.

Explain that the parent/caregiver's answers will be used to help the FCC, the DCS Specialist if applicable, and the parent/caregiver(s) identify things they want to work together to change with a goal of keeping the children safely with the family. Note there are some sections where the parent/caregiver will be asked to think about one child in the family. This should be the child that may present the greatest challenge to the parent/caregiver. (NOTE: it is very important that these sections consider the same child at the ninety-day assessment).

Explain to the parent/caregiver(s) that the survey includes a variety of question formats, which the FCC will ensure they know how to use. The FCC will sit with the parent/caregiver(s) for the introductory information and after that, the parent/caregiver can ask that the FCC to continue to read the questions aloud during the interview, clarify any technical/computer questions, or the parent/caregiver can complete the questionnaire by themselves. If the parent/caregiver chooses to continue on their own, the FCC should remain seated nearby where they cannot see the screen. Although the FCC and DCS Specialist (when applicable) will see the results of the questions, it is important to give parents/caregivers time, space, and privacy to consider and answer the questions on their own.

After answering any preliminary questions the parent/caregiver has, open up the CA-Self Interview program on the computer. Explain the following:

1. The FCC will help the parent/caregiver get started with entering some information about their family.
2. Let the FCC know if the parent/caregiver would like to take a break at any time during the questionnaire.
3. At any point during the process, the parent/caregiver has the right to either not answer a question, skip sections, or end the interview.
4. During the questionnaire, the FCC can help the parent/caregiver understand what certain questions mean but do not want to influence how to answer. Remember there are no right and wrong answers.
5. After the parent/caregiver has finished the questions, the FCC will save the answers. The parent/caregiver can let the FCC know when they get to the last screen.
6. The NPP Assessments are delivered after, either via a computer or hard copy. The FCC will either save the answers on the computer or take the completed hard copies with them.

Basic Tips: Try to minimize distractions for the parent/caregiver while they are answering questions. Offer suggestions for minimizing distractions, but allow the

EXHIBIT 9.2 – ASSESSMENT AND SCREENING TOOLS

Support Functions Scale (SFS, Deal, Trivette, & Dunst, 1988)

- The SFS is a self-report instrument that measures parents' needs for help and assistance, including emotional, instrumental, child, financial, and agency support.

Family Functioning Style Scale (FFSS, Deal, Trivette, & Dunst, 1988)

- The FFSS is an instrument for measuring two aspects of family strengths: (1) the extent to which a family is characterized by different qualities; and, (2) the manner in which different combinations of strengths define a family's unique functioning style.

Family Resource Scale (FRS, Dunst & Lee, 1987)

- The FRS is a 30-item self-report instrument that measures the adequacy of household resources. It was designed to assess whether or not the respondent and family had adequate resources (time, money, energy, and so on) to meet the needs of the family as a whole as well as the needs of individual family members.

Adult-Adolescent Parenting Inventory (AAPI-2) – Revised 2010 (Bavolek & Keene, 1999)

- Designed to assess the parenting and child rearing attitudes of adolescents and adult parent and pre-parent populations.

Parenting Attitudes about Raising Teens Inventory (PARTI, Bavolek & Keene, 2017)

- The PARTI is a self-report instrument designed to assess parenting beliefs of both parents and their teens who are ages 13-18 years.

Nurturing Skills Competency Scales 3.0 Short Version (NSCS, Bavolek & Keene, 2016)

- The NSCS Short Version is a self-report instrument designed to assess parenting practices, that may relate to risk of future child maltreatment.

Parenting Stress Index – Short Form (PSI-SF, Abidin, 1995)

- Designed to assess the parenting and child rearing attitudes of adolescents and adult parent and pre-parent populations.

Edinburgh Postnatal Depression Scale (EPDS)

- The EPDS screens women for self-reported symptoms of depression and anxiety.
- The tool can be administered both prenatally and post-partum.
- The screening asks the frequency they have had each of 10 feelings/thoughts over the past 7 days.

Life Events Checklist (LEC-5)

- The LEC-5 screens for traumatic events individuals may have some degree of experience
- with in their lives. They are to consider their exposure to each event across their entire life.
- The events on this tool are ones that may result in post-traumatic stress disorder (PTSD) (Weathers et al, 2013).

EXHIBIT 9.3 – COMPREHENSIVE FAMILY ASSESSMENT SUMMARY

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(11/21)

ARIZONA DEPARTMENT OF CHILD SAFETY

FAMILY CONNECTIONS
COMPREHENSIVE FAMILY ASSESSMENT SUMMARY

Date of FC service request

Family Information

Case Person | *Person ID* | *FC Consultant (FCC)*

Reason(s) for Referral

Summarize the family circumstances and history related to the reason for FC referral and current DCS involvement

Dates and Summary of Contacts with Family and Collaterals

Summarize the contacts with the family and collaterals. If applicable, list any missed appointments. Summarize the efforts made by the FCC to contact and engage the family after each missed appointment.

Documents/Reports Received and Reviewed for the CFA

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FAMILY CONNECTIONS
COMPREHENSIVE FAMILY ASSESSMENT SUMMARY

Assessment Instruments Related to the Core Outcomes

Summarize the results of each of the following assessment instruments.

Parenting Attitudes and Behaviors

Adult Adolescent Parenting Inventory (AAPI-2) – Revised 2010

Parenting Attitudes about Raising Teens Inventory (PARTI)

Nurturing Skills Competency Scale Short Form (NSCS-SF)

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FAMILY CONNECTIONS
COMPREHENSIVE FAMILY ASSESSMENT SUMMARY

Assessment Instruments Related to the Core Outcomes – *continued*

Family Functioning

Family Functioning Style Scale (FFSS)

Social Support

Support Functions Scale (SFS)

Family Resources

Family Resource Scale (FRS)

Managing Parenting Stress

Parenting Stress Index – Short Form (PSI-SF)

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FAMILY CONNECTIONS
COMPREHENSIVE FAMILY ASSESSMENT SUMMARY

Child Well Being

Summarize information provided by DCS and behavioral health providers, and observations and conversations with the parent and/or collaterals in regards to the Child Well-Being Indicators for each child

Emotion/Trauma

Behavior

Development/Early Learning *(applies to children under the age of 6 years)*

Academic Status *(applies to children 6 years of age and older)*

Positive Peer/Adult Relationships

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FAMILY CONNECTIONS
COMPREHENSIVE FAMILY ASSESSMENT SUMMARY

Child Well Being – *continued*

Family Relationships

Physical health

Cultural Identity

Substance Awareness

Preparation for Adult Living Skill Development *(applies only to children 14 and over)*

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FAMILY CONNECTIONS
COMPREHENSIVE FAMILY ASSESSMENT SUMMARY

Other Family Conditions Related to the Adult Functioning of the Parents/Caregivers

Summarize information provided by DCS and behavioral health providers, and observations and conversations with the parent and/or collateral contacts

Physical health

Mental health

Additionally, if administered, summarize the results of the following screening instruments

Edinburgh Postnatal Depression Screening (EPDS)

Life Events Checklist (LEC-5)

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FAMILY CONNECTIONS
COMPREHENSIVE FAMILY ASSESSMENT SUMMARY

Other Family Conditions Related to the Adult Functioning of the Parents/Caregivers – *continued*

Cognitive skills

Substance Use

Domestic violence/intimate partner violence

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FAMILY CONNECTIONS
COMPREHENSIVE FAMILY ASSESSMENT SUMMARY

Summary of Family Strengths and Needs

Include a summary of the assessment scale results, and document any additional information gathered related to each strength and need. Include clarification or explanation of the scores of each of the assessment instruments after discussion with the family

Family Environment and Social Support Strengths and Needs

Child Strengths and Needs

Parent/Caregiver Strengths and Needs

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FAMILY CONNECTIONS
COMPREHENSIVE FAMILY ASSESSMENT SUMMARY

Additional Information ~ *Additional space for notes and commentary to be used as needed*

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FAMILY CONNECTIONS
COMPREHENSIVE FAMILY ASSESSMENT SUMMARY

Core Outcomes to be the Target of Change Strategies

Select from the following and provide an explanation for each selection

☐ *Child Well Being* ☐ *Family Functioning* ☐ *Family Resources* ☐ *Managing Parenting Stress*

☐ *Parenting Attitudes and Behaviors* ☐ *Social Support*

Summary

Readiness for Change

Based on the response of the family in discussions with the FC Consultant, for each parent/caregiver and other family members, identify the stage of change and describe the degree of readiness to participate in change strategies toward selected outcomes.

Signatures

FC Consultant Signature *Date*

FC Supervisor Signature *Date*

Equal Opportunity Employer/Program. The Department of Child Safety (DCS) prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics, or retaliation or any other status protected by federal law, state law, or regulation. Reasonable accommodations to allow a person with a disability to take part in a program, service, or activity are available upon request. To request this document in alternative format or for further information about this policy contact your local office. TTY/TDD Services: 7-1-1. Free language assistance for DCS services is available upon request. Ayuda gratuita con traducciones relacionadas con los servicios del DCS esta disponible a solicitud del cliente.

CHAPTER 10: DEVELOPING GOALS AND THE FC SERVICE PLAN

Why is tailored, outcome-driven service planning important?

Outcomes are achieved through the attainment of positive and desirable goals developed in the service planning process and based on the Comprehensive Family Assessment. The service planning process is intended to help parents/caregivers and other family members take broader outcomes - reduction of risk or elimination of impending danger - and break them into manageable, achievable steps. This increases the likelihood of success and fosters motivation. The goals specific to the intervention of Family Connections services need to be realistic and matched to the 90-day increment of work with the family. They also need to be squarely focused on the particular needs and desires of the family. If attained, all goals can be anticipated to reduce risk of maltreatment, increase protective factors and/or enhance CPCs related to impending danger.

Arizona Family Connections (FC) is guided by tailored interventions based on time-limited, individualized service plans. FC service plans facilitate goal and outcome achievement to help families eliminate impending danger and/or reduce risk of child maltreatment and future DCS involvement. This is done by improving protectiveness and family functioning. Chapter 10 provides an overview of the steps and elements of creating meaningful service plans with families receiving FC.

GATHERING INFORMATION ON OTHER SERVICES OR PROGRAMS INVOLVED WITH THE FAMILY

Prior to development of the FC service plan, the FCC shall review the signed ROI with the family, ask the family to identify all external provider agencies and/or services currently involved with the parents and/or children, and learn about the expectations and services delivered by those agencies. If the family identifies additional external provider agencies and/or services after the ROI was obtained during the intake meeting, the FCC shall request each parent/caregiver complete a new ROI (when applicable) to add these service providers.

The FCC shall engage in discussion with the family regarding each external provider agency and/or services the family is involved with to:

- understand the family's schedule and availability for FC appointments;
- explore with the family any redundancy or duplication of services;
- determine if the family's current schedule is feasible and realistic; and
- determine the proper sequencing of services for the family.

With the family's permission, the FCC shall advocate with or on behalf of the family when there is redundancy or duplication of services, the family's schedule is not feasible or realistic, or services are not properly sequenced to allow a family to be successful. The FCC can empower families through development of problem-solving skills and other change-focused interventions to address these service plan needs.

The FCC shall develop the FC service plan within 45 calendar days of referral receipt, or sooner. The FCC shall submit the service plan to DCS and obtain DCS approval of the FC service plan prior to the DCS case plan staffing.

DEVELOPING THE FAMILY CONNECTIONS SERVICE PLAN

The FCC shall develop the FC service plan within forty-five calendar days of referral receipt, or sooner. The FCC shall submit the service plan to DCS and obtain DCS approval of the FC service plan prior to the DCS case plan staffing.

FC service plan development shall be used to finalize targeted outcomes, UBSMART (Understandable, Behaviorally Stated, Specific, Measurable, Achievable, Relevant and Timely) goals, and the interventions that will support family members to achieve outcomes and goals. The FCC shall ensure the UBSMART goals and services correlate with the FC Core outcomes identified throughout the CFA that relate to the protective factors to be strengthened or CPCs to be enhanced in the family. The FC service plan shall detail the priorities of change as a result of the FC program, and incorporate trauma-informed intervention strategies when appropriate.

If a family does not have an open DCS case and was referred for the FC program as part of Aftercare Planning and Services, the FCC shall work with the family to create UBSMART goals, FC Core outcomes, and change-focused intervention activities to be outlined on the service plan. Once agreement is reached, the FCC shall provide the final written service plan to the family to review and sign.

If the family has ongoing or in-home DCS case management, the FCC shall develop the service plan during a home visit with the family following the assessment coordination meeting. The FCC and family shall complete the following:

- develop an FC service plan that addresses the reason for the FC referral, is culturally relevant/sensitive, and is tailored to the individualized needs of the family;
- partner with the family to review FC Core outcomes and develop UBSMART goals, outlining action steps for family members and the FCC throughout the FC program;
- create clear understanding of FC service provision and expectations of the family's participation in the FC program; and
- ensure clear communication and understanding of the specific roles of the FCC and DCS Specialist.

The FC service plan shall include documentation in the following sections, according to the instructions in the Service Plan Form:

1. FC service connection to behavioral change goals in the DCS case plan (if applicable)
2. Family strengths
3. FC core outcome and related assessment instrument, individualized definition of the FC core outcome, and UBSMART goal(s) that match this outcome
4. Activities to be completed
5. Family involvement in service plan development
6. Formal services needed or referred
7. Additional services
8. Signatures by parents, children (when applicable), FCC, DCS Specialist and FC supervisor to confirm agreement with the plan

A blank Family Connections Service Plan can be found in Exhibit 10.1.

CASE PLAN STAFFING AND FC SERVICE PLAN APPROVAL PROCESS

During the DCS case plan staffing, the family and service team shall discuss the integration of the FC service plan into the case plan, including:

- whether the family has any non-FC related services, such as NPP, AFF, peer parent or behavioral health services, and how the FCC will assist the family in securing those services, including services that are culturally relevant to the family, and available in their community;
- the safety plan, and ways in which Family Connections change focused interventions could assist the family to meet the Conditions for Return and;
- the FC Core outcomes and UBSMART goals that will be the focus of change-focused FC intervention.

The DCS case plan shall contain the long-term behavior change statements, whereas the FC service plan shall contain short-term goals, like stepping-stones, guiding and encouraging the family toward reaching their long-term behavior changes.

ADDITIONAL INFORMATION: AGENCY PERSPECTIVE ON SERVICE FACILITATION AND ADVOCACY

A crucial piece of the service facilitation process is the actual agencies to which the FCC would like to refer family members. In this process, The FCC hopes that family members will receive timely, effective services. Understanding system dynamics within organizations is crucial knowledge for the FCC and supervisors to have. The following characteristics may describe some of the community agencies with which the FC program is working.

- At any one time, too many people may need the services of a particular agency.
- In some service areas, budgetary cutbacks have resulted in limited service availability.
- The providers may be poorly trained and/or have inadequate supervisory support.
- Burn out among the workforce may be a significant problem.
- The agency system may be dysfunctional and prevent good workers from doing good work.
- Waiting lists may be long.
- Fees may be increasing and/or rigid, with little or no available financial assistance.
- Caseloads may be too high.
- Hours of operation may be limited.

ADDITIONAL INFORMATION: HOW TO GO ABOUT SETTING GOALS

By the time of service plan development, the FCC should have a comprehensive picture of all that is expected of a family by all involved service providers or other agencies. The FCC should have obtained written consent via an ROI for each parent/caregiver during the intake meeting, outlining all other provider agencies and/or services involved with the parents/caregivers and children.

When the FCC is aware of all expectations placed on the family, the FCC can:

- ensure FC services are not duplicating other services, and are properly sequenced to allow for streamlined service delivery and greater chance of successful goal achievement;
- schedule FC service appointments at times that meet the family's needs and allow family members to be fully engaged;
- advocate with or on behalf of the family to address service duplication or inappropriate sequencing.

With the family's permission, the FCC can function as an advocate on behalf of the family, coaching and empowering the family through the problem solving process to request changes to service plans so that expectations of the family are feasible and realistic in the family's unique circumstances. The FCC can deliver change-focused interventions that enhance communication skills and foster development of advocacy and problem-solving behaviors.

The FC service plan shapes the prioritization of outcomes, specification of goals, and selection of specific interventions that will be provided by FC. Goals — the expected results or accomplishments to be reached — should be constructed clearly so that FCCs, FC supervisors, DCS Specialists, and parents/caregivers will know when they have been achieved.

Goals are changes in behaviors, conditions, skills, etc. Goals do not describe the treatment or change-focused services being provided to the parent/caregiver(s), but what is expected to be different in the parent/caregiver(s)'s actions.

When considering the service plan, the FCC should use the following questions as guidance:

1. What is reasonable goal achievement and service provision within ninety-days?
   Shorter time frames allow families to experience success at faster intervals and provide reinforcement more frequently for their successes. This, in turn, enables families to begin to feel a sense of control and optimism over their situation and encourages the continuation of work toward achieving longer-term goal(s).
2. What are the priorities for work?
   Families might become overwhelmed if they work simultaneously toward achieving numerous goals. They may have several behavioral change statements on their DCS case plan, related to several impending danger threats. Therefore, families should be guided to select a limited number of FC goals, considering: Maslow's hierarchy of needs as a helpful guide (Maslow, Frager, & Fadiman, 1987); the most urgent or significant conditions increasing child maltreatment risk or compromising child safety; and/or, the condition the family is ready and willing to work on at the present time.
3. Regarding FC goals, what is the likelihood of success?

FC staff should support the selection of goals that are important to families and have a high likelihood of attainment. This is especially important at the beginning of fostering the helping relationship between the family and FC staff. Most families need to believe in and experience success as well as see that their FCC will effectively support them. Later FC service plans, after the Evaluation of Change, may address different areas or contain more extensive change-focused interventions or activities as the family makes initial progress toward their first FC service plan.

The goals and activities in FC service plans may be worked on for a few days, a week, or even ninety-days. FC service plans are intended to be dynamic documents; just as families change, the assessment and planning process evolves too. Near the end of the period of service, the service plans are reviewed with families to collaboratively decide if:

- Change achieved/UBSMART goal achieved
- Substantial change has occurred
- Some change has occurred
- Minimal or no change has occurred
- Risk or safety issues are worsening

When goals are achieved, the FCC should stress that success is always a cause for celebration. When a goal has not been achieved, explore the reasons, and decide how to redirect the collective energies to try again or develop alternative goals.

ADDITIONAL INFORMATION: UBSMART CRITERIA

Working with the family to develop goals in their language (the best words are those used by the family), that match the selected FC Core outcome(s), is a skill requiring practice. The actual process of setting goals reflects the spirit of the FC program because it emphasizes family involvement, reflects the family's voice, respects the family's culture, and engages the family to decide what it wants to achieve. In addition, like assessment, goal setting is ongoing: work toward the achievement of goals needs to be continually tracked with the family, reviewed to ensure the goals make sense given ongoing assessment findings, and revisited or adjusted as needed. For families with DCS involvement, FC goals support them in incremental movement toward achievement of their behavior change statements and meeting Conditions for Return.

FIGURE 10.1: UBSMART GOAL CRITERIA

U = Understandable	• How is the goal related to the reason for involvement? • What is the comprehension level needed to understand it?
B = Behaviorally Stated	• What would positive behaviors look like? • How will you know if they are demonstrating this change?
S = Specific	• What is the desired result? (who, what, when, why, how)
M = Measurable	• How will you know the degree to which the goal is achieved? • How can you quantify (numerically or descriptively) completion? • How will you measure progress?
A = Achievable	• What skills are needed? • What resources are necessary to support goal achievement? • How does the environment impact goal achievement? • How does the goal match the degree of readiness of the parent and/or child to make change in this behavior or condition? • Bottom line, how likely is it that the family will achieve the goal in the time allotted?

R = Relevant	• How well does the goal align with the selected outcome? • If this goal is achieved, will the overall purpose of your work be at least partially achieved? • Given the resources available, how likely is it that this goal can be achieved? • Would a particular goal be more realistic if other goals were achieved first?
T = Time-limited	• What is the deadline? • How realistic is the deadline? • How likely is it that the goal can be achieved by or before 90 days?

In order to meet the "Relevant" criteria, UBSMART goals should match the selected FC Core outcome(s), aligning with the identified risk factor(s) or diminished protective capacity(ies). In addition, the family must view the goals as relevant to what the family needs and wants to accomplish.

ADDITIONAL INFORMATION: SERVICE COORDINATION OF SERVICE PLANNING

It is the responsibility of the FCC to research and be knowledgeable of different service options and providers available within a family's community. This includes determining which service providers accept the family's insurance (or will serve families without insurance); speak the same language as the family; are of the same cultural, ethnic, or tribal background as the family, and who are able to provide services relevant to the family's specific needs (i.e. trauma specialization for families impacted by trauma).

FIGURE 10.3: FC AND REFERRALS TO TREATMENT PROVIDERS

The FCC shall refer families impacted by the following conditions to the following providers:

CONDITION	PROVIDER
SUBSTANCE MISUSE/ABUSE	Arizona Families FIRST (AFF) referral made by DCS Specialist
DOMESTIC VIOLENCE/ INTIMATE PARTNER VIOLENCE	Domestic Violence Advocate referral by DCS Specialist; referral for individual counseling, or in partnership with adult survivor by FCC
MENTAL HEALTH	FCC assists parent in determining eligibility for Behavioral Health Services through RBHA, or DCS Specialist submits referral for psychological evaluation and/or individual counseling
PEER PARENT	DCS Specialist or FCC assists parent in securing peer parent

The Nurturing Parenting Program (NPP) is an evidence-based program that can be offered for families who have Parenting Attitudes & Behaviors identified as a FC Core outcome. This program may be offered to families for whom parenting knowledge, skill and/or beliefs contribute to the risk of child abuse and neglect or impending danger. The parenting-related assessments completed during the CFA (the PARTI, NSCS and the AAPI-2) are used by the NPP to help determine which coursework will be the most helpful to the family in addressing their specific parenting needs. The results of these tools will help the FCC to consider the possible benefit of NPP to a family.

When Parenting Attitudes & Behaviors is identified as a FC Core outcome, the NPP program should be considered as a service to be implemented. The results of the PARTI, NSCS and/or the AAPI-2 may be shared with the assigned NPP provider. The results then will guide which specific NPP coursework and intervention focus may help the family in achieving their goals. The FC service plan goal should not contain language about the parent/caregiver working with the NPP provider; as the goal should describe what will be different about the parent/caregiver's parenting attitudes and behaviors as a result of the change-focused intervention. The FC service plan should document the desired behavioral change(s) needed from the parent(s)/caregiver(s) that will be the result of participation in NPP services. The inclusion of a referral for NPP on the service plan is included in the "Formal Services Needed" section.

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FAMILY CONNECTIONS OUTCOME-DRIVEN SERVICE PLAN

Date of FC service request

Family Information

Case Person	*Person ID*	*FC Consultant (FCC)*

FC Service Connection to Behavioral Change Goals in the DCS Case Plan *(if applicable)*

Identify the protective capacities and/or protective factors and the related behavioral changes from the DCS case plan that the FC service plan aims to achieve. Summarize the discussion with the family members about the relationship between the FC Service Plan and the DCS Case Plan. If the DCS case is closing with no case plan, this section is not applicable.

Family Strengths

Identify the individual, family, cultural, or community strengths identified in the Comprehensive Family Assessment that can be used or grown to achieve the FC service plan goals.

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FAMILY CONNECTIONS OUTCOME-DRIVEN SERVICE PLAN

Identified FC Core Outcome(s)

Select the FC Core Outcome(s) that indicated a need for change focused work by check-marking the box. Complete the remaining sections if selected.

☐ **Social Support**

Individualized Definition of the FC Core Outcome: *(Using the FC Core Outcome definition(s) as a starting point, write an FC Core Outcome definition that is tailored to the families' needs and describes what must change to achieve the DCS case plan behavioral goals, strengthen family protective factors, and enhance parental protective capacities.)*

UBSMART Goal(s) that match this outcome:

☐ **Family Functioning**

Individualized Definition of the FC Core Outcome: *(Using the FC Core Outcome definition(s) as a starting point, write an FC Core Outcome definition that is tailored to the families' needs and describes what must change to achieve the DCS case plan behavioral goals, strengthen family protective factors, and enhance parental protective capacities.)*

UBSMART Goal(s) that match this outcome:

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FAMILY CONNECTIONS OUTCOME-DRIVEN SERVICE PLAN

Identified FC Core Outcome(s) – *continued*

☐ **Family Resources**

Individualized Definition of the FC Core Outcome: *(Using the FC Core Outcome definition(s) as a starting point, write an FC Core Outcome definition that is tailored to the families' needs and describes what must change to achieve the DCS case plan behavioral goals, strengthen family protective factors, and enhance parental protective capacities.)*

UBSMART Goal(s) that match this outcome:

☐ **Child Well-Being**

Individualized Definition of the FC Core Outcome: *(Using the FC Core Outcome definition(s) as a starting point, write an FC Core Outcome definition that is tailored to the families' needs and describes what must change to achieve the DCS case plan behavioral goals, strengthen family protective factors, and enhance parental protective capacities.)*

UBSMART Goal(s) that match this outcome:

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FAMILY CONNECTIONS OUTCOME-DRIVEN SERVICE PLAN

Identified FC Core Outcome(s) - *continued*

☐ **Parenting Attitudes and Behaviors**

Individualized Definition of the FC Core Outcome: *(Using the FC Core Outcome definition(s) as a starting point, write an FC Core Outcome definition that is tailored to the families' needs and describes what must change to achieve the DCS case plan behavioral goals, strengthen family protective factors, and enhance parental protective capacities.)*

UBSMART Goal(s) that match this outcome:

☐ **Managing Parenting Stress**

Individualized Definition of the FC Core Outcome: *(Using the FC Core Outcome definition(s) as a starting point, write an FC Core Outcome definition that is tailored to the families' needs and describes what must change to achieve the DCS case plan behavioral goals, strengthen family protective factors, and enhance parental protective capacities.)*

UBSMART Goal(s) that match this outcome:

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FAMILY CONNECTIONS OUTCOME-DRIVEN SERVICE PLAN

Activities To Be Completed

Include activities for the family and the FC Consultant that will occur during weekly change-focused meetings, and activities to occur between home visits

Who	What	When

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FAMILY CONNECTIONS OUTCOME-DRIVEN SERVICE PLAN

Additional Information ~ *Additional space for notes and commentary to be used as needed*

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FAMILY CONNECTIONS OUTCOME-DRIVEN SERVICE PLAN

Family Involvement in Service Plan Development

Describe the efforts to engage the family in the development of the plan and how input was obtained. Specify which family members were involved, their level of involvement, and any requests for changes from the family members

Formal Services Needed or Referred

List the formal change or treatment oriented services to which the family was recommended or referred that are relevant to the identified FC Core Outcome(s) and directed toward achievement of the UBSMART goal(s)

Additional Services

List all other services the family is currently and/or will be participating in that are not related to the identified FC Core Outcomes

Signatures

FC Consultant Name	*FC Consultant Signature*	*Date*
FC Supervisor Name	*FC Supervisor Signature*	*Date*
Family Member Name	*Family Member Signature*	*Date*
Family Member Name	*Family Member Signature*	*Date*
Family Member Name	*Family Member Signature*	*Date*
DCS Specialist (if applicable)	*DCS Specialist Signature*	*Date*

DEPARTMENT OF CHILD SAFETY
STATE OF ARIZONA

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CHAPTER 11: CHANGE-FOCUSED INTERVENTION STRATEGIES AND SERVICES

Why is change-focused intervention important? An important part of FC is the process in which the FCC works directly with families to reduce child abuse and neglect risk factors, strengthen protective factors and/or enhance diminished CPCs related to impending danger. This is done through at least weekly change-focused intervention.

The FCC provides the necessary, frequent and ongoing support to parents/caregivers and children to promote UBSMART goal attainment and improved outcomes. Change-focused intervention aims to attend to the readiness and motivation of family members to facilitate meaningful change in the behaviors and conditions that led to the need for the FC program. This chapter provides an overview of the skills and techniques used in change-focused intervention, as well as a description of various types of change-focused intervention services.

CHANGE-FOCUSED INTERVENTION

The FCC shall continue utilizing empathic skills, and select a range of tailored strategies uniquely targeted to individualized outcomes and UBSMART goals. The FCC shall facilitate change-focused interventions one to two times per week, depending on service level intensity.

The FCC shall ensure change-focused interventions correlate with one or more of the FC Core outcomes and UBSMART goals outlined in the FC service plan.

The FCC shall provide a range of change-focused skills and interventions to meet the identified needs:

- addressing internal working models of individuals;
- sharing perceptions, ideas, reactions and formulations;
- grief and loss work;
- developmental remediation;
- rehearsing action steps;
- reviewing action steps;
- evaluation;
- focusing;
- educating;
- advising;
- representing;
- responding with immediacy;
- reframing;
- confronting;
- pointing out endings;
- motivational interviewing;
    - engaging;
    - guiding;
    - evoking; and
    - planning

Trauma-informed approaches, such as:

- Realization

In Family Connections, "intervention" encompasses activities, services, or tasks that are undertaken at the individual, family, and/or group level to facilitate the family's change process.

- Recognizing
- Responding
- Resisting re-traumatization

Interventions aligned with the National Child Traumatic Stress Network's (NCTSN, 2020) essential elements of trauma-informed child welfare systems:

- Maximizing physical and psychological safety for children and families
- Identifying trauma-related needs of children and families
- Enhancing child well-being and resilience
- Enhancing family well-being and resilience
- Enhancing the well-being and resilience of those working in the system
- Partnering with children and families
- Partnering with agencies and systems that interact with children and families

Interventions may include:

- provision of concrete resources;
- social support interventions;
- individual-oriented interventions, including referral to therapeutic services such as substance abuse intervention (Arizona Families FIRST) or behavioral health services; referral to a curriculum-based parent skill building program (Nurturing Parenting Program); developmental remediation; cognitive-behavioral interventions; the therapeutic relationship; problem-solving interventions; crisis intervention; and grief and loss work;
- family-focused interventions, such as concrete and financial resource management, and family role interventions;
- service facilitation, such as referring and advocating to connect the family with community services and resources.

The FCC shall use standardized materials and/or programs identified by the Department to provide educational interventions that address financial resource management (AKA financial literacy), job readiness, nutrition, and any other area specified by the Department (when applicable to the family's FC Service Plan).

DOCUMENTING CHANGE-FOCUSED INTERVENTION

The FCC shall document what occurs during all contacts with the family, and results from meetings, in order to track progress on UBSMART goals and outcomes. The FCC shall document all contacts within the Weekly Progress Report, to include the following:

- length of time the FCC spends providing direct specific change-focused skills and interventions with the family;
- indirect services that the FCC implements or facilitates on behalf of the family;
- type of intervention provided and how it directly relates to supporting a FC Core outcome and UBSMART goal

ADDITIONAL INFORMATION: TYPES OF CHANGE-FOCUSED INTERVENTION

From the time we say "hello" to family members, a process of simultaneously assessing what is going on in the lives of families and intervening with them and on their behalf has begun. This process of assessment and intervention continues until the end of FC work with them. As the FCC develops the helping relationship and implements a service plan, they sharpen the focus on work promoting defined, desirable and lasting change. A key strategy for "doing the work" is to have, at minimum, one hour of planned weekly in-person change-focused intervention with the family to encourage and support their success. Additional in-person or electronic contacts are to occur as needed to support and implement service plan activities.

To help families meet the basic needs of their children, change-focused intervention needs to provide an individualized mix and intensity of services. Interventions are geared to increase the ability of families to successfully nurture their children by enabling them to use resources and opportunities in the community which will help them alleviate stress, overcome

knowledge and skill deficits, and build and maintain caregiving protective competencies. Since the contributors to risk factors and impending danger threats are varied, interventions may be directed to developing and/or providing: (1) concrete resources; (2) social support; (3) individually-oriented interventions; (4) family-focused interventions; (5) group interventions; and/or (6) service facilitation. These are explained below.

PROVISION OF CONCRETE RESOURCES

A crucial component of intervention is responding to the complex basic needs of families often associated with living in poverty. Emergency and concrete services are provided at any point when families need them. Examples of concrete services provided in conjunction with other community organizations include emergency food or clothing; financial assistance to prevent eviction or other family disruption; and, household furniture and supplies.

Chapter 8 provided information about methods for assessing and responding to concrete or emergency needs. Since circumstances can occur at any time, we respond to the need for concrete resources and then if appropriate, help families build the skills to negotiate how to obtain needed resources on their own in the future. It is important to note these interventions may be provided at any time and do not have to match a change-focused UBSMART goal.

SOCIAL SUPPORT INTERVENTIONS

Social support serves as a protective factor and can serve to off-set specific risk factors. It can also help address the "unmanaged" aspect of impending danger. For example, if a family is socially isolated, knowing they have at least one person they can call on through thick and thin may help to reduce stress and social isolation (DePanfilis, 1996). The FCC may help families establish or mobilize a personal social connection to serve one or more social support functions, i.e., emotional, instrumental, or tangible support; cognitive aid; appraisal support; and companionship.

Studies on the stress-buffering role of social support and studies from intervention programs involving mobilization of social support suggest that having both a confidant and a network help buffer and defend families against a range of stressors (DePanfilis, 1996).

Opportunities to help families build or reconstitute previously existing social supports are varied and multiple and can offer hope that someone will be there for the family, long after formal interventions have ended. These services are crucial to an empowerment philosophy. Extended family, neighbors and friends; faith-based groups and community group members; children's school groups; parent and home health aides; and self-help groups are some ways to build new, supportive relationships.

INDIVIDUALLY ORIENTED INTERVENTIONS

Since maltreatment risk and impending danger is due to multiple factors, individually-oriented intervention is sometimes needed to address problems which interfere with caregiving, e.g., mental health challenges, destructive stress-related coping skills, or substance use/abuse problems. The FCC provides interventions in the home, while referring families to any necessary formal treatment services.

The FCC, in collaboration with the DCS Specialist when relevant, determines which individual interventions may be best suited for each family member, based on their unique situations, capabilities, priorities, and family culture and values. The FCC helps the family consider and decide upon individual intervention which will support the achievement of specific outcomes and UBSMART goals, specific to the risk factor and/or diminished protective capacities related to impending danger in the family.

Potential interventions which may be applicable to families and their individual needs include substance abuse intervention, developmental remediation, cognitive-behavioral techniques, problem-solving therapy, crisis intervention, grief and loss work, narrative therapy, play therapy, and/or art therapy. While the FCC is not directly providing clinical services, they may employ some of the skills and techniques of these formal interventions in their change-focused work. Trauma-informed approaches are an important part of change-focused intervention. The FCC will also help the parent/caregiver access and utilize necessary formal treatment services. Details on several of these interventions follow.

1. The Nurturing Parenting Program (NPP)

If the FC service plan includes Parenting Attitudes & Behaviors as a Core Outcome, NPP may have been a service included to help increase their parenting knowledge and skills. The NPP coursework and areas of focus administered as a part of change-focused intervention should directly relate the parenting needs and areas of risk/safety threat to the child(ren). Regardless of who is administering the NPP to the parent/caregiver(s), the FCC must be aware of what material is being covered each week. The FCC then builds in activities to support discussion, application, and reinforcement of the NPP material during weekly change-focused interventions.

FCC discussion with parents/caregivers about application of NPP materials may include, but is not limited to: (1) what the parent/caregiver liked about the material; (2) what they did not like or agree with in the material; (3) what they do and do not feel is feasible for their family; (4) what they have tried differently and how it went; (5) ideas of how they might apply content to their own parenting situation; and, (6) what they would like to further gain from participation in NPP specific related to their UBSMART goal.

2. Substance Use Disorder Intervention

A collaborative treatment approach to help parents/caregivers recover from an alcohol or other drug problem will also improve their capacity to provide adequate care. If the family has ongoing or in-home DCS case management, many parents/caregivers are engaging in substance misuse that has resulted in their children being unsafe or at risk of child abuse and neglect. The FCC is in a role to help support the parent/caregiver in determining the best treatment option, help create short-term plans in the home related to the FC Core outcomes that have likely been influenced by the substance misuse, and support motivation to change related to substance use.

Olsen and colleagues (1996) suggest that risk of child abuse and neglect among families whose caregivers have a substance abuse problem is affected by eight dimensions: (1) commitment to recovery; (2) patterns of use; (3) effect on child caring; (4) effect on life-style; (5) supports for recovery; (6) parent's self-efficacy; (7) parent's self-care; and (8) quality of neighborhood. It is likely that no single provider could address all eight dimensions, so a collaborative approach would be needed.

Parents/caregivers engaging in substance misuse are often referred to Arizona Families FIRST (AFF). The FCC obtain information about the treatment activities the parent(s)/caregiver(s) are participating in, and their frequency and scheduling, in order to avoid duplication and overwhelming the parent/caregiver with appointments, and to identify activities to support application and reinforcement of behavior change achieved through the AFF treatment. The FCC will communicate with the AFF coordinator to learn about needs identified through the AFF assessment and services provided or arranged through the AFF program or auxiliary services.

FCC discussion with parent(s)/caregiver about application of AFF treatment may include, but is not limited to: (1) what the parent/caregiver has learned within treatment; (2) ideas of how to apply new knowledge to parenting; and, (3) what they would like to further gain from participation in AFF specifically related to the UBSMART goals.

3. Developmental Remediation

This perspective views human behavior and social functioning within an environmental context. It goes beyond ecology by bringing in other aspects such as the stages and tasks of the family's life cycle; the bio-psychosocial principles of individual growth and development; and goals and needs common to all human beings and families. It considers the particular aspirations, needs, and qualities of each person and each family in light of diversity in such areas as culture, ethnicity, race, class, and sexual orientation.

Developmental remediation intervention should be guided by an optimistic view of the capacity of children and adults to overcome deprivation through nurturing experiences throughout the life cycle. This optimistic view should be balanced by a realistic appraisal of the capacity of parents/caregivers to meet the developmental needs of themselves and their children.

Children whose basic needs have not been met consistently may require individual attention to help them overcome deficits in cognitive, academic, social, and emotional skills. Special education programs; school or community-based tutorial programs; individual therapy and

medication; and personal or social skills development groups may be considered.

For children, pre-school programs like Head Start and pre-kindergarten programs enhance self-esteem and skills. Many therapeutic day care programs also recognize their intervention will be more successful if they target intervention to the whole family. They may provide both child-oriented services and involve caregivers in parent education and support experiences.

4. Cognitive Behavioral Interventions

These techniques are especially useful with vulnerable families when they target both the environment and the individual. The FCC selects specific techniques after the completion of the Comprehensive Family Assessment. These techniques may include the following:

- Verbal Instruction, e.g., about basic childcare tasks, often in combination with other techniques;
- Social Skills Training, such as modeling, role play, and behavior rehearsal skills when parents/caregivers are moderately depressed or experience other negative effects of life stressors;
- Cognitive Restructuring, a process to assist individuals to gain awareness of dysfunctional and self-defeating thoughts and misconceptions impairing functioning and replacing them with beliefs and behaviors that lead to enhanced functioning. This skill is useful when parents/caregivers are feeling overwhelmed and powerless in their life situation;
- Communication Skill Building;
- Employment Counseling/Training;
- Financial Management Counseling; and,
- Behavior Modification Techniques to reinforce certain behaviors.

5. Therapeutic Relationship

Carl Rogers (1957,1959) believed individuals seek therapeutic assistance because of inadequate functioning due to perceptual distortions. He described six conditions that needed to be present in the therapeutic relationship to result in constructive personality change:

- A relationship in which there is a perception "that this makes a difference";
- Vulnerability which motivates the individual;
- Genuineness articulated by the therapist;
- Unconditional positive regard demonstrated by the therapist:
- Accurate empathy displayed by the therapist; and,
- Individual's perception that the helper is genuine.

While the FCC is not providing therapy, they may engage and support change in parents/caregivers when they value and demonstrate these characteristics.

6. Problem-Solving Therapy

Problem-solving therapy involves helping individuals through a problem-solving process to define their problems and needs and then to mutually develop goals, resources, and plans to implement strategies that will address them.

While not providing therapy, the FCC can help parents/caregivers problem solve in new ways, which address risk and/or safety concerns in the family.

7. Crisis Intervention

As previously discussed, when crises occur, it is important the FCC applies the nine principles of crisis intervention (Ell, 1996, pp. 179-180):

- Aid is provided as quickly as possible, often through outreach to families;
- Crisis interventions are time-limited and brief;
- The FCC role is active;
- Symptom reduction is a primary goal;
- Practical information and tangible support are provided;

- Social support is mobilized;
- Expression of feelings, symptoms, and worries is encouraged;
- Effective coping is supported to restore a sense of competency as early as possible; and,
- Cognitive issues about reality testing and confronting the experience are addressed.

8. Grief and Loss Work

Loss is likely to be an enduring theme in the work with all the different members of the families involved in FC. There are many forms and manifestations of grief and loss individuals may experience. This includes both the adults and the children being served by DCS. For example, children may have been abandoned by their biological parents and/or lost another close family member through murder, illness, or drug overdose. Grandparents with a primary caregiving role may be grieving the loss of the same individuals as well as experiencing loss in terms of the life they had envisioned for themselves once their children were raised. The purpose of grief and loss counseling is to find adaptive mechanisms for alleviating distress (Sharp & Cowie, 1998).

Arizona Family Connections will work with families whose children have been removed and placed into out of home care. This population of children may have additional needs as a result of the trauma of the separation from their parent(s). Parents also experience the removal of their children as a loss, and there are a myriad of lasting emotions they may experience as a result of this (grief, despair, shame, guilt, relief, hopelessness, etc.).

While removal and placement provides for children's physical safety, research is increasingly finding there are effects on removed children's brain development, emotional safety and ability to maintain secure attachments with a caregiver. Movement of children between placements further exacerbates the loss of the substitute caregiver as a potential external regulator of the child's stressors (Schuengel et al, 2009). Removal is perceived as a threat to the child, and there are hormonal and chemical reactions which can result in the child having dysregulated stress responses. This may manifest in negative behavior; and, long-term physical health consequences (Goudarzi, 2018).

After reunification, the child(ren) may have different behaviors, eating/sleeping patterns, impaired attachment to their parent(s) and different reactions to stressors. In considering this, the FCC will need to be prepared to help the parent/caregiver(s) learn about the effects of separation on children, and ways to support the returned children in feeling safe and secure and addressing the resulting behaviors. The FCC should discuss with the parent/caregiver(s) and the DCS Specialist referrals to a clinician skilled in disordered attachment and the effects of separation on parents and children.

FAMILY FOCUSED INTERVENTIONS

Often, family focused interventions are combined with the provision of concrete services, including the range of emergency and concrete resources previously discussed. Thus, a major part of family focused intervention includes helping the family obtain concrete services. It is also important that families learn more effective ways to manage their limited resources to avoid crises such as evictions, loss of food, and shortage of other resources to meet the basic needs of their children.

Polansky, et al. (1981) suggested that assertive intervention is necessary with families to disturb the dysfunctional family balance in the interest of achieving a more functional family system that does not sacrifice the needs of the children. Gaudin (1993) suggests family interventions may "seek to reallocate family role tasks, establish clear intergenerational boundaries, clarify communication among family members, reframe parents' dysfunctional perceptions of themselves and their children, and enable parents to assume a strong leadership role in the family " (pp. 36-37).

SERVICE FACILITATION AND ADVOCACY

Each family presents with a unique set of strengths and needs. Our understanding of the dynamic picture of the family, including who they are and what they need, is developed during the assessment process. The implementation of the shared service plan for enhancing those strengths and addressing the needs takes place throughout FCC's' work with families.

However, because families' needs are usually complex, few families can be enabled to meet their goals with the help of only one provider, professional, or agency.

When most families begin services, they will already have connections to a variety of community systems. These connections may be with human service, health, education, legal, and mental health resources, to name a few. It is very likely the FCC's work with them will result in an identified need to expand those connections. Because few families can be assisted by one system and because families with multiple needs can be overwhelming for a single provider or system, it is crucial for the FCC to understand the clinical dynamics of service facilitation and become familiar with the diverse resources that may be available to families with children in their community. If the family has ongoing or in-home DCS case management, there will often be more complex or severe family conditions present, requiring diligent and purposeful service connection by the FCC.

Simply handing family members slips of paper with names and numbers of referral sources and expecting them to make effective connections with other agencies usually does not work. FCC's can maximize the likelihood of a successful referral by keeping in mind the complex interplay among individuals, agencies, and community systems. Making appropriate referrals on behalf of family members requires strong verbal and written language skills, an assertive nature, patience, and a willingness to tackle new situations.

HOW CAN FCC'S SUPPORT THESE OBJECTIVES?

- Know the resources available
- Correctly match outcomes and the family's preferences and cultural values and practices with community services
- Use interpersonal and group skills to interact with other professionals
- Develop FC service plans that are clear to all parties
- Lead and coordinate the service delivery process

ADDITIONAL INFORMATION: CHANGE-FOCUSED INTERVENTION SKILLS & TECHNIQUES

At this stage of the FC case process, the FCC moves from skills used primarily for collecting information, developing a helping relationship, formulating an assessment, and establishing a service plan to those skills which promote the work that must be done to reduce maltreatment risk, enhance diminished CPCs, and strengthen the family's functioning. During this phase, the FCC should continue to use the empathic skills discussed earlier, but also select a range of tailored strategies uniquely targeted to individualized outcomes and UBSMART goals.

The efforts of the FCC and families should be shaped by the agreed-upon UBSMART goals and FC Core outcomes. All the work the FCC and families do should, in some way, directly relate to one or more of the outcomes and goals. As discussed in Chapter 10, if the family's situation significantly changes and new needs or risks are identified, service plans should be renegotiated or adjusted to reflect the new or revised focus of work.

The FCC will receive training and coaching through regularly scheduled supervision related to each of the change-focused intervention skills and techniques outlined throughout the chapter.

An essential skill to support the change-focused intervention process is Motivational Interviewing. This skill should be used during assessment and service planning as well, but it is critically important to discussion and intervention related to the family's efforts to change. Other skills which are especially helpful in carrying out change-focused work include: (1) sharing perceptions, ideas, reactions, and formulations, (2) rehearsing action steps, (3) reviewing action steps, (4) evaluating, (5) focusing, (6) educating, (7) advising, (8) representing, (9) responding with immediacy, (10) reframing, (11) confronting, and (12) pointing out endings (Cournoyer, 2017).

1. Motivational Interviewing

As described in Chapter 9, motivational interviewing is essentially a conversation about

change, particularly behavior change (Miller & Rollnick, 2013). The purpose of this technique is to evoke and strengthen personal commitment and motivation for change. At the core of this method is the helping relationship since motivational interviewing relies on collaboration, engagement, and trust between the FCC and family. Additionally, motivational interviewing affirms the individual's right to self-determination and the right to make choices in both deciding to change and in selecting the specific behaviors that will be the focus of change.

Motivational interviewing involves the use of specific skills in particular prescribed ways matched differentially to each family member and situation. In other words, although motivational interviewing is grounded in a set of principles and values, it is not a "one-size-fits-all" approach. To be effective, the FCC must consider individual readiness for change (stage of change) and the specific behaviors or conditions targeted for change. The FCC must then provide intervention strategies that will best support the family member at their particular stage of change. Some of these strategies have been described earlier in this manual. Supervisors should provide consultation to the FCC to consider the strategies which will most effectively support the individual's change process.

There are four essential principles of using motivational interviewing (Miller & Rollnick, 2013):

EXPRESS EMPATHY	Acceptance of the individual facilitates change; skillful reflective listening is fundamental to expressing empathy; recognizes ambivalence is normal.
DEVELOP DISCREPANCY	Accomplished by thorough goal and value exploration; helps the individual identify own goals and values; identifies small steps toward goals; focuses on what is feasible and healthy; allows individuals to make own argument for change.
ROLL WITH RESISTANCE	Avoids argumentation; affirms the individual's right to make own decisions.
SUPPORT SELF-EFFICACY	Expresses optimism that change is possible; reviews past success in making change; uses reflective listening, summaries, and affirmations to reinforce positive statements; validates frustrations while remaining optimistic about the prospect of change.

These principles build on the fundamental processes in motivational interviewing:

(1) Engaging – fostering the relational foundation that began with the first family contact;
(2) Guiding – using the strategic focus that began during the family assessment process;
(3) Evoking – drawing forth the family member's own motivation and commitment to change using the techniques described in Chapter 9 and the principles above; and,
(4) Planning – making the bridge to change: arriving at FC Core outcomes and UBSMART goals in the assessment and service planning stages.

Motivational interviewing during change-focused intervention incorporates change talk (Miller & Rollnick, 2013), which is a statement by the individual revealing consideration of, motivation for, or commitment to, change. In motivational interviewing, The FCC guides the family member to expressions of change talk as the pathway to change. The more someone talks about change, the more likely they are to change. Different types of change talk can be described using the phrase, **DARN-CATS** (Miller & Rollnick, 2013):

Preparatory Change Talk (For individuals in the Pre-Contemplation or Contemplation Stage of Change): DARN

DESIRE	"I want to change."
ABILITY	"I can change."
REASON	"It's important to change."
NEED	"I should change."

Implementing Change Talk (For individuals in the Preparation or moving into the Action Stage

of Change): CATS

COMMITMENT	"I will make changes."
ACTIVATION	"I am ready, prepared, willing to change. "
TAKING STEPS	"I am taking specific actions to change."

PROVIDING FEEDBACK: SHARING PERCEPTIONS, IDEAS, REACTIONS, AND FORMULATIONS

An important role of the FCC in change-oriented work is the provision of candid feedback concerning individuals' needs or problems. Hepworth, Rooney, Rooney, Strom-Gottfried & Larson (2017) suggest this type of feedback facilitates the change process in one or more of the following ways:

- To heighten individuals' awareness of dynamics that may play an important part in problems.
- To offer a different perspective regarding issues and events.
- To help individuals conceptualize the purposes of their behavior and feelings.
- To enlighten family members on how they affect others (including the FCC).
- To bring family members' attention to cognitive and behavioral patterns (both functional and dysfunctional) that either operate at an individual or group level.
- To share here-and-now affective and physical reactions of the FCC to family members' behavior or to processes occurring in the helping relationship.
- To share positive feedback concerning family strengths and growth.

This feedback process should begin with the FCC's first contact with the family. Communicating upfront that feedback will be offered keeps the family informed about what to expect. It is likewise important to provide strengths-based and constructive feedback. Positive feedback can increase the likelihood that it will be heard and foster the family member's sense of optimism and self-efficacy. For example, when someone in the family feels overwhelmed with their financial situation, the FCC might say, "How have you managed so well until now? You must feel proud you have been able to provide for your family with so little money to go around."

Rehearsing Action Steps

There are many barriers which may impede an individual's implementation of planned actions to change behaviors or conditions. Proper preparation and practice can enhance the potential for successful or partial completion of action steps. Careful rehearsal of all the action steps helps individuals stay abreast of and attend to their own intentions and reactions. The FCC can facilitate planning and modification of the action steps when necessary, increasing the likelihood families will translate an expressed intention into desirable behavior. The FCC may opt to model or role-play rehearsing action steps with family members to help them identify different ways of acting/reacting (Cournoyer, 2017).

Reviewing Action Steps

Whether family members have successfully completed, partially completed, or not completed action steps, it is always important to review results with them. This sends the message that what has happened is important. It also holds families and the FCC accountable to the agreements they made and increases the likelihood that future action steps will be attempted. In addition, it provides information related to goal attainment and helps guide the process of identifying future action steps (Cournoyer, 2017).

If families have partially or successfully completed action steps, verbal praise should be offered. In addition, the factors which may have contributed to the accomplishments should be explored so that families may develop insight into their desirable behavior. Also, individuals should be encouraged to express satisfying thoughts and feelings accompanying actions toward goal achievement. For individuals who are unaccustomed to success or its acknowledgment, this may be a threatening or otherwise uncomfortable request which is at least as difficult as taking the targeted action. It may require its own action plan to increase the family member's comfort level.

When action steps have been partially completed, reviews of what occurred may also reveal challenging factors needing additional attention and a revised plan. Families may decide that partial completion is acceptable and further action is not desirable. If this occurs, the FCC should reassess the situation with their Supervisor—keeping child maltreatment risk factors and/or diminished protective capacities/impending danger threats at the forefront of their consideration—and decide if they need to encourage families to reconsider or support the changed decision.

When action steps have not been attempted, the FCC should not express disapproval or criticism. Rather, they should convey concern and ask family members to help them understand what may have gotten in the way. The FCC should try to help family members express the thinking and feeling contributing to the change in plans and how they are thinking and feeling about it now. Then, they should continue a process similar to that conducted for partially completed action steps.

Evaluating

Evaluating involves both the FCC and families exploring and reviewing progress made toward family goals and activities (Cournoyer, 2017). Informal evaluation occurs during weekly visits. The FCC is constantly assessing progress toward the UBSMART goals and FC Core outcomes and discussing them with families. A formal evaluation occurs ninety-days post finalization of the service plan. Two weeks prior to the ninety-days, The FCC should re-administer the assessment instruments through the CA-Self Interview. See Chapter 12 for details.

Focusing

Focusing is a crucial skill which is not always easy to consistently implement. Many families face multiple challenges and needs. Their lives are often chaotic and unpredictable. They may have learned that "the best laid plans…" always seem to go astray. In attempts to support and empathize with families, the FCC may become overwhelmed by the families' needs and disorganized in their attempts to help families implement service plans. In addition, diversions—attempts to dismiss, avoid, or change the subject—may occur because of external demands, psychological processes, or familial dynamics. In focusing, the FCC, together with the family, sustains attention on a particular topic. There are times patterns become apparent and this can be reflected to family members to help them monitor their own processes and how they cope with challenges, distractions, avoidances, or other factors which can throw them off course. Focusing can likewise benefit the FCC and families by renewing shared understanding of the key priorities or needs which are the target for change.

Example of focusing to address a family member's tendency toward diversion:
FCC: "It seems as though when I ask about Johnny's father, you change the subject."

Sometimes, diversions are productive. They may lead the FCC and the family to an enhanced understanding of what is really going on; in turn, this can facilitate the development of more realistic plans. Sometimes, diversions are unproductive and repeatedly take the FCC and family members further astray. Through the skill of focusing, all parties can gain insight and consider how to redirect shared energies to relevant content.

Example of focusing a family members thinking:
FCC: "Would you please hold that thought so that we can finish talking about what happened at school today? It seems that what occurred at school needs our attention right now. We will get back to your other thought."

In addition, focusing can draw a family member's attention to something they might otherwise not be aware or appreciative of. By directing attention to it, staff may heighten the individual's awareness of it (Cournoyer, 2017).

Example of focusing to increase an individual's awareness:
FCC: "I don't know if you realize it, but often when I compliment you about something you have done, you change the subject. I'm wondering if it's hard for you to hear nice things about yourself."

Educating

It sometimes becomes clear family members lack information or competency which is helpful or necessary for completing an action step. To assist family members, the FCC assumes the role of educator. In doing so, it is essential to give careful consideration to the reciprocal role of learner (Cournoyer, 2017). To be effective, both roles require being open and receptive. In addition, the educator should understand basic principles of teaching and learning.

First, the FCC is often in a position to share knowledge or an informed opinion. These should be expressed in such a manner that family members feel free to ask questions, dispute, or discard a suggestion (Cournoyer, 2017). For example, many parents have unrealistic expectations of their young children. The FCC may see the need to help parents better understand the developmental capacity of their children, as well as share suggestions on how to respond appropriately to particular developmental stages and/or specific behaviors. One approach is to first ask permission to share before automatically giving a suggestion or information.

Second, people have different learning styles. Some are deductive thinkers – they do well taking the theoretical and applying it to a particular situation. Others are inductive thinkers – they do best with specific examples that can be applied to their situations. Either type of learner may then have the skill to generalize what they have learned to other situations; or, they may need help doing so. When there is risk of maltreatment and/or impending danger to a child, we often find the parent/caregiver needs the FC program to learn how to apply pieces of knowledge to novel situations, adapt to variances in situations, and seek out solutions to situations which they have not previously encountered.

How a parent/caregiver receives information and learns may be influenced by their family's characteristics, background and experiences with educators.

EFFECTIVE SERVICE FACILITATION SUPPORT

1) Continuity of change-focused intervention
2) Accessibility and accountability of service systems
3) Efficiency of services

Information provided by outside professionals (such as the FCC) may be valued; or, the parent/caregiver may not feel the FCC has knowledge which is relevant to the family. The FCC must first engage the family, recognize what they do not know about this family, and demonstrate genuine caring before information provided by the FCC will be considered. The FCC must engage the family in a mutual process of exploring new pieces of information, if they are relevant to the family, and how they align with the family's values. Enlisting trusted and respected family supports (i.e. elder relatives, parenting providers from agencies providing services to specific ethnic groups, members of the family's faith-based community) to help navigate learning within the context of the family's culture may support successful FC service delivery.

Some individuals learn best through telling a story that can then be applied to their situation; biblio-therapy is an example of this technique. In addition, some people learn best by seeing, hearing, or doing or through a combination of these approaches (multisensory learning). As the FCC tries to help family members learn new information, it is important to understand their learning styles and to adapt their teaching techniques accordingly (Cournoyer, 2017).

Advising

It is sometimes appropriate and effective to give advice. In general, the FCC should not offer advice based on personal feelings, attitudes, and preferences. Instead, they should offer suggestions and encouragement based on professional knowledge and experience. It is preferable the FCC provides advice in a way that makes it clear families may accept or reject it (Cournoyer, 2017). The FCC could simply say, "May I offer you some advice to consider?" or "Can I give you advice on that? You don't have to agree with me but it might be helpful to hear me out." Advice should be given so that families are empowered and should be avoided if it engenders dependency.

The exception is when there is a life-threatening situation or a significant risk to safety or well-being.

Representing

Representing includes actions the FCC takes on behalf of families with their knowledge and permission to assist them in obtaining their goals. These actions are intended to facilitate families having effective and successful interactions with members of formal and informal helping systems outside of the FC program (Cournoyer, 2017). Representing incorporates the social work roles of brokering, advocating, and mediating (Cournoyer, 2017).

Representing family members can be extremely satisfying when interactions with other providers are easy and successful. However, interactions can sometimes be frustrating, even infuriating at times. It is crucial the FCC remembers they are acting in a professional capacity on behalf of the family and must keep the family's best interests in mind. Additionally, the FCC must remain aware of their relationship with DCS, when DCS is involved with the family. The FCC must maintain frequent contact with DCS so they are clear as to the risk and/or safety concerns in the family, the corresponding FC Core Outcome(s) and UBSMART goal(s), and how the FC change-focused work supports progress toward the goal(s).

The FCC must remain cognizant and self-aware of any possible triangulation or becoming overly aligned with the family. The FCC is encouraged to consult with their colleagues and supervisor on ways to navigate challenging interactions and effectively represent families while maintaining strong professional boundaries and positive working partnerships with DCS.

Responding with Immediacy

The relationship between family members and the FCC is an area where family members can experience new ways of relating and expand their skills of engaging others in meaningful relationships. To facilitate this experience, it may be helpful to reflect on the relationship development process that occurs between a family member and the FCC. In responding with immediacy, the FCC focuses on the individual's experiences in the relationship, in the here and now, including their reactions to the FCC and the work in which they are engaged (Cournoyer, 2017).

Example:
FCC: "It seems to me that right now, you seem to be (thinking/feeling/doing/experiencing)..."

When responding with immediacy, the FCC may be modeling an open and attentive communication style with which family members are unfamiliar. The interaction may prompt a similar response, such as greater openness from and by family members.

The individual's past and present problematic relationship patterns may also exist in the family - FCC interactional patterns. The FCC's ability to respond with immediacy during the present time may assist in the individual's development of self-awareness and create healthier interaction styles (Cournoyer, 2017).

Responding with immediacy is not appropriate for use with all individuals. It depends on the service plan and the individual's capacity for insight. In general, immediacy would be used when individual reactions are clearly relevant to the goals for work.

Reframing

Sometimes, individuals rigidly embrace a point of view that is, in itself, an obstacle to goal achievement. Reframing is applicable when fixed attitudes impede or sabotage work on the FC service plan. The overall goal is to liberate family members from negative perspectives getting in the way of their best interests (Cournoyer, 2017). One type of reframing is turning a negative into a positive, such as describing an individual's negatively-labeled attribute as a positive one. For example, a parent who is "overprotective" of her children could be described as careful and caring about their safety. A second type of reframing is personalizing meaning (Cournoyer, 2017). This skill is used to encourage individuals to shift from placing responsibility on others, to "owning responsibility" and hopefully build their sense of self-empowerment.

Example of reframing to personalize meaning:
Parent: "My mother is always on my case. She's so controlling – I can't do anything I want to do."

FCC: "You experience your mother as controlling and that's frustrating for you because you think you should be assuming more responsibility for your own decisions."

A third form of reframing is situational meaning (Cournoyer, 2017). The FCC reflects an understanding of the individual's feelings or behaviors, and then suggests they may also be viewed as resulting from external, situational, or other factors beyond the individual's control or responsibility. For example, a parent may feel their child is a "bad sleeper" and is misbehaving due to not following rules in class or at home, including bedtime. In working with the family, the FCC learns the child is losing sleep because she is worried about how she is failing her classes due to difficulties understanding the material. The child feels "stupid" and has started acting out in class out of frustration with her lack of understanding. The FCC explores this information with the parent to help address the underlying issue, which is not child misbehavior as initially identified.

Example of reframing around situational meaning:
Child: "I can't sleep; all I do is think about talking to her and how hard it's going to be."
FCC: "I know this is really bugging you and you can't get it off your mind. This is a big deal and I'd think it would keep anyone up just trying to figure out how to do it."

Confronting

In confronting, the FCC helps individuals understand how their words, feelings and actions may be contradictory, inconsistent, or otherwise illogical. This is done directly and without condemnation or judgment. In confronting, the FCC challenges individuals' behaviors but do not discount their personhood (Cournoyer, 2017). One format for confronting is:

"On the one hand you (say/feel/think/do)_____, but on the other hand you (say/feel/think/do)_____" (Cournoyer, 2017).

Confrontation is powerful and may have significant negative effects on some family members. Family members might feel attacked, accused, judged, or defensive. Therefore, before using this skill, the FCC should be certain a family member has the ego strength and social support to tolerate and grow from being confronted. Also, the FCC should be confident the helping relationship is well established.

Confronting techniques are good opportunities for the FCC to role-play or otherwise practice interactions during supervision, before attempting the skill with the parent/caregiver.

Pointing Out Endings

In pointing out endings on risk cases for which there is not concurrent DCS involvement, FCC's maintain the focus on the goal-oriented FC service plan by periodically reminding family members that the working relationship will end at a predetermined time (Cournoyer, 2017). Service provision is intended to be time-limited; and the need for continued FC intervention is evaluated every ninety-days. This defined duration of service may help to motivate family members to stay focused on the service plan and work hard to achieve the mutually agreed-upon goals.

If the family has ongoing or in-home DCS case management, the FC program likely will occur for a longer duration; however, is still intended to be as short-term as necessary. The FCC can help the family identify the progress they have already made. The FCC can also use motivational interviewing techniques to help the family look honestly at their lives, their decisions, and the consequences of their decisions. When the family moves into the Preparation and Action Stages of Change, progress is more readily and commonly visible and can be used to continue to motivate the parent/caregiver(s) as the end becomes closer in sight.

ESSENTIALS OF A TRAUMA-INFORMED APPROACH

There are foundational principals in the delivery of trauma-informed services as well as essential elements of a trauma-informed approach in Family Connections. Foundational principals in the delivery of trauma-informed services are addressed by SAMHSA in the

Concept of Trauma and Guidance for a Trauma-Informed Approach and include **realizing, recognizing, responding, and resisting re-traumatization** (2014). The practical application of these principles in trauma-informed service delivery can be summarized as follows:

Realization: Realization is the basic understanding that trauma exists and is "understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past, whether they are currently manifesting, or whether they are related to emotional distress that results in hearing about firsthand experiences of another" (Substance Abuse and Mental Health Administration, 2014). When FCCs realize the impact of trauma within the context of a person's coping strategies, they are better able to engage by meeting individuals "where they are at," which is also a critical component of trust building.

Recognizing: FC staff recognize trauma through stories told; through observations of individualized and collective behaviors; through responses to trauma-inducing situations and circumstances; and through emotions expressed. Different settings, situations, and circumstances (i.e., triggers) may provoke trauma symptoms that are related to current or historical traumatic events and experiences. In the article, 21 Common Reactions to Trauma, author Seth J. Gillihan, Ph. D. discusses the distinct ways that individuals re-experience their trauma (2016):

- Replaying the memory
- Nightmares
- Flashbacks
- Fear and anxiety
- Anger
- Sadness
- Guilt
- Feeling numb
- Trying not to think about the event
- Avoiding things related to the event
- Difficulty trusting people
- Believing the world is extremely dangerous
- Blaming yourself for the trauma
- Thinking you should have handled the trauma differently
- Seeing yourself as weak or inadequate
- Criticizing yourself for reactions to the trauma
- Feeling constantly on guard
- Seeing danger everywhere
- Being easily startled
- Difficulty sleeping
- Loss of interest in sex or intimacy

Depending on the type of trauma (i.e., acute, chronic, or complex) and supportive resources available, these reactions may increase or decrease over time (Gillihan, Ph. D., 2016).

As FCCs work with families they become attuned to these types of trauma reactions, recognizing how they are manifesting in physical and emotional ways, or through avoidance and hypervigilance, or a state of increased alertness. For example, the FCC may notice the individual appears focused on guilt and self-blamefor the events that contributed to the trauma experience, making comments such as "if only I had…" or "I should have…." When FCCs recognize trauma responses, they use skills such as reframing, probing, clarifying, etc., to help the person describe what has occurred. During this process the FCC may assist with the development of different perspectives about the individual's role in what was experienced or may assist the person with identifying needs that can be connected to future trauma-specific intervention services.

Responding: FC staff respond to the trauma experiences of the families through a foundation of training, skills, and self-care strategies developed over time. "The program, organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly" (Substance Abuse and Mental Health Administration, 2014). Trauma language is integrated and emphasized throughout the organization, its policies, and in training offered to FC staff. FCCs are best prepared to respond to families when they receive routine coaching and support from their supervisors to process the impact of learning about, and processing, other individuals' traumas.

When responding to the trauma of individuals and families, the FCC integrates understanding of people's traumatic experiences/events into their approach. The FCC considers the context of the trauma, and describes the trauma and the impacts of it on family members and the family system, in the overall Comprehensive Family Assessment. The information is integrated in meaningful ways, connected to sources of strength and areas of need, helping to understand both risk and protective factors. FCCs also respond by helping facilitate individual and family access to trauma-specific interventions.

Resisting Re-traumatization: Resisting re-traumatization requires knowledge of the traumatic event/experience and the active use of that knowledge in ways that prevent re-traumatization. For example, if a person's traumatic experience induced feelings of fear or anxiety around confined spaces, the FCC may work to ensure that meetings are conducted in an open-space environment with fewer people around. In this way, the FCC actively seeks to engage individuals and families using a trauma-sensitive lens, avoiding as much as possible triggering a person's trauma history.

Further, the National Child Traumatic Stress Network (NCTSN) cites seven essential elements of a trauma-informed child welfare system:

1. Maximizing physical and psychological safety for children and families
2. Identifying trauma-related needs of children and families
3. Enhancing child well-being and resilience
4. Enhancing family well-being and resilience
5. Enhancing the well-being and resilience of those working in the system
6. Partnering with children and families
7. Partnering with agencies and systems that interact with children and families (NCTSN Essential Elements, 2020)

These same elements are evident in Family Connections programming and related service delivery. Family Connections aligns with these essential elements in the following ways:

Maximizing physical and psychological safety for children and families: In Family Connections, the physical and psychological safety needs of children and families may be identified at any point in the FC process, beginning with information shared by DCS in the referral. Once a family accepts participation in FC, the impacts of trauma on the physical and psychological safety of each family member can be further explored and characterized through a collaborative process. This may assist individuals and families with identifying their unique strengths and challenges, based on their individualized and collective family history and experiences. Family Connections accomplishes this through the Comprehensive Family Assessment process, the identification of UBSMART goals connected to Core Outcomes, and the Evaluation of Change. As the family and its individual members engage in services, child and family well-being are addressed to increase physical and psychological safety related to the impact of trauma.

FCCs should be in tune to how they plan each interaction with an individual who has experienced trauma. The set up of meetings, tone of voice and body language of the FCC may be interpreted differently than they would be by someone who is not impacted by trauma (Substance Abuse and Mental Health Administration, 2014). The FCC must actively seek to ensure all family members feel safe. This may include such activities as asking permission to enter the home, asking where the family would like the FCC to sit, and never unexpectedly reaching out to touch another person's body. If any portion of a conversation appears to be increasing a family member's distress, the FCC may ask the individual what would help the family member to feel better, such as taking a break or changing topics.

Identifying trauma-related needs of children and families: Family Connections uses a broad range of skills and techniques to assist individuals and families with identifying the events and experiences that have contributed to trauma in their lives. Throughout the Family Connections process of information gathering, the FCC uses skills such as:

- open- and closed-ended questions,
- paraphrasing,
- verbal encouraging,
- probing,
- reflective listening,
- seeking clarification,
- summarizing,
- reflections of feeling and meaning,
- partializing,
- going beyond what is said, and
- motivational interviewing.

Together, these skills help elicit individual and family perspectives, experiences, and stories that assist with understanding the current family situation. Often, through these conversations, current and historical traumatic experiences and events are revealed. Additionally, the LEC-5 (Life Events Checklist) tool, administered during the Computer Assisted Self-Interview (CA-Self Interview) will help the family and FCC mutually understand the scope and range of the family's traumatic experiences. At the conclusion of the Comprehensive Family Assessment meetings, the information gathered is analyzed and tentative conclusions are discussed with the family to jointly determine priority interventions. During this process, all available information is carefully weighed to determine the family's greatest needs and to prioritize core outcomes. Trauma may impact each of the core outcomes.

Enhancing child and family well-being and resilience: According to the National Child Traumatic Stress Network (NCTSN), well-being is defined as a "state of being comfortable, healthy, or prosperous" and "considers the whole person spread across several domains of overall life quality and functioning: 1) cognitive, 2) physical health development, 3) emotional and behavioral, 4) social, 5) financial or economic security, and 6) occupational." Additionally, when considering well-being, other areas to reflect on include the role that spirituality, religion, and cultural traditions play in relation to their impact, and potential support of, each of these 6 domains (National Child Traumatic Stress Network, 2020). NCTSN also defines resiliency as "a dynamic developmental process that occurs over time, resulting from a culmination of both internal and external influences, as well as past trauma, genetic makeup, and individual capacities" (Child Welfare Trauma Training Toolkit, 2020).

When a person experiences trauma, access to supportive relationships with others is part of their path to healing, recovery, and resilience-building. For children, the most accessible support comes in the form of supportive caregivers. When a child's caregiver is overwhelmed by their own trauma history and have unmet needs related to their trauma experiences, they may not have the capacity to provide the support and reassurance their children may require. In some family systems, caregiver and family resilience may need to be enhanced, in order to increase child well-being and resiliency. As FCCs work with individuals and families impacted by trauma, they consider the supportive resources already in place and help the family to access them as part of the process of building resilience and improving well-being (Child Welfare Trauma Training Toolkit, 2020). The process of building resilience is assisted by the creation of structure, clear communication, and by accessing shared beliefs amongst family members within the home, as well as those outside of the household (Child Welfare Trauma Training Toolkit, 2020). The FCC may also assist with building or reestablishing connections with other individuals who hold close connections like long-time friends, social groups, or supports found in the context of community organizations. The FCC also assists with connecting families to trauma-specific intervention services through advocacy and referrals. As this work continues, the internal structure of the family system is changed in positive ways, strengthening the well-being and resiliency of children and their families.

Family Connections prioritizes understanding the different experiences, thoughts, and perceptions that influence individual and family behaviors. FCCs do this through a lens that acknowledges how each family member is complex and unique, just as each family system itself. Additionally, because of the interconnectedness of the members within the family system, it is understood that changes in one family member's behavior will affect, at some level, the system as a whole. Accordingly, as parents and caregivers begin to heal from their traumatic experiences, their individual resiliency also begins to increase. Throughout this process children benefit by being able to access, and rely upon their caregivers as supportive resources, thereby increasing child resilience as well. In Family Connections, as family members work towards their goals and achieve core outcomes, the changes that have taken place work together to improve child and family well-being and strengthen resilience.

Enhancing the well-being and resilience of FC Staff: In Family Connections staff are encouraged to continually examine personal feelings, reactions, and responses to the family situations they are exposed to, as well as the stories that they hear. Additionally, since Family Connections work occurs in relationship with the family and its individual members, it is natural that the FCC may experience their own feelings of loss, as the relationship edges toward its own natural conclusion. In these moments, FCCs may experience feelings that remind them of personal situations or of their own past endings.

Working with people from a human service perspective requires a certain use-of-self. The work itself can leave the FCC feeling anywhere from delighted and fulfilled to frustrated and drained. For these reasons, FCCs are encouraged to stay self-aware and in touch with the feelings this work may provoke. During supervisory meetings and coaching sessions, FCCs are encouraged to explore these feelings in an open, supportive, and constructive environment to help build self-awareness and coping skills, allowing them to resolve personal feelings, before those feelings inhibit work with families or begin to manifest and impact the FCC's own daily life.

Partnering with children and families: Family Connections is built on a foundation of partnering with children and families through relationship building and voluntary participation. As in any helping relationship, trust building is essential to providing trauma-informed service delivery. Without trust it would be extremely difficult for anyone to expose their most personal and vulnerable parts of themselves, including their traumatic experiences. Additionally, family engagement is critical to understanding both the individual and familial context of trauma. When engaging families through a trauma-lens, skills such as active listening, empowerment, and maintaining a strengths-based focus are integral to the process. Additionally, during individual and family engagement it is essential the FCC avoids any direct or indirect messages that could be perceived as shaming. For example, instead of asking "why didn't you run if you were scared?" the FCC might ask, "tell me more about how you felt in that moment, when you were fearful." While the FCC facilitates the program and interventions, the family consistently directs their own path and progress, with the support of the FCC and the services they choose to engage in.

Partnering with agencies and systems that interact with children and families: Family Connections partners with agencies that interact with children and families through information gathering, advocacy and referral services, or as partnered service providers. Once given permission, some examples may include: teachers, schools, physicians, treatment providers, mental health services, religious organizations, cultural centers, crisis response services, community service providers, etc.

ADDITIONAL INFORMATION: EXAMPLES OF CHANGE-FOCUSED INTERVENTIONS

After the FC service plan is finalized, the primary purpose of weekly contacts is to conduct change-focused interventions. The following are examples of change-focused interventions connected to each Core Outcome.

SOCIAL SUPPORT

- Work with parent to build network of people parent can talk to when they are having problems with parenting or when they are feeling down or frustrated
- Social skill training: Role play and rehearse action steps related to making new social connections/contacts
- Help parent increase awareness of lack of healthy social supports; explore with parent positive and negative aspects of social relationships (decisional balance), and solution-focused techniques around what they want to gain from social supports
- Employ strategies of grief & loss work, if applicable
- Identify person(s) in family system or community who care for the child, can babysit/spend time with the child, and can help when needed
- Brainstorm and problem solve barriers related to reliable transportation or other tangible resources
- Identify person(s) or resources to help fix thing around the home or help with chores.
- Provide advocacy and facilitate linkage to long-term social supports for the child, adult and/or family as a whole.

FAMILY FUNCTIONING

- Group work with the family to identify what each person contributes to the family; talk about ways to deal with problems; create and plan time to spend together; etc.
- Create a chore chart for all family members
- Work with family to develop and implement new ways of handling disagreements
- Facilitate practice of new disagreement strategies so each family member has an opportunity to share their feelings and opinions without anyone talking over them
- Create a list of family rules
- Create a family schedule. Where there are conflict, facilitate discussion to set family priorities. Guide family to identify opportunities to show their commitment to one another and support each other (i.e. going to child's sports game).
- Facilitate weekly family meeting, where each family member points out accomplishments of each other
- Discuss what it means to prioritize the family. Have each family member write a story, letter, poem, draw a picture, etc. as to what this means to them.
- Create a forum for family to discuss worries or problems, ideas for dealing with it, and ways to make a plan together
- Create a process for decisions which will impact the whole family (i.e. decisions pros and cons chart, everyone shares their opinion, etc.)
- Create a list of people outside of the family unit who the family can ask for help and what kind of help might they provide.
- Role play conversations of asking available supports for help.
- Research and implement materials and activities which will build family communication skill

FAMILY RESOURCES

- Research food resources and create a plan for obtaining adequate food (i.e. strategic shopping, use of food pantries)
- Create and implement a budget
- Help the family locate and secure concrete resources, such as: Clothing, Furniture/household supplies, Housing, Telephone, etc.
- Help family access and apply for public assistance (SSI, TANF, Medicaid, etc.)
- Help family find a free/low cost medical or dental provider
- Help family research and secure daycare; including applying for any necessary assistance
- Advocate to get debt forgiven or family put on a payment plan (i.e., utilities, rent, etc.)
- Research and secure transportation resources
- Create a daily schedule so parent has time to rest, time to self, time to engage in self-care or exercise, etc.
- Plan ways for adult partners to have time together without the children
- Research free or low cost family entertainment options and resources
- Link family to employment counseling/training

CHILD WELL BEING

- Work with parent to identify, research and secure services to enhance child's cognitive, social, academic and emotional skills
- Advocacy and linkage of child to services to support developmental remediation:
    - Special education services
    - Tutoring programs
    - Head Start/pre-K
    - Individual therapy/medication management
    - Personal or social skills development groups
    - Therapeutic daycare

PARENTING ATTITUDES & BEHAVIORS

- Discussing parent's understanding of child development/parenting education materials
- Explore how the parent will apply parenting education materials to specific situations
- Create a plan for supervision of the children; aide/teach the parent to assess safety of substitute caregivers
- Child proof the home with the parent, exploring parent's understanding of what needs to be done and why each part is necessary for child safety
- Practice, support and reinforce new parenting skills for specific child behaviors/condition
- Locate, review and discuss literature on child development, disciplinary techniques, etc. to supplement what they have learned in NPP
- Develop a reward and consequences plan for each child based on their age and stage of development
- Discuss new discipline techniques and plan for how they will be used
- Flipchart parent expectations of each child, guiding and educating parents when expectations are unrealistic
- Create a routine and daily schedule for each family member
- Create a plan for parent-child activities which are appropriate for the child's development
- Create a list of discussion topics which are "age appropriate" for the child and those which should be discussed with adults
- Discuss what the parent is going to work on with formal treatment provider, how they feel it went, what challenges they are having in implementing the new practice, and what questions the parent has (i.e. individual therapy to address the origin of their rigid parenting beliefs; what they will learn from NPP about physical discipline; new communication techniques)

MANAGING PARENTING STRESS

- Provide social support interventions for parent, allowing them to vent about worries and stress
- Teach parent stress reduction or coping techniques when frustrated with their children. Help parent make a plan to build the techniques into their daily parenting
- Employ cognitive restructuring techniques in conversation to help parent develop insights into their stress and reframe how they think about and respond to a stressful situation
- Teach parents behavior management techniques to change how they respond to stress in parenting
- Observe parent/child interactions and offer suggestions for ways to reduce parenting stress (i.e. ways to more effectively deescalate the child's behavior)
- Use motivational interviewing techniques to explore what parent is willing to do to change their reactions to their child(ren)
- Discuss what parent is going to work on with formal treatment provider related to perceptions of, and interactions with, the child
- Guide parent through deep breathing exercises when they are frustrated with their child(ren)
- Help the parent to begin journaling, writing one good thing that happened with the child each day and one stressful parenting situation
- Work with the parent to create a routine with the child to decrease difficult behaviors (i.e. ensuring they get adequate sleep so they are not fussy)
- Employ crisis intervention skills/principles when needed

EVALUATION OF CHANGE (EOC) AND PROGRESS

Assessment of progress is ongoing, and FC requires a formal reassessment every ninety-days following the FC service plan development. The reassessment shall inform objective determination of progress based on changes in standardized assessments, as well as explicit evaluation of levels of achievement of UBSMART goals and core outcome attainment; including those related to the effects of trauma in the family. It also is a time when the family, the FC Consultant (FCC), and the DCS Specialist (when applicable) discuss whether risk factors and impending danger have been sufficiently reduced and protective factors and CPCs sufficiently increased.

PLANNING FOR THE EOC PROCESS

The FCC shall engage parents/caregivers to prepare for and complete the formal EOC two weeks prior to the expiration of the ninety-day FC service plan. FCCs shall discuss and review the following with the parent/caregivers:

- components of the EOC process and how information will be collected from multiple sources to assess progress;
- review of the CA-Self Interview and how the information gathered through it will be used for the EOC, and
- answers to questions the parents/caregivers may have.

The FCC shall schedule and complete the CA-Self Interview re-assessment with the parent(s)/caregiver(s) after the preparation discussion, during a separate FC visit and within the two weeks prior to the end of expiration of the ninety-day FC service plan.

EOC

The FCC shall utilize the data/scores from the following assessment tools in the EOC:

- Support Functions Scale (SFS)
- Family Functioning Style Scale (FFSS)
- Family Resource Scale (FRS)
- Adult-Adolescent Parenting Inventory (AAPI-2) – Revised 2010
- Parenting Attitudes about Raising Teens Inventory (PARTI)
- Nurturing Skills Competency Scales 3.0 Short Version (NSCS)
- Parenting Stress Index – Short Form (PSI-SF)

In addition to the assessment tools, the FCC shall gather information for the EOC from the following sources:

- Information documented on the FC Service Request
- Verbal reports from family members
- Direct observation of nonverbal behavior
- Direct observation of the interaction between family members, including between adult caregivers, between parents/caregivers and children, and between the family and other household members who may not have a direct caregiving role
- Collateral information from relatives, friends, physicians, teachers, employers, and other professionals
- Psychological tests and/or Alcohol or Other Drug (AOD) assessments
- General health care status of all family members as well as any physical health evaluations of chronic or acute illness experienced by family members
- The Family Profile and NPP Assessments generated from the family's completion of standardized assessment measures (see Chapter 9 for further information on the CA-Self Interview assessment measures)

- Information contained within the most recent Family Functioning Assessment, and other DCS documents, including any new reports, referrals, and services

After re-administering the CA-Self Interview and gathering additional information, the FCC shall document and summarize the information in the EOC Summary [Exhibit 12.1] according to the instructions provided in the EOC Summary Form:

- date last CA-Self Interview completed;
- date of CFA approval;
- date of FC Service Plan approval;
- date current CA-Self Interview(s) completed;
- comparison of changes from CA-Self interview, including social support, family functioning, family resources, parenting attitudes and behaviors, managing parenting stress, and child well-being;
- other family conditions related to the adult functioning of the parents/caregivers;
- summary of activities;
- assessment of core outcome(s) and UBSMART goal(s);
- FCC recommendation about service closure or continuation and;
- signatures.

ASSESSMENT COORDINATION MEETING - EOC

The DCS Specialist and FCC shall conduct the assessment coordination meeting - initial as prescribed in chapter 9. In addition, the DCS Specialist and FCC shall conduct an assessment coordination meeting – EOC following each EOC is completed with the family.

The assessment coordination meeting – EOC shall occur:

- after the FCC has re-administered the CA-Self Interview, compiled the results of the standardized assessment and screening tools, and analyzed the information to measure progress toward the FC UBSMART goals;
- after the DCS Specialist has gathered updated information about the six domains of family functioning, including information from other service providers;
- prior to the finalization of the updated FC service plan (when applicable);
- before meeting with the parent/caregiver(s) to discuss progress and any necessary adjustments to FC change-focused intervention and/or formal service provision

During the assessment coordination meeting – EOC, the DCS Specialist and FCC shall discuss:

- information gathered during contacts with the family;
- the results of the FC EOC assessment;
- the results of the most recent FFA-Progress Update or Protective Factors Framework assessment;
- any discrepancies between information and assessments, including a plan to resolve those discrepancies; and
- whether the FC program shall continue and, if applicable, the behavioral change statements that will be the focus of continued services.

Upon completion of the assessment coordination meeting – EOC, the DCS Specialist and FCC shall meet with the family to discuss and review:

- the current reason for DCS involvement with the family and the behavioral change goals in the DCS case plan;
- progress towards the behavioral change statements and UBSMART goals in the FC Service Plan;
- the results of the initial CA-Self Interview compared to the results of the re-assessment CA-Self Interview;

- any additional information that may influence (support or refute) the conclusions about CPCs, protective factors, or changes in the CA-Self Interview scores; and
- whether the FC program shall continue, be modified, or discontinue and close.

When the FC program shall continue, the FCC shall update and finalize the FC service plan within 14-business days of completing the EOC. The FCC and DCS Specialist shall review the updated FC service plan with the family, outlining the new UBSMART goals identified to be the focus of the change-focused interventions.

CONSIDERATIONS FOR CONTINUED FC INTERVENTION DURING THE EOC

If the family does not have an open DCS case and was referred for the FC program as part of Aftercare Planning and Services, the family will not be eligible for continuation of the FC program beyond the initial service authorization timeframe (approximately 150 days). The FCC shall facilitate an EOC prior to service closure.

If the family has ongoing or in-home DCS case management, the FCC shall conduct an EOC with the family every ninety-days following the creation of the FC service plan. Family Connections services may be approved to continue when family members are attending appointments and actively engaging in Family Connections services, and

- there has not been sufficient behavioral change related to the reason for DCS involvement, or;
- the family is in or entering the reunification transition period.

When sufficient change has occurred related to the FC core outcomes and reason for DCS involvement so that the FC program will end, the FCC shall assess if the family needs continued services to sustain the changes. If so, the FCC and DCS Specialist (when applicable) shall assist the family to connect with relevant community-based services before closing the FC program. See Chapter 11 for effective service facilitation and advocacy methods and Chapter 13 for service closure with the family.

Families may receive continued Family Connections services if the criteria are met at each ninety-day EOC. The EOC shall be utilized as the referral form for continued service. Continuation of services requires approval by DCS, at the levels listed below:

- First EOC and continuation - DCS Supervisor
- Second and third EOC and continuation - DCS Program Manager
- Continuation of Family Connections services after twelve months requires an approval by the DCS Program Administrator.

ADDITIONAL INFORMATION: PLANNING FOR THE EOC PROCESS

The Edinburgh Postnatal Depression Scale (EPDS), and the Life Events Checklist-Revised (LEC-R) are not utilized for the CA-Self Interview during the EOC process as they are screening tools. Therefore, they are not beneficial as a measure of behavior change. However, during the FCC's work with the family, circumstances may change and these instruments will be used to screen whenever depression and/or trauma are suspected. This could include instances such as new or worsening depression symptoms, being newly postpartum, or disclosing trauma history for the first time. The FCC would then administer the applicable screens and coordinate follow-up evaluations or services as needed. If new core outcomes or additional goals are identified, case planning skills used during the EOC process are consistent with those described in Chapter 10 about FC service plans with UBSMART goals.

ADDITIONAL INFORMATION: CONDUCTING THE EOC

The DCS case plan behavioral change statements define what will be different in how parent/caregiver(s) think, feel, and act when specific diminished protective capacities are enhanced and there is no longer danger to the child(ren) in their family's home, or family protective factors are strengthened to reduce the likelihood of future abuse or neglect. These are long-term goals and define when DCS intervention is no longer needed to ensure child safety or reduce risks.

The FC UBSMART goals are written related to FC Core outcomes, paired with the diminished protective capacities that must be enhanced or protective factors that must be strengthened.

The UBSMART goals define what will be different in the parent's feelings, thoughts and actions over a smaller increment of time: ninety-days. The FCC will re-administer the assessment instruments related to each respective Core Outcome to aid in measuring change. Knowing that permanent and lasting change often takes more than ninety-days, the FC UBSMART goals may be viewed as intermediate steps in defining benchmarks for progress toward the larger case plan behavioral change statements.

The FCC can use these guiding questions to evaluate family member progress. Supervisors should be available to provide consultation about these questions:

1. Evaluation of change on standardized assessments
What changes occurred in the CA-SELF INTERVIEW assessment measures?

2. Evaluation of current child maltreatment risk and safety
If the family were referred today, would this be an appropriate referral, i.e., would circumstances meet FC eligibility criteria?
Does this family still need a change-focused intervention?

3. Evaluating core outcomes and UBSMART goal achievement
If all goals were achieved, what would justify continued services?

COMMUNICATING ABOUT LENGTH OF THE PROGRAM

It is expected families have been prepared to work collaboratively with FC toward service closure, beginning with the first introductory meeting with the FCC. Unless there is a child safety or serious risk concern, it is not likely that working for a longer period of time will achieve significantly different change than has already occurred after the first ninety-days. In families in which there are risks and no safety threats, sufficient change may be accomplished within the first ninety-days. In some cases, service provision may need to be extended another ninety-days or longer. There should be clear communication of this to families so they understand the timing of the FC program, the circumstances in which services may continue past ninety-days, and the commitment that is expected of them.

ADDITIONAL INFORMATION: CONTINUATION OF THE FC PROGRAM OR AFTER SERVICE CLOSURE

Comparing the results of the previous CA-Self Interview and re-assessment CA-Self Interview can offer a clear picture of the family's progress after three months of change-focused intervention.

It is important to review what led to successful goal achievement and to support the family members' expressions of satisfaction or other thoughts and feelings about their accomplishments. When there is no progress, some progress, or a decline or regression in progress, family members and the FCC should explore barriers hindering progress.

If at any time during work with the family the FCC suspects or identifies the existence of domestic violence, substance use, or mental health issues, the FCC will take steps to coordinate the needed service referrals. When there is DCS oversight, this will include collaboration with the DCS Specialist to discuss the issue and determine what service or evaluation referral is best, who will be responsible for ensuring the referral is made, and how it will be discussed with the family. If there is no DCS oversight, the FCC will be responsible for determining the best referral and coordinating the service for the family. In some cases, the FCC may need collaboration with outside entities such as a DV Advocate to assist in finding the best resources for the family.

Depending on the results of these evaluations and input from the service providers, the FCC may need to amend the service plan to include additional UBSMART goals or change existing goals. These new goals would be assessed at the time of the EOC.

EXHIBIT 12.1: EVALUATION OF CHANGE (EOC) SUMMARY

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FAMILY CONNECTIONS
EVALUATION OF CHANGE (EOC) SUMMARY

Case Information

Case Person _____ *Person ID* _____

DCS Specialist _____ | *FC Consultant* _____ | *Phone* _____

Date Last CA-Self Interview Completed _____ | *Date of CFA Approval* _____ | *Date of FC Service Plan Approval* _____ | *Date Current CA-Self Interview(s) Completed* _____

Approval dates are the dates each document was approved by the FC Supervisor.

If this is the first EOC, current CA-Self Interview scores are compared with those from the initial CA-Self Interview. If this is the second or later EOC, scores are compared with those from the prior EOC. This allows for changes over the most recent 90 days to be the focus of evaluation.

If more than one parent/caregiver completed the CA-Self Interview, the following chart should be completed separately for each individual. If the parents/caregivers provided different information, explore and analyze the differences.)

Social Support		
Support Function Scale (SFS)	**Prior CA-Self Interview (CFA or last EOC)**	**Current Re-assessment CA-Self Interview**
Emotional Support		
Child Support		
Financial Support		
Instrumental/Concrete Support		
Agency Support		
Total Score		

Family Functioning		
Family Functioning Style Scale (FFSS)	**Prior CA-Self Interview (CFA or last EOC)**	**Current Re-assessment CA-Self Interview**
Interactional Patterns		
Family Values		
Coping Strategies		
Family Commitment		
Resource Mobilization		
Total Score		

Family Resources		
Family Resource Scale (FRS)	**Prior CA-Self Interview (CFA or last EOC)**	**Current Re-assessment CA-Self Interview**
Growth & Support		
Necessities & Health		
Physical Necessities & Shelter		
Intrafamily Support		
Childcare		
Personal Resources		
Total Score		

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FAMILY CONNECTIONS
EVALUATION OF CHANGE (EOC) SUMMARY

Parenting Attitudes & Behaviors		
If the PARTI is not relevant to the family based on the age(s) of the child(ren), do not include that assessment instrument.		
Adult-Adolescent Parenting Inventory (AAPI-2) Scales	Prior CA-Self Interview (CFA or last EOC)	Current Re-assessment CA-Self Interview
Inappropriate expectations of children		
Parental lack of empathic awareness of children's needs		
Strong belief in the use and value of corporal punishment as a means of discipline		
Reversing parent-child role responsibilities		
Oppressing children's power and independence		
Total Score		

Parenting Attitudes About Raising Teens Inventory (PARTI)	Prior CA-Self Interview (CFA or last EOC)			Current CA-Self Interview CFA or last EOC		
	No. Items Parent/Child agreed on	No. Items Parent/Child disagreed on	No. Items Parent/Child uncertain about	No. Items Parent/Child agreed on	No. Items Parent/Child disagreed on	No. Items Parent/Child uncertain about
Psycho-Social Development						
Giving and receiving respect and dignity						
Working with the teen in establishing discipline						
Teen roles and responsibilities within the family						
Empowering teens in making healthy choices						
Total Score						

Nurturing Skills Competency Scales Short Form (NSCS-SF)	Prior CA-Self Interview (CFA or last EOC)	Current Re-assessment CA-Self Interview
A. About me		
E. My knowledge of nurturing parenting		
F. My utilization of nurturing parent skills		
Total Raw Score (E+F)		

Managing Parenting Stress		
Parenting Stress Index Short Form (PSI-SF)	Prior CA-Self Interview (CFA or last EOC)	Current Re-assessment CA-Self Interview
Parental distress		
Parent-child dysfunctional Interaction		
Difficult child		
Defensive Responding		
Total Score		

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ARIZONA DEPARTMENT OF CHILD SAFETY

FAMILY CONNECTIONS
EVALUATION OF CHANGE (EOC) SUMMARY

Child Well Being

Summarize the current status of each of the Child Well-Being Indicators for each child, describing any notable changes

Emotion/Trauma

Behavior

Development/Early Learning *(applies to children under the age of 6 years)*

Academic Status *(applies to children 6 years of age and older)*

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FAMILY CONNECTIONS
EVALUATION OF CHANGE (EOC) SUMMARY

Child Well Being – *continued*

Positive Peer/Adult Relationships

Family Relationships

Physical health

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FAMILY CONNECTIONS
EVALUATION OF CHANGE (EOC) SUMMARY

Child Well Being – *continued*

Cultural Identity

Substance Awareness

Preparation for Adult Living Skill Development *(applies only to children 14 and over)*

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FAMILY CONNECTIONS
EVALUATION OF CHANGE (EOC) SUMMARY

Other Family Conditions Related to the Adult Functioning of the Parents/Caregivers

Summarize the current status, describing any notable changes, of each of the following. Describe how each relate to the identified FC Core Outcome(s), protective factors, protective capacities, and behavioral change goals.

Physical health

Mental health *(Consider if prior screening indicated needs related to trauma and/or depression)*

Cognitive skills

Substance use

Domestic violence/intimate partner violence

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FAMILY CONNECTIONS
EVALUATION OF CHANGE (EOC) SUMMARY

Summary of Activities

Summarize the activities of the family, the FC Consultant, and other service providers during the last 90 days.

(a) Summarize the family's participation in, and results of, change-focused FC activities over the last 90 days

(b) Discuss the family's view of progress and change

(c) Summarize the FC Consultant's change-focused activities over the last 90 days

(d) Summarize discussions, referrals and/or advocacy completed by the FC Consultant related to formal service providers/agencies over the last 90 days

(e) Summarize the family's enrollment, attendance and results of participation in formal services over the last 90 days

(f) Indicate if there are supplemental reports or records which have been received from service providers that contributed to this Evaluation of Change

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FAMILY CONNECTIONS
EVALUATION OF CHANGE (EOC) SUMMARY

Assessment of Core Outcome(s) and UBSMART Goal(s)

Based on this assessment, summarize significant changes observed in strengths and needs related to the behavioral change goals and reason for FC involvement. Use results from the standardized CA-Self Interview assessment instruments and other information gathered over the past 90 day, including information from interviews, collateral contacts, and/or observations. Consider family protective factors and caregiver protective capacities.
Select the FC Core Outcome(s) that were included in the FC Service Plan by check-marking the box. Complete the remaining sections if selected.

☐ **Social Support**

FC Core Outcome and Definition included in the FC Service Plan

UBSMART Goal(s) matching this Core Outcome included in the FC Service Plan

For each UBSMART goal, rate progress

Explanation *(Provide a summary to explain your rating for this UBSMART goal. Incorporate and synthesize all prior information to justify the conclusion)*

☐ **Family Functioning**

FC Core Outcome and Definition included in the FC Service Plan

UBSMART Goal(s) matching this Core Outcome included in the FC Service Plan

For each UBSMART goal, rate progress

Explanation *(Provide a summary to explain your rating for this UBSMART goal. Incorporate and synthesize all prior information to justify the conclusion)*

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FAMILY CONNECTIONS
EVALUATION OF CHANGE (EOC) SUMMARY

Assessment of Core Outcome(s) and UBSMART Goal(s) ~ *continued*

Based on this assessment, summarize significant changes observed in strengths and needs related to the behavioral change goals and reason for FC involvement. Use results from the standardized CA-Self Interview assessment instruments and other information gathered over the past 90 day, including information from interviews, collateral contacts, and/or observations. Consider family protective factors and caregiver protective capacities.

☐ **Family Resources**

FC Core Outcome and Definition included in the FC Service Plan

UBSMART Goal(s) matching this Core Outcome included in the FC Service Plan

For each UBSMART goal, rate progress

Explanation *(Provide a summary to explain your rating for this UBSMART goal. Incorporate and synthesize all prior information to justify the conclusion)*

☐ **Child Well-Being**

FC Core Outcome and Definition included in the FC Service Plan

UBSMART Goal(s) matching this Core Outcome included in the FC Service Plan

For each UBSMART goal, rate progress

Explanation *(Provide a summary to explain your rating for this UBSMART goal. Incorporate and synthesize all prior information to justify the conclusion)*

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FAMILY CONNECTIONS
EVALUATION OF CHANGE (EOC) SUMMARY

Assessment of Core Outcome(s) and UBSMART Goal(s) ~ *continued*

Based on this assessment, summarize significant changes observed in strengths and needs related to the behavioral change goals and reason for FC involvement. Use results from the standardized CA-Self Interview assessment instruments and other information gathered over the past 90 day, including information from interviews, collateral contacts, and/or observations. Consider family protective factors and caregiver protective capacities.

☐ **Parenting Attitudes and Behaviors**

FC Core Outcome and Definition included in the FC Service Plan

UBSMART Goal(s) matching this Core Outcome included in the FC Service Plan

For each UBSMART goal, rate progress

Explanation *(Provide a summary to explain your rating for this UBSMART goal. Incorporate and synthesize all prior information to justify the conclusion)*

☐ **Managing Parenting Stress**

FC Core Outcome and Definition included in the FC Service Plan

UBSMART Goal(s) matching this Core Outcome included in the FC Service Plan

For each UBSMART goal, rate progress

Explanation *(Provide a summary to explain your rating for this UBSMART goal. Incorporate and synthesize all prior information to justify the conclusion)*

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FAMILY CONNECTIONS
EVALUATION OF CHANGE (EOC) SUMMARY

Additional Information – *Additional space for notes and commentary to be used as needed*

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FAMILY CONNECTIONS
EVALUATION OF CHANGE (EOC) SUMMARY

Recommendations

Based on this evaluation, this FCC recommends:

☐ Family Connections services should move to case closure.

☐ Family Connections services should continue.

Closure of Family Connections services is independent of DCS case status. If the family has an open case with DCS, the case may remain open after FC services end.

If continued Family Connections services are approved, proceed to develop a new FC Outcome-Driven Service Plan.

If Family Connections services are approved for case closure by DCS, the FC Consultant should proceed to develop a Family Resource Plan with the family and provide a copy to the family

FC Consultant Name _____ *Date* _____

FC Supervisor Name _____ *Date* _____

Equal Opportunity Employer/Program. The Department of Child Safety (DCS) prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics, or retaliation or any other status protected by federal law, state law, or regulation. Reasonable accommodations to allow a person with a disability to take part in a program, service, or activity are available upon request. To request this document in alternative format or for further information about this policy contact your local office. TTY/TDD Services: 7-1-1. Free language assistance for DCS services is available upon request. Ayuda gratuita con traducciones relacionadas con los servicios del DCS esta disponible a solicitud del cliente.

EXHIBIT 12.2: GOAL PROGRESS CLASSIFICATIONS

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ARIZONA DEPARTMENT OF CHILD SAFETY

GOAL PROGRESS AND CLOSURE CLASSIFICATIONS FAMILY CONNECTIONS AND NURTURING PARENTING PROGRAM

When closing FC services with a family, the FCC must assess all progress and behavior changes to identify an overall level of achievement. This includes results of the CA –Self Interview (section 1 of the EOC), progress towards UBSMART goals (section 2 of the EOC), activities towards goals and outcomes (section 3 of the EOC), changes in risk and safety (section 4 of the EOC), and the sufficiency of change (section 5 of the EOC).

When closing NPP services with a family, the NPP Practitioner must assess all progress and behavior changes to identify an overall level of achievement, utilizing Outcome Evaluation Methods. This includes the results of The Adult-Adolescent Parenting Inventory (AAPI-2), The Parenting Attitudes About Raising Teens Inventory (PARTI), Nurturing Skills Competency Scale, (NSCS), Session Evaluation Forms, the Family Nurturing Plan, Home Practice Check-Ins and Family Logs.

Goal Progress Classifications

When evaluating change regarding the UBSMART goals for Family Connections (section 2 of the EOC document), and/or utilizing Outcome Evaluation methods for Nurturing Parenting Program, there are five levels of progress:

1. Change achieved/UBSMART goal achieved
2. Substantial change has occurred
3. Some change has occurred
4. Minimal or no change has occurred
5. Risk or safety issue worsening

Change/UBSMART Goal Achieved:

The caregiver is in the maintenance stage of behavior change related to the goal. This is evidenced by the caregiver consistently demonstrating and sustaining behavior identified by the goal.

Some examples may include but are not limited to:

- The caregiver is open about the value of the changed behavior, the need for the changed behavior, and the circumstances that required the changed behavior.
- The caregiver prefers the changed behavior over previous ways of behaving.
- There is evidence of secondary gains such as changes in life circumstances, changes in child behavior, changes in relationships, and so on.

Substantial Change:

The caregiver is in the action stage of behavior change related to the goal. The caregiver repeatedly demonstrates the behavior identified by the goal.

Some examples may include but are not limited to:

- The caregiver is actively participating in planned services.
- The caregiver is committed to addressing what must change.
- The caregiver has made great strides towards reaching the goal but has not yet achieved it fully.

Some Change:

The caregiver is in the preparation stage of change related to the goal and is beginning to demonstrate the behavior identified by the goal.

Some examples may include but are not limited to:

- The caregiver is taking small steps towards making the needed changes.
- The caregiver has begun to engage in services.
- The caregiver acknowledges the changes will be beneficial.

Minimal/No Change:

The caregiver is in the pre-contemplation or contemplation stage of change related to the goal. The caregiver has not demonstrated the behavior identified by the goal.

Some examples may include but are not limited to:

- The caregiver is contemplating the need to change and/or is open to discussing issues.
- The caregiver maintains there is not a problem that needs to be addressed.
- The caregiver avoids contact with FC/NPP and/or treatment service providers or interaction is characteristically passive aggressive or "fake cooperation."

Risk/Safety Issue Worsening:

The caregiver is not demonstrating the behavior identified by the goal and the problematic behavior is worsening.

Some examples may include but are not limited to:

- The caregiver refuses contact with FC/NPP and/or service providers.
- The caregiver's risky/unsafe behavior is escalating.
- Protective factors are diminishing rather than improving.

WHY IS SERVICE CLOSURE IMPORTANT?

As the FCC looks towards the planned ending with a family, the FCC shall evaluate progress toward identified outcomes. If all of the outcomes have been sufficiently achieved, the process of these achievements is recognized and celebrated. If the family is still experiencing substantial challenges, risks or dangers and needs further intervention, a new FC service plan with UBSMART goals is developed based on the EOC following DCS approval of service continuation. If the family has ongoing or in-home DCS case management, the FCC also collaborates with the DCS Specialist to understand the findings of the FFA-Progress Update, remaining risks, and safety threats; refers the family to other agencies; and identifies informal helpers, such as family or friends.

SERVICE CLOSURE PROCESS*

The FCC shall facilitate the service closure process within ten business days of the assessment coordination meeting-EOC.

The FCC shall meet with the family and review the family's overall progress throughout the FC program, noting family accomplishments and strengths, and ongoing needs to continue to be addressed through community services and supports. The FCC shall review the DCS Aftercare Plan (CSO-1349A) and assess if there are any additions or revisions that need to be made to support the family following service closure.

The FCC shall begin the service closure process when one of the following closure reasons has been identified:

- Services Completed
- No Contact
- Declined Services
- Disengagement from Services
- Moved Outside of Geographic Service Area
- No Longer Eligible
- Unable to Participate

A complete list of definitions for each closure reason can be found in Exhibit 13.2.

A family may disengage or request to withdraw from Family Connections services at any point that the family is receiving services. If the family withdraws or disengages, the FCC shall attempt to speak with the family to understand the family's reasons for discontinued participation and attempt to re-engage the family in the FC program.

Service closure is a process that, in fact, begins when the FCC says "hello" to families for the first time and continues throughout their work together until the final, "goodbye." The FCC knows that relationships with families will be time-limited and defined by a variety of factors that include family strengths and needs, the scope of the work as defined by agency procedure and practice guidelines, and the particular role or roles that are assumed.

SERVICE CLOSURE SUMMARY

Upon determination that the FC program will not continue based on one or more of the identified closure reasons listed above, the FCC shall complete the Family Connections Service Closure Summary (see Exhibit 13.1). The FCC shall complete the Service Closure Summary for all families who are referred for the FC program, regardless of the closure reason.

The FCC shall include the following information within the Service Closure Summary:

- outreach attempts;
- closure classification;

**Options for service closure reasons come from the original Family Connections program model with additions from Arizona Family Connections to add more specificity.*

- summary of the family circumstances and history related to FC referral and current DCS involvement;
- children living in household;
- last home visit with the family;
- reason for service closure;
- status of safety and risk to children; and
- Family Resource Plan

ADDITIONAL INFORMATION: SERVICE CLOSURE PROCESS

Reviewing the process refers to the mutual recollection of the beginning, middle, and end of the relationship. All of the members of the family system are encouraged to share their memories, sometimes individually and, whenever possible, together. As in all professional transactions, it is important FCCs do not discount anyone's impressions. Rather, FCC may acknowledge the differences and, perhaps, encourage individuals to hypothesize about what may be contributing to the differences. It is also important FCCs share their own memories of the work that has been done together.

Concurrently, final evaluating is also pursued. Again, FCCs encourage family members, and families as a whole, to identify accomplishments and strengths as well as remaining unmet needs. FCCs encourage family members to own the successes and to celebrate them. Whenever possible, FCCs should also help family members identify and appreciate the problem-solving skills they have practiced and internalized, and support them as they begin to explore how they may apply those skills to address remaining problems or challenges.

Whenever possible, the final meeting should be with the whole family system with which the FCC has been working. This reinforces the sense of mutuality of the members and reminds them that, in the end, they all have been and will continue to be important to each other. The FCC may want to encourage families to plan a special activity to mark the end of their working relationship. A trip to the neighborhood ice cream shop or other favorite location are often popular choices.

ADDITIONAL INFORMATION: SERVICE CLOSURE

FCCs receive commitments from family members to participate in change-focused intervention in ninety day increments. This timeframe is used as a reminder to sharpen the focus of work and, as necessary, to renegotiate the FC service plan to fit with the time that remains. When families have an open case with DCS due to impending danger, it is also important to discuss how the change-focused intervention of FC relates to progress in enhancement of diminished protective capacities, and that DCS involvement may continue after closure of the FC program as FC goals and outcomes are just part of the behavior changes included in the DCS case plan. Service closure of the FC program is separate from DCS case closure, which is dependent on achievement of all the case plan goals. DCS case closure is measured by DCS and/or the courts.

When possible, the FCC should explore with families the reason(s) for the decision to discontinue the FC program. Closure refers to the process of ending the relationship with families, and enabling the family system to end the relationship with FC. It is a time that may generate a range of feelings for FCCs and for family members. Those feelings may, in part, be determined by the kind of ending FCCs and families choose together or that families unilaterally select. It is a process that remembers the relationship that has been established, the work that has been done, what was accomplished with and on behalf of families, and what still remains to be addressed. It also explores the meaning that the relationship had for everyone involved and how it feels to say "goodbye."

Finally, it may be a time of choice for families if they are ending services. In every instance the process reflects parallel relationships, memories of relationships, previous endings, issues related to grief and loss, and other individual and family dynamics focused on individuation and separation. It is a time of stress and opportunity to address unresolved issues from the past and create productive patterns of interaction and self-reflection.

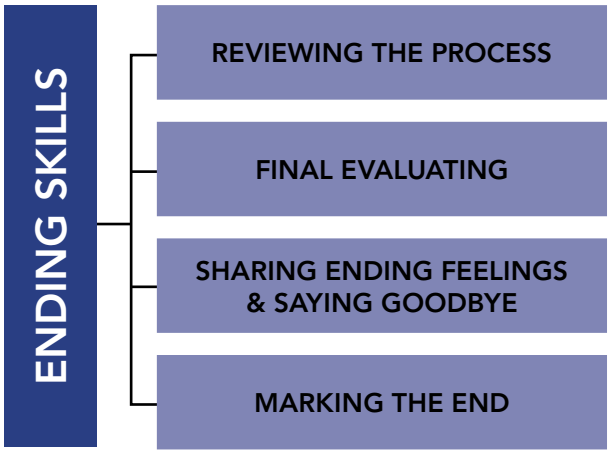
- The Personal to Professional Continuum

  The genuineness FCCs present to clients is one of the most powerful dynamics contributing to the building and maintaining of a working professional relationship. At the same time, it is crucial FCCs continually examine personal feelings and reactions during each interaction, and throughout the intervention process as a whole. Closure is a dimension of that process that may be especially difficult for some because of losses or endings staff have experienced in their own lives. Often, the most painful of these experiences are ones that leave FCCs the most vulnerable to counter transference or, stating it more simply, feeling like ones' proverbial buttons have been pushed.

  It is a myth and a mistake to believe that any professional can consistently separate personal emotions from professional impressions. Instead, it is crucial FCCs try to consciously stay in touch with the personal feelings this work may elicit. This continued self-awareness will usually enable FCCs to accurately identify the personal feelings, to take them out of the professional transaction, and to identify and utilize strategies to effectively cope with and resolve feelings. Sometimes, colleagues or supervisors may need help to identify and acknowledge these personal feelings before staff can appropriately address them.

- The Skills of Ending

  Although there are different "types" of closure, as outlined above, there is a shared content across all of them. Cournoyer (2017) identifies a set of skills that are central to the process:



  Sharing ending feelings and saying goodbye may be the most challenging dimension of the ending process, for both families and FCCs. Family members may experience a wide variety of feelings that can include, but are not limited to, sadness and loss, anger, betrayal, powerlessness, fear, rejection, and denial. These feelings are influenced by the duration and quality of the helping relationship, and the personal characteristics of individual family members. FCCs may also experience an array of emotions that may include any or all of those listed above as well as confusion, ambivalence, and relief.

  Endings are a type of loss. Depending on the families and FCC's own life experiences, terminating a relationship may trigger unexpected and strong feelings. It is helpful to encourage family members to recall past endings, with both friends and helping professionals, and to explore the feelings, coping strategies, and support systems that may have come into play in those situations. It is equally important FCCs talk with their supervisors about their own losses and explore the ways in which their own experiences may impact work with families at this time in the clinical process. In addition, it is important FCCs deliberately determine which, if any, of their personal feelings should be shared with families.

  At the same time, it is crucial to remember that all families will experience the ending of the relationship in a unique way. In addition, their behavior will be unique. It is a mistake for FCCs to assume all family members will want to discuss their feelings with them. In some instances, individual family members may have learned that such feelings will be discounted or ridiculed. In others, it may not be part of a family's culture. In still others,

individual family members may have the conscious or unconscious fantasy that if they do not acknowledge the relationship is ending then it can't really end. However, it is still important FCCs encourage this kind of sharing while acknowledging the difficulty and discomfort it may precipitate.

Marking the end is often desirable to finish the "work" of closure before the last session, and to the end of the relationship with a final meeting that is different in setting and content. Rituals are important in cultures and in families. They serve to assist us in normalizing, managing, and understanding experiences. Rituals create a context in which specific life events are framed. An ending is a time to "mark" a significant life experience. This is also a time that may be marked by the giving a certificate of completion.

When working with children, it may be helpful to complete a small project together, which the child(ren) can keep as a concrete remembrance of the relationship and its accomplishments. A story written using a mutual story-telling process, a picture drawn together, or a recording reminding the family of some of the skills they have learned in their work, are a few appropriate suggestions. With adults, a diary or memory book that the FCC helps them construct may be meaningful. For families as a whole, any of these may work. Use imagination!

EXHIBIT 13.1: FAMILY CONNECTIONS SERVICE CLOSURE SUMMARY

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FAMILY CONNECTIONS SERVICE CLOSURE SUMMARY

Date

Family Information

Case Person

Person ID

Agency Name

FC Consultant

Phone

Date of Service Request

Date of Service Closure

Date of Current FC Service Plan

Date of Final Home Visit with Family

Section A

This section is to be completed only when the FCC has conducted all required initial outreach activities and was unable to locate the parent/caregiver(s)

First In-Person Initial Outreach Attempt *(within one (1) business day of referral receipt)*

Date

Time

Outcome:

Additional Initial Outreach Attempts *(telephone call, in-person outreach and contact letter over three (3) business days or until an appointment is scheduled)*

Date

Time

Outcome:

Date

Time

Outcome:

Date

Time

Outcome:

Date

Time

Outcome:

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FAMILY CONNECTIONS SERVICE CLOSURE SUMMARY

Section A – *continued*

Additional Initial Outreach Attempts *(telephone call, in-person outreach and contact letter over three (3) business days or until an appointment is scheduled)*

Date
Time
Outcome:

Date
Time
Outcome:

Date
Time
Outcome:

Date
Time
Outcome:

Date
Time
Outcome:

Date
Time
Outcome:

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FAMILY CONNECTIONS SERVICE CLOSURE SUMMARY

Section B

This section is to be completed when one of the closure types is selected. This section summarizes the work that has been done, what was accomplished, and what remains to be addressed.

- ☐ *Services Completed*
- ☐ *No Longer Eligible*
- ☐ *Disengagement from Services*
- ☐ *Moved Outside of Geographic Service Area*
- ☐ *Declined Services*
- ☐ *No Contact*
- ☐ *Unable to Participate*

1. ***Summarize the family circumstances and history related to the reason for FC referral and current DCS involvement***

2. ***Children living in the household at the time of the service closure:*** *(Include the name and date of birth for each child.)*

3. ***Last home visit with the family:*** *(All family members must be seen within thirty-days before service closure. If they have not all been seen, there must be specific documentation of the diligent efforts made to see all family members.)*

4. ***Reason for service closure:*** *(See the most recent Evaluation of Change for a status of goal achievement. Provide a summary of the service case that supports the decision for service closure, including the family's strengths, accomplishments, and any outstanding behavioral change goals. Describe services provided to the family, interventions used, and family input that would sustain change. Note any formal or informal community support that has been referred or arranged to support the family's functioning)*

5. ***Status of safety and risk to children:*** *(Only complete this section if there is not currently an open DCS case. Review the DCS Aftercare Plan (CSO-1349A) and note any additions or revisions to support the family following service closure. If applicable, describe concerns about dangers in the home or high risk of future abuse or neglect.)*

EXHIBIT 13.2: SERVICE CLOSURE CLASSIFICATIONS

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GOAL PROGRESS AND CLOSURE CLASSIFICATIONS
FAMILY CONNECTIONS AND NURTURING PARENTING PROGRAM

Service Closure Classifications

When closing FC or NPP services with a family, the FCC or NPP Practitioner must identify the closure reason. Only one closure reason will be identified for a family. The types of closures are as follows:

Services Completed:

- The family met all FC/NPP outcomes and goals/constructs.
- All identified behavioral changes are achieved.
- Caregiver Protective Capacities/Protective Factors are enhanced.
- Risk/Safety issues are rectified.

No Contact:

- The FCC/NPP Practitioner had no communication with the family, including in-person, phone or email; or
- The family could not be located.

Declined Services:

- The FCC/NPP Practitioner conducted all required initial outreach and engagement activities, but the parent(s)/caregiver(s) declined participation in FC/NPP services; or
- The family declined FC services prior to completing the initial CA-Self Interview; or
- The family declined NPP services prior to completing the Family Nurturing Plan.

Disengagement from Services:

- The family disengaged from FC services following completion of the initial CA-Self Interview but prior to completion of the CFA and FC service plan; or
- The family disengaged from FC services following completion of the FC service plan, but prior to the reassessment CA-Self Interview and EOC; or
- The family disengaged from NPP services following completion of the Family Nurturing Plan; or
- The family is no longer attending appointments and no longer actively engaging in FC/NPP services, despite concerted efforts by the FCC/NPP Practitioner to engage or re-engage the parents

Moved Outside of Geographic Service Area:

- The family has re-located more than 50 miles outside of the original geographic service area (county line); and
- The Provider is no longer willing to provide service.

No Longer Eligible:

- There is no parenting time occurring between the child and parent; or
- The family's needs can be met with community resources.

Unable to Participate:

- The parent(s)/caregiver(s) will no longer benefit from FC/NPP services (e.g. cognitively delayed parent who has not made any improvement and no further intervention options are feasible); or
- The parent(s)/caregiver(s) will be detained or incarcerated for more than 30 days; or
- The parent(s)/caregiver(s) is unable to participate (e.g. active psychosis, physical illness requiring hospitalization or residential care, pervasive substance use impacting reality orientation)

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WHY IS STAFF DEVELOPMENT IMPORTANT?

All Family Connections provider staff must receive initial training prior to delivering Family Connections services. During training, staff learn engagement skills, motivation techniques, and change-focused interventions. FC training is a core component to delivering the FC program with fidelity. Facilitated learning and supervisory coaching to develop core helping skills aligned with FC's philosophical practice principles, and to build competency in FC practice, is a strategic implementation expectation of FC. FC supervisors must understand application of the social work theories underlying the FC practice model and the purposeful alignment with these theories at each level of FC implementation and practice. Details on each of these theories can be found in Chapter 4.

STAFF QUALIFICATIONS

FC services are provided by a Family Connections Consultant who is a bachelor's level professional with a bachelor's of social work degree or a related bachelor's degree, and a minimum of one year of human services work related experience.

FC services are supervised by a Family Connections Supervisor who is a master's level professional with a master's of social work degree or related master's degree, and a minimum of one year of human services work related experience.

TRAINING

All staff providing FC services shall participate in the required initial and ongoing trainings to develop family engagement and change-focused intervention skills, and promote professional development. The training expectations are as outlined below:

INITIAL TRAINING

- All FCCs and FC supervisors shall participate in all fourteen (14) e-learning modules (approximately twelve (12) hours) and the four (4) day in-person classroom modules. The e-learning modules shall be available through TraCorp and must be completed prior to attending the in-person classroom modules.
    - Initial Training: as related to FC providers also providing the SENSE component, all FCCs and FC supervisors shall take the required SENSE CBT training available through Tracorp.
- Upon completion of the e-learning and in-person classroom modules, FC supervisors must complete the following additional trainings:
    - two-day coaching curriculum; and
    - Four (4) hours of supervisory practicum following completion of initial training and assignment of initial cases. The supervisory practicum shall include review, analysis, and discussion of two (2) completed cases, and may occur via one-on-one video conference. The four (4) hours of practicum typically occurs in thirty (30) or sixty (60) minute sessions.
- When possible, the two-day coaching curriculum is to occur prior to their attendance in the four (4) day initial in-person training.

ONGOING TRAINING

- All FCCs providing direct services to families shall participate in a minimum of fifteen hours of competency based training annually by contract year. Training topics include, but are not limited to:
    - NPP annual refresher training
    - Family Connections Program essential components, related social work theories, family engagement skills, standardized assessment tools, and change-focused interventions
    - Cultural competency

    - Motivational interviewing
    - Knowledge of, and ability to connect clients with community resources
    - The DCS safety assessment model, including caregiver protective capacities
    - The protective factors framework
    - Substance use and the effect on parent protective capacities and child development
    - Intimate partner violence, domestic violence, family violence, and the effects on child development
    - Self-harm and suicide risk assessment
- An FCC or FC Supervisor that has completed the initial trainings and has changed employment to another FC provider within one (1) year of receiving trainings is not required to re-take the initial training however the on-going learning is still mandatory. All transcripts and/or certifications must be in both employer's (previous and current) personnel files for audit purposes.

FC SUPERVISION

FC supervisors shall provide coaching and skill development to FCCs during individual supervisory consultation, providing constructive feedback applied to real cases. Weekly individual and group supervision shall routinely apply coaching strategies to support staff's development of critical thinking skills and enhancement of understanding of the core components of FC. This approach allows for the FCC to be guided to find their own answers to questions and develop solutions to challenges. Supervisory consultation shall occur for each case at the following case decision points, and with each FC at least weekly:

- before initial outreach;
- after initial outreach and engagement;
- during Comprehensive Family Assessment (CFA);
- during service planning;
- during change-focused intervention;
- during the Evaluation of Change (EOC)
- before service closure; and
- whenever a parent/caregiver declines the FC program or misses appointments.

BEFORE INITIAL OUTREACH

- The FC supervisor shall schedule supervisory consultation with the FCC upon referral receipt and prior to the FCC's in-person initial outreach with the family.
- The FC supervisor and FCC shall review all available case information prior to supervisory consultation.
- The FC supervisor shall achieve the following purposes during this supervisory consultation:
    - Ensure the FCC contacted DCS to initiate information sharing and collaboration, and schedule the intake meeting
    - Elicit the FCC's analysis of the information and identify any gaps in information related to the extent and nature of continued DCS involvement, parent behavioral changes, or how the FC eligibility criteria was met

AFTER INITIAL OUTREACH & ENGAGEMENT

- The FCC shall participate in supervisory consultation with the FC supervisor after in-person initial outreach with families and prior to the CFA process. The purposes of this supervisory consultation are to:
    - debrief the objectives of the initial in-person outreach and intake meetings;
    - ensure any remaining objectives of the initial in-person outreach and intake meetings are accomplished;

- discuss the family's willingness to participate in the FC program, including efforts to engage the family if they declined, or communicated reluctance;
- review the assessment of emergency/concrete needs and the FCC's plan to assist the family in meeting those needs;
- review the FCC's plan for how the CFA process will occur, including participants, location, areas of necessary information collection, when/how to administer the CA-Self Interview, and how to ensure the family's input can be sought and used in planning the CFA process;
- discuss the family's cultural background, what is known/unknown about the impact of culture on parenting and family functioning, and how the FCC will engage the family to learn more about this; and
- evaluate how the FCC presented FC to the family, including discussion related to trauma screening and interventions and how the FCC plans to use trauma-informed care approaches.

DURING COMPREHENSIVE FAMILY ASSESSMENT (CFA)

- The FC supervisor shall reinforce the primary activities during the CFA as listed below:
  - Ensure that all necessary family members are observed and interviewed sufficiently.
  - Assist the FCC in conducting interviews by discussing interpersonal techniques and guiding the FCC to identify approaches for collecting information.
  - Ensure any non-custodial parents and other relevant collaterals are being contacted and relevant information is gathered from them.
  - Assist the FCC in planning for the administration of the CA-Self Interview.
  - Review the results of the CA-Self Interview Family Profile to ensure the FCC can accurately interpret and discuss the results with families.
  - Guide the FCC through analysis and convergence of all information gathered during the CFA process to understand the family's needs and strengths, interpret the meaning of the CA-Self Interview Family Profile results, and select the FC Core outcome(s) to be the focus of the FC service plan.
  - Ensure the CFA process is proceeding in a timely manner.
  - Ensure that the FCC is conducting CFA information collection with due diligence.
- FC supervisory consultation must include discussion about how trauma-informed approaches will be used by the FCC. The FC supervisor must also elicit how the FCC is responding to learning about the family's traumatic events, and caring for self as helper. Supervisors provide mentoring and coaching, assisting staff with addressing secondary traumatic stress that may arise.
- The FC supervisor shall assist the FCC in identifying and problem-solving situations in which the parent/caregiver is unable to complete the CA-Self Interview independently. The FC supervisor and FCC shall consider the following as possible solutions:
  - have a support present, who can assist the parent/caregiver (with prior consent);
  - having an interpreter present while the FCC completes the CA-Self Interview based on the interpreted answers;
  - having the FCC read the questions to the parent/caregiver and completing the CA-Self Interview based on the answers provided;
  - having a parent/caregiver skip questions that they cognitively do not understand; and
  - spreading the administration of the CA-Self Interview out over several visits.
- The FCC shall consult with the FC supervisor when parents/caregivers express desire to withdraw from completing the CA-Self Interview. The FC supervisor and FCC shall review information provided to the parent/caregiver as to how the results of the CA-Self Interview Family Profile are used, the parent/caregiver's reason(s) for not finishing the CA-Self Interview, and what the FCC did in response.

- The FC supervisor shall ensure the FCC does not use any degree of coercion or influence, but instead provides the parent/caregiver with clear information about what will happen if the CA-Self Interview is not completed and options to address the parent/caregiver's concerns.
- If the family has ongoing or in-home DCS case management, the FC supervisor shall ensure the FCC and DCS Specialist have scheduled the assessment coordination meeting - initial prior to the case plan staffing. The FC supervisor shall review the results of the CFA Summary and assessment coordination meeting - initial with the FCC, and use coaching skills to prepare the FCC for the meeting.

DURING SERVICE PLANNING

- The FC supervisor shall provide supervisory consultation during the service planning process to include a review of the FCC's drafted goals and FC service plan. The FC supervisor shall utilize coaching strategies to help the FCC analyze their drafted service plan and the degree to which the goals:
  - meet UBSMART criteria;
  - directly relate to the identified FC Core outcome(s);
  - impact the identified risk or safety concern;
  - describe the parent/caregiver's behavior and functioning that will result from the FC change-focused intervention;
  - do not describe participation or compliance with community partner services as a UBSMART goal; and
  - are culturally relevant and sensitive to the family's cultural background.
- The FC supervisor shall ensure the FCC has frequent communication with the DCS Specialist, families, and other service providers. Coaching strategies will be applied to elicit and develop the FCC's understanding of the effects and value of their functioning as an advocate on behalf of the family and promote coordinated service planning, so that:
  - services are feasible for the family to complete;
  - services are properly sequenced; and
  - services are not duplicative.
- The FC supervisor shall review and approve the draft FC service plan within five business days following completion of the FC service plan.

DURING CHANGE-FOCUSED INTERVENTION

- The FC supervisor shall conduct weekly supervisory case consultation for each family assigned to the FCC during change-focused intervention. During weekly case consultation, the FC supervisor shall apply coaching strategies to elicit the FCC's perceptions and guide them to develop critical thinking skills and more in-depth understanding in discussing the following with the FCC:
  - progress completing the activities in the FC service plan;
  - ideas for continued change-focused intervention; and
  - the purpose of the next family visit and type of service activity to be delivered that specifically targets the UBSMART goal(s).
- The FC supervisor and FCC shall review any additional services the family is participating in, such as NPP, behavioral health services, or other service provided by other agencies.
  - For families participating in NPP services, the FC supervisor will elicit the FCC's analysis of information as to how the FCC is reviewing, reinforcing and supporting the family in implementing parenting techniques during change-focused intervention contacts.
  - For families referred to other agencies, the FC supervisor and FCC shall assess the status of those referrals and explore alternative options should the family be unable to receive services in a timely manner due to lack of available services and/or other

contributing factors. The FC supervisor and FCC may request assistance from the assigned DCS Specialist, enlist assistance from informal supports, or seek additional resources or options.

DURING EVALUATION OF CHANGE

- The FC supervisor shall ensure the re-administered CA-Self Interview and EOC are completed every ninety days with the family.
- If the family has ongoing or in-home DCS case management, the FC supervisor shall conduct supervisory consultation with the FCC prior to the assessment coordination meeting – EOC. This supervisory consultation shall apply coaching strategies to guide the FCC through the following areas::
  - a comparison of the previous and current results of the re-administered CA-Self Interview Family Profile, eliciting and guiding the FCC's analysis of any changes;
  - information learned about the family over the past ninety days that would inform the DCS Specialist's assessment of safety threats and risk of another abuse or neglect;
  - the FCC's summary of how well the intended change-focused activities occurred, any barriers to their success, and the family's reaction to these activities; and
  - the family's progress made toward UBSMART goal achievement and the degree to which the family has been impacted by service participation.
- If the family has ongoing or in-home DCS case management, the FC supervisor shall ensure the FCC and DCS Specialist have scheduled the assessment coordination meeting - EOC prior to meeting with the family. Details on the assessment coordination meeting – EOC can be found in Chapter 12 - EOC.

BEFORE SERVICE CLOSURE

- During this supervisory consultation, the FC supervisor shall:
  - explore the FCC's personal feelings regarding service closure;
  - coach the FC to identify and utilize strategies that will help the FCC cope with and resolve those feelings; and
  - discuss how to maintain professional boundaries throughout the service closure process.

WHENEVER A PARENT/CAREGIVER DECLINES THE FC PROGRAM OR MISSES APPOINTMENTS

- During supervisory consultation, the FC supervisor shall coach the FCC to:
  - prepare how to explain to the family that their participation in the FC program is voluntary;
  - identify the next steps to be taken by the FCC and DCS Specialist (when applicable) in response to any safety threats or risks of future abuse or neglect that are the reason for DCS involvement and/or may be currently present; and
  - elicit the FCC's understanding of motivational and coaching techniques the FCC may use to assist a parent/caregiver to progress toward readiness for change or resolve other barriers to participation.
- The FC supervisor shall ensure the FCC follows the initial outreach protocol for re-engagement with the family outlined in Chapter 7 – Initial Outreach & Engagement.

FC supervisors shall accompany the FCCs on home visits to provide opportunity for debriefing and coaching. This shall occur a minimum of one time per quarter for FCC staff during the first year of employment, and semi-annually thereafter.

FC supervisors shall provide additional supervisory consultation and coaching for new FCCs during their first year of employment, upon request and as needed. These supervisory consultations may consist of topics such as:

- how to initiate contact with families;
- how to conduct the CA-Self Interview with family members;

- discussion around recognition of the FCC's preconceptions, personal biases or beliefs and how to best deliver services without the FCC's personal biases or beliefs influencing services to families; and
- assessing the emergency and concrete needs of families.

GROUP SUPERVISION

FC supervisors shall provide weekly supervisory consultation to FCCs during group supervision. Group supervision shall use a coaching approach and shall focus on:

- nurturing skills and qualities in the helping alliance;
- implementing and achieving the FC practice principles;
- developing proficiency in change-focused intervention skills; and
- peer-to-peer learning through demonstrations, role-plays, observations, and other means.

FC SUPERVISION SKILLS & TECHNIQUES

Supervisory consultation provides the opportunity and context to bring meaning to the FCC's work, beyond required tasks and activities. Consultation encourages mutual respect and ownership within the provider agency, reinforces collaboration among FCCs to build competency, resulting in staff independence and proficiency.

The FC supervisor shall use and model the following skills and techniques during supervisory consultations with the FCC:

- centering/tuning in;
- communicating empathy;
- communicating respect;
- communicating authenticity;
- active listening skills;
- confronting;
- motivational interviewing; and
- maintaining professional boundaries

REPORTS OF SUSPECTED ABUSE, NEGLECT, OR SAFETY THREATS

At least one time per week, the FCC will observe the children of the parents/caregivers who are subject to the referral and residing in the household, regardless of relationship to the parent/caregiver engaged in FC. As mandated reporters, the FCC must report any suspicion, observation, or concern about possible child abuse, neglect, exploitation, or abandonment to DCS (ARS §13-3620).

The FCC does not conduct safety assessments (present or impending danger assessments) or oversee safety plan to manage dangers, but may be the first professional to observe a behavior or condition in the home that could threaten a child's safety. If a child is in immediate danger, the FCC must act to ensure immediate protection of the child until DCS or another emergency responder arrives or the danger is no longer active.

When a DCS report is made, the FCC shall consult with the supervisor about how to discuss the new report with the family, and whether transparency about the source of the report will benefit or harm the helping alliance with the family.

PROVIDER MEETINGS

FC supervisors shall participate in provider network meetings at a frequency determined by DCS, not to exceed bi-monthly (every two weeks). AZ DCS will co-chair the meetings with a representative of the contracted provider agencies. Provider network meetings will provide the opportunity for all parties to problem solve, collaborate, and increase practice proficiency. Provider network meeting agendas may include, but are not limited to, review and discussion of FC program fidelity and outcome data, barriers and facilitators to service delivery, program essential components, related social work theories, family engagement skills, standardized assessment tools, change-focused interventions, and case studies.

ADDITIONAL INFORMATION: SUPERVISION SKILLS & TECHNIQUES

Many, if not all, of the skills and techniques FCCs use with families can also be used by supervisors with the FCC in supervision. While supervisors are coaching their staff to use a range of skills and techniques to deliver the FC intervention, these same skills are modeled by the supervisor for staff. Skills can be practiced or enhanced during group peer-to-peer learning through demonstrations, role-plays, observations, and other means.

CHAPTER 15: DCS AND FCC ROLES

DCS Specialists and Family Connections Consultants have distinct expertise that define their separate roles in working with families. FC Consultants are experts in needs assessment, service planning and behavioral change interventions; and meet with the family at least one time per week, which allows frequent observation of the individuals and family. DCS Specialist are experts in safety assessment, safety management and permanency planning. The DCS Specialist uses the information provided by the FC Consultant when assessing safety threats, caregiver protective capacities, conditions for return, and family protective factors.

SAFETY ASSESSMENT AND SAFETY PLANNING

DCS SPECIALIST ROLE

DCS Specialists are child safety practice experts and are responsible for assessment, recommendations, and decisions about:

- present and impending danger;
- present danger plans and safety plans;
- safety plan oversight;
- caregiver protective capacities and identified behavioral changes;
- parenting time, including level of supervision;
- selection of out-of-home caregivers; and
- reunification or selection of an alternative permanency goal.

When a child is assessed as unsafe, the DCS Specialist will develop and immediately implement a Safety Plan to control all identified impending danger threats. Safety plans must be sufficient, feasible, sustainable, and least intrusive.

Safety Plans are not the same as case plans. Safety Plans describe actions to control danger threats and may describe supportive resources (such as child care or nurse home visiting services) to support those actions. Case plans describe services and supports to effect long-term behavioral change by enhancing parental protective capacities to eliminate the need for a Safety Plan.

The determination that a child is unsafe does not always mean that the child must be removed from the home. In some cases, the danger can be sufficiently controlled, and the child can remain in the home, with help and support from family members, other responsible adults, and other people or resources that support safety actions. An in-home Safety Plan will be considered and is typically appropriate when all five of the in-home safety analysis questions are answered yes. For more information on safety planning and the in-home safety analysis, see DCS Program Policy, Chapter 2, Section 7, Safety Planning.

The DCS Specialist maintains responsibility for oversight of the sufficiency and implementation of the Safety Plan, which includes ensuring that all responsible parties are carrying out the actions and duties in the plan.

If a child is assessed as unsafe due to impending danger, and an out-of-home Safety Plan is implemented, the Department shall identify the conditions for return of the child to the parent(s). Conditions for return are written statements of specific behaviors, conditions, or circumstances that must exist before a child can return and remain in the home with an in-home Safety Plan.

The conditions for return are directly connected to the specific reasons why an in-home safety plan could not be put into place. Conditions for return describe the caregivers' behaviors and family circumstances that would need to exist in order for a sufficient, feasible, sustainable in-home safety plan to be implemented. For more information on conditions for return, see DCS Program Policy, Chapter 2, Section 7.1, Conditions for Return.

FAMILY CONNECTIONS CONSULTANT ROLE

The FCC has in-person contact with parents and children, and provides information to the DCSS about parent behavioral changes and observations of the family members and the

home in weekly reports. The DCSS considers this information when assessing child safety and making decisions or recommendations about child safety and permanency planning. The FCC does not assess child safety or make recommendations about safety plans, parenting time, selection of out-of-home caregivers, or reunification or selection of an alternative permanency goal.

The FCC must review the current safety plan and conditions for return upon referral assignment and:

- immediately contact the DCS Specialist if there is any observation that indicates the plan is insufficient to manage dangers in the home, or responsible adults have not taken action to support or supplement the parent's protective capacity as described in the safety plan; and
- support and assist the family to meet conditions for return, when Family Connections change-focused interventions would do so.

SERVICE PLANNING

DCS SPECIALIST ROLE

During the Family Functioning Assessment-Ongoing and Family Functioning Assessment-Progress Update, the DCS Specialist will gather information from the family, service agencies working with the family and other collateral sources, and utilize that information to guide decision making related to safety, permanency and child well-being. Upon synthesizing the information, the DCS Specialist should disclose the information to all involved parties working with the family (e.g. court, service agencies, behavioral health, etc.)

The DCS Specialist will develop an individualized, family-centered, written case plan for every child, youth, and family receiving ongoing or in-home DCS case management. The DCS case plan defines long-term behavioral changes within the family. The DCS Specialist will work with the FCC to integrate the FC service plan within the DCS case plan. To avoid becoming overwhelmed, families should be guided to select the right number of FC UBSMART goals, considering the most urgent or significant conditions increasing child maltreatment risk or compromising child safety and the conditions the family is ready and willing to work on at the present time. The FC service plan may be viewed as intermediate steps in defining benchmarks for progress towards the larger DCS case plan behavioral change statements.

Family Connections Consultant Role

The FCC is responsible for ongoing engagement with families, service planning, change-focused interventions and assisting families in meeting the CFRs, including:

- assessing for emergency and concrete needs within the family;
- identifying the most effective service approaches to utilize while working with families;
- facilitating the Comprehensive Family Assessment (CFA) process;
- utilizing standardized assessment and screening tools, including those that measure trauma symptoms and exposure;
- service plan development, to include the identified FC Core outcomes and UBSMART goals to be the focus of change-focused intervention; and
- facilitating change-focused interventions to motivate change within the family.

While the FCC is completing the CFA process, the DCS Specialist will meet with the family to complete FFA-Ongoing Exploration activities. Upon completion of the CFA process, the FCC and DCS Specialist will meet to conduct the assessment coordination meeting – initial, to discuss the results of the assessments, resolve discrepancies between the assessments and reach consensus on the behavioral change statements that will be discussed with the family at the DCS case plan staffing and other family and service team meetings. The FCC will develop an individualized, outcome-driven FC service plan for every family that is referred to the FC program. The FCC will develop UBSMART goals that are related to the identified FC Core outcomes, paired with the behavioral change goals identified through the DCS FFA-Ongoing. The FCC and DCS Specialist communicate to families that the UBSMART goals may be viewed as intermediate steps in defining benchmarks for progress towards the larger case plan behavioral change statements.

Upon integration of the FC service plan into the DCS case plan, the FCC will begin to facilitate change-focused interventions that support the family to achieve UBSMART goals and FC Core outcomes over the next ninety-days. The FCC should continue to engage and motivate families throughout the FC program, and function as an advocate to ensure families have a feasible, effective and realistic DCS case plan.

At the conclusion of service delivery for change-focused interventions, the FCC re-administers the CA-Self Interview and complete the EOC process. The FCC and DCS Specialist conduct the assessment coordination meeting – EOC, where they will discuss the information gathered during contacts with the family, the results of the assessments, resolve discrepancies between the assessments, and discuss the family's overall progress towards UBSMART goal(s) achievement and the behavioral change statements in the current DCS case plan, in order to assess the need for continued service or service closure. If the FCC and DCS Specialist determine a family is to continue the FC program, the FCC creates a new FC service plan that will be integrated into the DCS case plan and change-focused interventions are delivered in ninety-day increments. More details can be found in the respective chapters: Chapter 9: CFA, Chapter 10: Service Planning, and Chapter 12: EOC.

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- AZ Council of Human Service Providers
- Capacity Building Center for States
- Cradle to Crayons
- Family Development Resource Center