

CWTI: Strengthening Practice HANDBOOK

This training handbook encompasses documents and handouts to provide additional information on the following: Engagement, Assessment, Case Planning, and Teaming. The practice and teaming skills incorporated in this handbook are intended to serve as a guide to child welfare staff on how to work together with children, families, caregivers, internal and external partners to achieve outcomes that focus on safety, stability, well-being and permanency of children and their families.



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Objectives

Strengthening Practice

Day 1: Engagement & Case Planning

1. Understand the reasons for engaging and the Four Core Conditions of Engagement
2. Improve their self-awareness and communication skills
3. Know the Skills of Engagement
4. Understand the importance of utilizing engagement to “dig deep” when completing Assessments
5. Understand how to be clear, concrete, and inclusive in Case Planning and Interventions

Strengthening Practice

Day 2: Teaming & Mentoring

1. Understand the purpose of teaming informally and formally
2. Gain knowledge on how to prepare for a Team Meeting and the process
3. Gain techniques to utilize with difficult participants
4. Understand what makes a good mentor and how these skills can be used with various partners
5. Understand the importance of utilizing mentoring skills throughout the case to empower families and youth

Department of Human Services

Mission, Vision, and Principals

DHS Mission

DHS assists children, families, and vulnerable adults to be safe, stable and self-supporting.

DHS Vision

We will:

- Reduce poverty.
- Help all children have a great start in life.
- Help all clients achieve their full potential.

Michigan's Child Welfare Mission

The State of Michigan is committed to ensuring that economic, health and social services are available and accessible to vulnerable families, children and youth.

Services are designed to:

- Strengthen families and help parents create safe, nurturing environments for their children.
- Reduce child maltreatment, abandonment, neglect, preventable illness, delinquency, homelessness, and other risks to a child's development and well-being.
- Strengthen economic security, promote strong nurturing parenting and improve access to health care and safe housing.

Principals

Michigan achieves its mission and vision through the following guiding principles:

SAFETY

Our first priority is to keep children safe. We recognize that parents (or other legal guardians) have primary responsibility for keeping their own children safe, but when they cannot or do not, we have been entrusted with the authority to intervene on behalf of the child.

CHILDREN'S NEEDS

Children must have a voice in decisions that affect them. We must consider the specific needs of each child as we make decisions on his or her behalf. Those decisions must reflect consideration of community, ethnic, and cultural values, and be free of bias.

FAMILIES' NEEDS

We must treat families with dignity and respect, recognize and value their ethnic and cultural traditions, and actively include them in decisions that affect them and their children. We must help families identify and use their existing strengths and we must consider family safety as we determine the intervention plan for a child. We must ensure that birth and adoptive families have access to at least the same level resources and services as those available to foster parents.

Department of Human Services

Mission, Vision, and Principles

COMMUNITIES

We must actively partner with communities to protect children and support families. We must take into consideration community safety issues as we determine the intervention plan for a child and family.

PLACEMENT

The ideal place for children is in their own home with their own family. When we cannot ensure their safety in the family home we must place siblings together whenever possible and place them in the most family-like and least restrictive setting required to meet their unique needs, and we must strive to make the first placement the best and only placement. We must first consider placement with the non-custodial parent or extended family (maternal or paternal relatives, or appropriate non-relatives known and trusted by the child); if that is not possible or appropriate, we must strive to place the child with a foster or adoptive family so the child can stay in his or her school and maintain relationships with friends and family. When it is not possible or appropriate to place the child with siblings or relatives, we must make every effort to ensure that those relationships are maintained and fostered.

REUNIFICATION AND PERMANENCE

We must reunify children with their siblings and families as soon as safely possible. When reunification is not possible, we must provide children with a permanent home and/or a permanent connection with caring, supportive adults as soon as possible. We must also ensure that children under our care are connected with the resources necessary for physical and mental health, education, financial literacy, and employment; and that they acquire the life skills necessary to become successful adults.

SERVICES

When we intervene on behalf of children we must strive to leave children and families better off than if there had been no intervention. We must tailor services to meet the unique needs of each family member, and provide those services in a manner that is respectful of the child and family. Services should be outcome based, data-driven and continuously evaluated.

PRACTICE SKILLS

Michigan utilizes the following practice skills to achieve positive outcome for families and children:

- **Teaming/Planning-**The ability to assemble, become a participant of, or lead a group or groups that provide needed support, services and resources to children or families and that help resolve critical child and family welfare related issues. Child welfare is a community effort and necessitates a team approach.
- **Engaging-**The ability to successfully establishing a relationship with children, parents, and individuals that work together to help meet a child or family's needs to resolve child welfare related issues.
- **Assessing/Intervening-**The ability to acquire information about significant events and underlying causes that trigger a child and family's need for child welfare related services. This discovery process helps children and families identify issues that affect the safety, permanency, or well-being of the child, helps children and families recognize and promote strengths they can use to resolve issues, determines the child or family's ability to complete tasks or achieve goals, and ascertains a family's willingness to seek and utilize resources that will support them as they try and resolve their issues.
- **Mentoring-** The ability to guide and empower youth and parents. Mentoring is a developmental partnership through which one person shares knowledge, skills, information and perspective to foster the personal and professional growth of someone else. The power of mentoring is that it creates a one-of-a-kind opportunity for collaboration, goal achievement and problem-solving.

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G. Caseworker Contacts and Visits

Policy:

(FC) FOM 722-6

(CPS) PSM 713-3

G. Caseworker Contacts and Visits

1. The provisions of this section shall apply to all children in DHS foster care custody, including those children placed through private CPAs.
2. *Worker-Child Contacts:* By October 2011, each child in foster care shall be visited by the assigned foster care case manager at least two times during the child's first month of placement, and at least one time per month thereafter. At least one visit each month shall take place at the child's placement location and shall include a private meeting between the child and the case manager. By October 2012, the requirement of two visits per month shall apply for the first two months following an initial placement or a placement move.
1. *Worker-Parent Visits:* For each child in foster care with a permanency goal of reunification, the child's caseworker shall have face-to-face contacts with the child's parent(s) as follows: (a) for the first month the child is in care, two face-to-face contacts with each parent, at least one of which must occur in the home; (b) for each subsequent month, at least one face-to-face contact with each parent and phone contact as needed, with at least one contact in each three-month period occurring in the parent's place of residence.
4. *Parent-Child Visits:* DHS shall take all reasonable steps to assure that children in foster care with a goal of reunification shall have at least twice-monthly visitation with their parents. Reasonable exceptions to this requirement shall include cases in which: (a) a court orders less frequent visits; (b) the parents are not attending visits despite DHS taking adequate steps to ensure the parents' ability to visit; (c) one or both parents cannot attend the visits due to exigent circumstances such as hospitalization or incarceration; or (d) the child is above the age of 16 and refuses such visits. All exceptions, and all reasonable steps to assure that visits take place, shall be documented in the case file. If such exceptions exist, DHS shall review the appropriateness of the child's permanency goal.
5. *Sibling Visits:* DHS shall take all reasonable steps to assure that children in foster care who have siblings in custody with whom they are not placed shall have at least monthly visits with their siblings who are placed elsewhere in DHS foster care custody. Reasonable exceptions to this requirement shall include cases in which: (a) the visit may

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be harmful to one or more of the siblings; (b) the sibling is placed out of state in compliance with the Interstate Compact on Placement of Children; (c) the distance between the children's placements is more than 50 miles and the child is placed with a relative; or (d) one of the siblings is above the age of 16 and refuses such visits. All exceptions, and all reasonable steps taken to assure that visits take place, shall be documented in the case file.

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B. Provision of Health Services

Policy:

FOM 722-6

B. Provision of Health Services

1. *Health Services Plan*: By September 30, 2011, DHS shall submit to the Monitors a detailed Health Services Plan, which shall set forth the specific action steps DHS shall implement in order to ensure that each child entering foster care receives medical, dental, and mental health services as described in Section VIII(B)(2). The Health Services Plan shall be subject to the approval of the Monitors. DHS shall implement the plan after the Monitors' approval.
2. *Medical, Dental, and Mental Health Services*: DHS shall take all necessary and appropriate steps to ensure that each child entering foster care receives each of the following:
 - a. Any needed emergency medical, dental, and mental health care.
 - b. A full medical examination and screening for potential mental health issues within 30 days of the child's entry into care and a referral for a prompt further assessment by an appropriate mental health professional for any child with identified mental health needs. DHS shall implement this provision as follows:
 - i. By December 31, 2011, 75% of children shall have the initial medical and mental health examination within 45 days of the child's entry into foster care.
 - ii. By June 30, 2012, 95% of children shall have the initial medical and mental health examination within 45 days of the child's entry into foster care.
 - iii. By December 31, 2012, 75% of children shall have the initial medical and mental health examination within 30 days of the child's entry into foster care.
 - iv. By June 30, 2013 and thereafter, 95% of children shall have the initial medical and mental health examination within 30 days of the child's entry into foster care.
 - c. An initial dental examination within 90 days of the child's entry into care unless the child has had an exam within six months prior to placement or the child is less than four years of age. DHS shall implement this provision as follows:
 - i. By December 31, 2011, 40% of children shall have a dental examination within 90 days of the child's entry into foster care.
 - ii. By June 30, 2012, 60% of children shall have a dental examination within 90 days of the child's entry into foster care.
 - iii. By September 30, 2012, 80% of children shall have a dental examination within 90 days of the child's entry into foster care.
 - iv. By June 30, 2013, and thereafter, 95% of children shall have a dental examination within 90 days of the child's entry into foster care.
 - d. All required immunizations, as defined by the American Academy of Pediatrics, at the appropriate age.
 - e. Periodic and ongoing medical, dental, and mental health care examinations and

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B. Provision of Health Services

screenings, according to the guidelines set forth by the American Academy of Pediatrics. DHS shall implement this provision as follows:

- i. By December 31, 2011, the Monitors, in consultation with DHS, shall determine the baseline for periodic medical, dental, and mental health examinations and set an interim target to be met by September 30, 2012.
 - ii. By June 30, 2013, DHS shall ensure 80% of children have received periodic medical, dental and mental health care examinations.
 - iii. By December 31, 2013 and thereafter, DHS shall ensure 95% of children have received periodic medical, dental and mental health care examinations.
- f. Any needed follow-up medical, dental, and mental health care as identified.

3. *Medical Files:* DHS shall maintain an up-to-date medical file for each child in care, including medical history information reasonably available to DHS.

a. At the time a child is placed in a foster home or residential care facility, the foster care provider receives specific written information about the child's present health status and any present medical needs or health concerns, as well as any medical history of which DHS is aware, that is reasonably necessary for the foster care provider to responsibly care for the child.

i. By December 31, 2011, the Monitors, in consultation with DHS, shall determine the baseline for foster care providers receiving specific written health information about the child entering their care and set interim targets to be met by September 30, 2012 and June 30, 2013.

ii. The Monitors, in consultation with DHS, shall also set the final standard, which shall not be later than December 31, 2013, or less than 95%.

b. In maintaining medical records, DHS shall ensure that it is in compliance with MCL 722.954c(2) by preparing, updating, and providing medical passports to caregivers. In addition, DHS shall ensure that the medical passport, or some other DHS document inserted in each child's file, includes a complete and regularly updated statement of all medications prescribed to and given to the child. All such information shall be provided to all medical and mental health professionals to whom the child is referred and accepted for treatment, as well each foster care provider with whom a child is placed.

i. By December 31, 2011, the Monitors, in consultation with DHS, shall determine the baseline for foster care providers receiving specific written health information about the child in their care and set interim targets to be met by September 30, 2012 and June 30, 2013.

ii. The Monitors, in consultation with DHS, shall also set the final standard, which shall not be later than December 31, 2013, or less than 95%.

4. *Medical Care and Coverage:*

a. Each child entering foster care shall be provided access to medical care immediately upon placement. The foster parent or other placement provider shall receive a Medicaid card, or

Modified Settlement Agreement: B. Provision of Health Services

an alternative verification of the child's Medicaid status and number as soon as it is available, but in no case later than 30 days of the child's entry into foster care.

- i. By December 31, 2011, DHS shall assure 90% of children have access to medical coverage within 30 days of entry into foster care.
- ii. By June 30, 2012 and thereafter, DHS shall assure 95% of children have access to medical coverage within 30 days of entry into foster care.

b. For any subsequent placement during the same episode of care, the foster parent or other placement provider shall receive the child's Medicaid card or alternative verification of Medicaid status and number upon the child's placement.

- i. By October 31, 2011, the Monitors, in consultation with DHS, shall determine the baseline for foster children to have access to medical coverage upon the child's placement for any subsequent placement during the same episode of care.
- ii. If the baseline determines that DHS's compliance is at 85% or greater, then, by June 30, 2012 and thereafter, DHS shall assure 95% of children have access to medical coverage upon subsequent placement.
- iii. If the baseline determines that DHS's compliance is less than 85%, then, by December 31, 2012 and thereafter, DHS shall assure 95% of children have access to medical coverage upon subsequent placement.

5. *Psychotropic Medications:*

a. DHS shall maintain a full-time Health Unit Manager, with appropriate qualifications, who shall, among other things, be responsible for overseeing the implementation of policies and procedures concerning the use of psychotropic medications for all children in DHS foster care custody. The Health Unit Manager shall have the authority to recommend corrective actions. The Health Unit Manager shall report directly to the Children's Services Administration. DHS shall hire or contract for the services of a medical consultant who shall be a physician. The medical consultant shall provide consultation on all health related matters required under this Agreement. The medical consultant shall report to the Health Unit Manager. The duties and responsibilities of the medical consultant and the hours required to fulfill those duties and responsibilities shall be set forth in the health services plan required in Section VIII(B)(1) and subject to approval of the Monitors.

b. When possible, parents shall consent to the use of medically necessary psychotropic medication. In the event that a parent is not available to provide consent for psychotropic medication, DHS shall comply with applicable sections of state law.

c. DHS shall maintain processes to ensure documentation of psychotropic medication approvals, documentation of all uses of psychotropic medication, and review of such documentation by appropriate DHS staff, including the Medical Consultant. The Medical

Modified Settlement Agreement: B. Provision of Health Services

Consultant and the Health Unit Manager shall take immediate action to remedy any identified use of psychotropic medications inconsistent with the policies and procedures approved by the Monitors.

6. *Reconfiguration of Mental Health Services Spending*: Beginning October 2008, DHS was to redirect at least \$3 million to fund mental health services. In order to help ensure that children in foster care in each county have access to the range of mental and behavioral health services and supports necessary to address their needs, including behavior management training and supports for caregivers working with children with behavioral problems, DHS shall gather and analyze data on the way in which DHS funds are utilized to provide mental health services. DHS shall determine whether the allocation of these funds matches the priority needs of the children served, and if not, shall implement a plan to reallocate those funds to support the development and provision of services to meet the priority needs.

Mental Health Services Spending has been reconfigured using the SED waiver and implemented as follows:

- a. By October 2009, in Wayne, Kent, Oakland, Genesee, and Macomb Counties;
- b. By October 2010, in Ingham, Kalamazoo, and Saginaw Counties; and
- c. By October 2011, in Muskegon, Washtenaw, Eaton, and Clinton Counties.
- d. For all remaining counties, DHS shall continue to engage the Michigan Department of Community Health, Community Mental Health Service Providers, and Medicaid Health Plans to ensure that all children with mental health needs are assessed and served.

This paragraph is not intended to limit any other obligations under this Agreement.

Modified Settlement Agreement:

X. Placement Standards & Limitation

Policy:

FOM 722-3

A. General Standards:

DHS shall place children according to the following standards:

1. All children shall be placed in accordance with their individual needs, taking into account a child's need to be placed as close to home and community as possible, the need to place siblings together, and the need to place children in the least restrictive, most home-like setting.
2. Children for whom the permanency goal is adoption should, whenever possible, be placed with a family in which adoption is a possibility.
3. Race and/or ethnicity and/or religion shall not be the basis for a delay or denial in the placement of a child, either with regard to matching the child with a foster or adoptive family or with regard to placing a child in a group facility. Race and/or ethnicity shall otherwise be appropriate considerations in evaluating the best interest of an individual child to be matched with a particular family. DHS shall not contract and shall immediately cease contracting with any program or private CPA that gives preference in its placement practices by race, ethnicity, or religion.
4. Children in the foster care custody of DHS shall be placed only in a licensed foster home, a licensed facility, or, subject to the requirements of Section VIII(C)(6) of this Agreement, an unlicensed relative home.

B. Placement Limitations: DHS shall make placement decisions pursuant to DHS placement selection criteria.

1. Limitations on Placements Outside a 75-Mile Radius: DHS shall place all children within a 75-mile radius of the home from which the child entered custody unless:

- a. The child's needs are so exceptional that they cannot be met by a family or facility within a 75-mile radius;
- b. The child needs re-placement and the child's permanency goal is reunification with his/her parents who at that time reside out of the 75-mile radius;
- c. The child is to be placed with a relative/sibling out of the 75-mile radius; or,
- d. The child is to be placed in an appropriate pre-adoptive or adoptive home that is out of the 75-mile radius.

If a child is placed outside the 75-mile radius:

- a. In a Designated County, the county Child Welfare Director shall be specifically required to certify the circumstances supporting the placement in writing, based on his or her own examination of the circumstances and the child's needs and best interests;

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X. Placement Standards & Limitation

b. In any other county, the County Director shall be specifically required to certify the circumstances supporting the placement in writing, based on his or her own examination of the circumstances and the child's needs and best interests.

2. *Limitations on Separation of Siblings:* Siblings who enter placement at or near the same time shall be placed together, unless doing so is harmful to one or more of the siblings, one of the siblings has exceptional needs that can only be met in a specialized program or facility, or the size of the sibling group makes such placement impractical notwithstanding efforts to place the group together. If a sibling group is separated at any time, except for reasons set forth above, the case manager shall make immediate efforts to locate or recruit a family in whose home the siblings can be reunited. These efforts shall be documented and maintained in the case file and shall be reassessed on a quarterly basis.

3. *Limitations on Number of Children in Foster Home:* No child shall be placed in a foster home if that placement will result in more than three foster children in that foster home, or a total of six children, including the foster family's birth and/or adopted children. No placement shall result in more than three children under the age of three residing in a foster home. Exceptions to these limitations may be made, on an individual basis, documented in the case file, when in the best interest of the child(ren) being placed, as follows:

- a. In a Designated County, by the county Child Welfare Director;
- b. In any other county, by the County Director.

4. *Limitations on Use of Emergency or Temporary Facilities:*

a. *Time limit for placement in emergency or temporary facility:* Children shall not remain in emergency or temporary facilities, including but not limited to shelter care, for a period in excess of 30 days. An exception to this limitation may be made for:

- i. Children who have an identified and approved placement but the placement is not available within 30 days of the child's entry to an emergency or temporary facility.
- ii. Children whose behavior has changed so significantly that the County Director or his/her manager designee has certified that a temporary placement for the purposes of assessment is critical for the determination of an appropriate foster placement. In no case shall a child remain in an emergency or temporary facility more than 45 days.

b. *Number of placements in an emergency or temporary facility:*

Children shall not be placed in an emergency or temporary facility, including but not limited to shelter care, more than one time within a 12-month period. An exception to this limitation shall be made for:

- i. Children who are absent without legal permission;
- ii. Children facing a direct threat to their safety, or who are a threat to the safety of others such that immediate removal is necessary; or

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X. Placement Standards & Limitation

iii. Children whose behavior has changed so significantly that the County Director or his/her manager designee has certified that a temporary placement for the purposes of assessment is critical for the determination of an appropriate foster placement.

iv. Children experiencing a second emergency or temporary-facility placement within one year shall not remain in an emergency or temporary facility for more than seven days.

5. Limitations on Placement in Jail, Correctional, or Detention Facility: No child in DHS foster care custody shall be placed, by DHS or with knowledge of DHS, in a jail, correctional, or detention facility unless such child is being placed pursuant to a delinquency charge. DHS shall notify the State Court Administrative Office and the Michigan State Police of this prohibition, and provide written instructions to immediately notify the local DHS office of any child in DHS foster care custody who has been placed in a jail, correctional, or detention facility.

If it comes to the attention of DHS that a child in DHS foster care custody has been placed in a jail, correctional, or detention facility, and such placement is not pursuant to a delinquency charge, DHS shall ensure the child is moved to a DHS foster care placement as soon as practicable, and in all events within five days, unless the court orders otherwise over DHS objection.

If a child in DHS foster care custody is placed in a jail, correctional, or detention facility pursuant to a delinquency charge, and the disposition of such a charge is for the child to return to a foster care placement, then DHS shall return the child to a DHS placement as soon as practicable but in no event longer than five days from disposition, unless the court orders otherwise over DHS objection.

6. Limitations on Placement of High Risk Youth: DHS shall not place any child determined by a clinical assessment to be at high risk for perpetrating violence or sexual assault in any foster care placement with foster children not so determined without an appropriate assessment concerning the safety of all children in the placement.

7. Limitations on Residential Care Placements: No child shall be placed in a child caring institution unless there are specific findings, documented in the child's case file, that: (1) the child's needs cannot be met in any other type of placement; (2) the child's needs can be met in the specific facility requested; and (3) the facility is the least restrictive placement to meet the child's needs. A description of the services available in the facility to address the individual child's needs must also be documented in the case file. The initial placement must be approved as follows:

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- a. In a Designated County, the county Child Welfare Director;
- b. In any other county, the County Director.

The need for a residential placement shall be reassessed every 90 days. Children shall not be placed in a residential placement for more than six months without the express authorization, documented in the foster care file, of:

- a. In a Designated County, the county Child Welfare Director;
- b. In any other county, the County Director.

No child shall be placed in a residential placement for more than 12 months without the express authorization, documented in the foster care file, of Child Welfare Field Operations.

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VII. Assessment, Case Planning & Provision of Services

Policy:

FOM 722-6, FOM 722-7, FOM 722-8, FOM 722-8A, FOM 722-8B, FOM 722-8C, FOM 722-9, FOM 722-9A, FOM 722-9B, FOM 722-9C, and FOM 722-9D

A. Assessments and Service Plans: DHS shall complete a written assessment of the child(ren)'s and family's strengths and needs, designed to inform decision-making about services and permanency planning, within 30 days after a child's entry into foster care, and shall update the assessment at least quarterly thereafter. Assessments shall be of sufficient breadth and quality to usefully inform case planning. DHS shall complete an Initial Service Plan within 30 days of placement, and an Updated Service Plan at least quarterly thereafter. The written service plan shall accord with the requirements of 42 U.S.C. § 675(1), and shall indicate:

1. The assigned permanency goal;
2. How DHS, other service providers (including the private CPAs, where applicable), parents, and foster parents shall work together to confront the difficulties that led to the child's placement in foster care and achieve the permanency goal;
3. The services to be provided to the child(ren), parent(s), and foster parent(s);
4. Who is to provide those services and by when they are to be initiated; and
5. The actions to be taken by the caseworker to help the child(ren), parent(s), and foster parent(s) connect to, engage with, and make good use of services.

The service plan shall contain attainable, measurable objectives with expected timeframes, and shall identify the party or parties responsible for each task. Service plans shall be signed by the caseworker, the caseworker's supervisor, the parent(s), and the child(ren), if of age to participate. If the parent(s) and/or child(ren) are not available or decline to sign the plan, the service plan shall include an explanation of the steps taken to involve them and shall identify any follow-up actions to be taken to secure their participation in services. When a child is placed with a private CPA or CCI, the private CPA or CCI shall complete the assessment and the service plan in accordance with the provisions above.

B. Supervisory Oversight of Assessments and Service Plans: Supervisors shall meet at least monthly with each assigned worker to review the status and progress of each case on the worker's caseload. Supervisors shall review and approve each service plan. The plan can be approved only after the supervisor has a face-to-face meeting with the worker, which can be the monthly meeting.

C. Provision of Services: DHS shall ensure that the services identified in the service plan are made available in a timely and appropriate manner to the child and family, and shall monitor the provision of services to determine whether they are of appropriate quality

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VII. Assessment, Case Planning & Provision of Services

and are having the intended effect. DHS is responsible for helping the parent(s) from whom the child has been or may be removed, the child(ren), and the foster parent(s) identify appropriate, accessible, and individually compatible services; assisting with transportation when necessary; helping to identify and resolve any barriers that may impede parent(s), child(ren), and foster parent(s) from making effective use of services; and intervening to review and amend the service plan when services are not provided or do not appear to be effective.

D. Family Engagement Model: DHS shall develop the policies, procedures, and organizational structure necessary to implement a family engagement model, which shall include family engagement, child and family team meetings, and concurrent permanency planning. DHS shall implement the model under the timetables set in Section VII(D)(6) below.

1. *Family Team Meetings:* Family Team Meetings shall be utilized to engage families in case planning, service identification, assessing progress, and safety planning. A Family Team Meeting (FTM) shall be offered to make or recommend critical case decisions. Should the family decline to attend, the meeting shall proceed with the other participants in attendance. FTMs shall be led by a trained facilitator, and shall include written invitations in advance of the FTM whenever possible to the parent(s) of the child; foster parent(s); child(ren) if of age to participate; family, friends, or other supports identified by the parent(s) and child(ren); other service providers as appropriate; Lawyer Guardians Ad Litem (LGALs), parents' attorneys and the caseworker, with supervisory participation when necessary.

a. At a minimum, the following events shall trigger Family Team Meetings for in-home cases:

- i. CPS case opening/transfer to ongoing worker
- ii. Case service plan development/identification of safety issues
- iii. Prior to removal or at the earliest date possible after removal
- iv. Case closure

b. At a minimum, the following events shall trigger Family Team Meetings for out-of-home cases:

- i. Case service plan development
- ii. Permanency goal change
- iii. Placement preservation/disruption
- iv. Permanency Planning at six months in care
- v. Annual Transition Planning for Youth – every six months from age 16 to case closure
- vi. 90-Day Discharge Planning for Youth
- vii. Case closure

2. At the conclusion of each FTM, the facilitator shall prepare a written report detailing the decisions and recommendations emerging from the meeting. The report shall be

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VII. Assessment, Case Planning & Provision of Services

provided to the worker, family, the worker's supervisor, and other appropriate team members and shall include a section identifying areas in which follow-up is needed.

3. *Transition from PPC to FTM:* PPCs shall continue to occur at three trigger points in the case until full implementation of the FTM:
 - d. Removal
 - e. Re-placement
 - f. Six months in care to review permanency plan
4. Concurrent planning shall continue in Clinton, Gratiot, and Ingham counties and shall be fully implemented in the Family Engagement Model.
4. *Pre-Implementation:* Prior to full implementation of the FTM, the State shall engage in the following activities:
 - a. Finalization of the Family Engagement Model by March 2012.
 - b. Policy development surrounding the Family Engagement Model by June 2012.
 - c. Communication of model to all counties, private CPAs, and key stakeholders by June 2012.
 - d. Identification of Peer Coaches in county offices and private CPAs – ongoing.
 - e. Conduct training for peer coaches, management, and caseworkers – ongoing.
6. *Implementation:* The FTM model, including concurrent planning, shall be implemented in phases as follows:
 - e. Big 14 counties by March 2013.
 - f. Big 14 contiguous counties by February 2014.
 - g. Northern Michigan counties by August 2014.
 - h. Upper Peninsula counties by December 2014.

ENGAGEMENT SECTION

Skills of Engagement

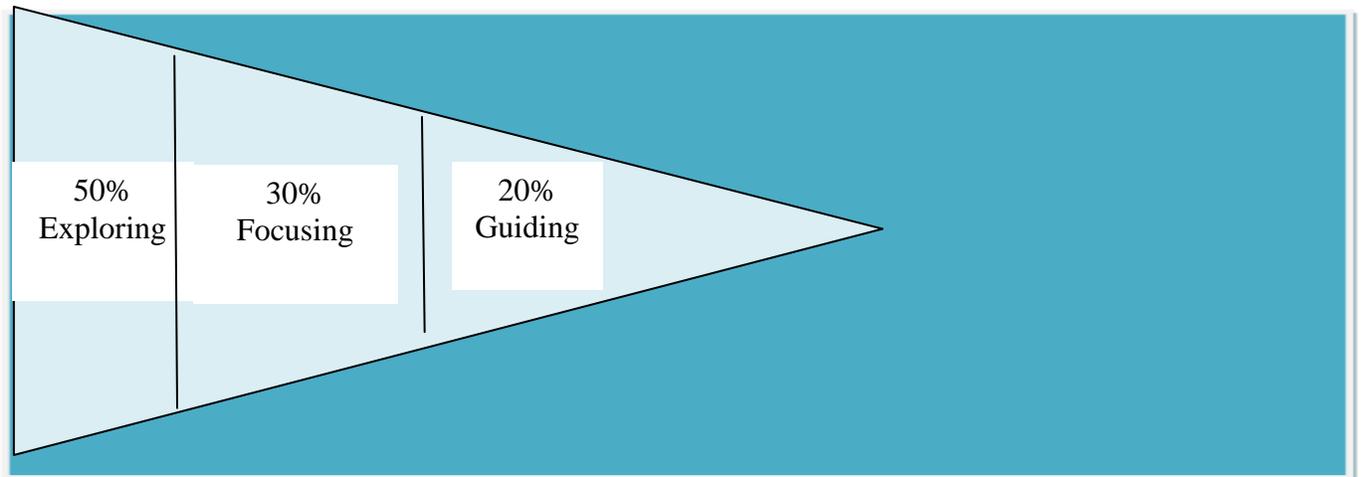
- ☑ **Being Genuine** (Being yourself — not “faking it.”)
 - “*For Real*” ...open...honest...real people in real encounters
 - “*Freely and deeply express yourself without facades, without being phony.*”
 - You are “*not thinking and feeling one thing and saying something different.*” You are being “*authentic.*”
 - “*Genuineness does not require that we **ALWAYS** share our feelings **IT DOES** require that whatever we express is real and genuine and non- incongruent, impulsive, insincere, dishonest or phony.*”

- ☑ **Showing Empathy** (Putting yourself in someone else’s shoes)
 - *EMPATHY* = the capacity to show an awareness of, and to some extent feel what the member is trying to express, verbally or non-verbally.

- ☑ **Showing Respect** (Seeing individuals’ strengths as well as problems, i.e. seeing the “*whole*” person --- not just the reason s/he became involved with child welfare.)
 - Make no assumption about race, ethnic origin, marital status, religion
 - Do not address a person by his/ her first name unless specifically asked to
 - Do not call the person by his/ her illness (an alcoholic, a diabetic, a crack addict)
 - Do not invade another’s personal space
 - Do not interrupt without good reason
 - Do not refer to a parent or a child in the third person
 - Ask or recommend ***Don’t*** tell

Note: When you do all the above and follow through with what you say, then you show others that you are **Competent.**

TOOLS FOR ENGAGEMENT



EXPLORING:

Open ended question help us to hear the “*Family’s Story*” and allow us time and thought the case the ability to determine where and when to focus and guide.

- Tell me about your family. How did you get involved with the Child Welfare Agency?
- What is the best thing that happened to you this week?
- What does your son do that makes you proud of him? Tell me about your extended family.
- What are your friends like?
- What do you and your family, do to relax and have fun?
- If I could wave a magic wand and give you what you want most for your family, what would it be?
- What’s been helpful to you in the past?

FOCUSING:

▪ On a scale 1 thur 10. 10 being that alcohol or other drugs are really messing up your family. And 1 is that there is no effect on your family at all, where would you say your family is on the scale?

(Substance Use)

- How do you and your husband handle differences of opinion? **(Household Relationships/Domestic Violence)**
- Who do you call when you want to chat or just need some support? **(Social Support Systems)**
- What makes you most proud of your child? What really challenges you about your child?

Adapted from “Building Trust Based Relationships”, The Child Welfare Policy and Practice Group; Montgomery, Alabama.

TOOLS FOR ENGAGEMENT

(Parenting Skills)

- Are there any times when you feel Anxious or Depressed? **(Mental Health)**
- How do you manage to stretch your income to keep your family fed for the whole month? **(Resource Management/Basic Needs)**
- Tell me about your health. **(Physical Health)**

GUIDING:

- What kind of services or supports might be helpful to you?
- Do you have any friends or family member who can help baby-sit?
- Would you be interested in participating in a job training program?

***Note:** All bulleted items are examples and can be interchanged depending upon a family's circumstances

Adapted from "Building Trust Based Relationships", The Child Welfare Policy and Practice Group; Montgomery, Alabama.

Stages of Problem Solving

Step 1

Identify The Problem That Needs A Solution

- Be Sure To Be Clear About The Problem And The Desired Goal – Not Everyone Hears Things The Same Way
- Don't Deal With Solutions Yet – Just Focus On The Problem At Hand
- Be Open To Various Definitions Of The Problem

Step 2

Make A List Of Possible Solutions

Step 3

Discuss The Benefits And Consequences Of Each Suggestion

- Evaluate The Benefits And Consequences Of Each Solution
- Make An Action Plan To Address What Is Needed To Make These Things Happen

Step 4

Come To A Solution Where All Are Satisfied

Examples of Strength Based Questions



For Families

- ✓ What were you like as a child?
- ✓ Who has had the biggest influence on your life?
- ✓ What makes you happy? What is the best time you ever had?
- ✓ Who are your closest friends and why are they special to you?
- ✓ What do you like to do in your free time?
- ✓ What are the best things about you? Your family? Your neighborhood?
- ✓ What do you admire the most about your parents?
- ✓ What do you like best about your son/daughter?
- ✓ How do you “blow off steam?”
- ✓ Describe the best time you ever had with your son/daughter.
- ✓ When was that and what was your life like at the time?
- ✓ Who helps you out when you’re in a crisis?



For Kids

- ✓ What is the best thing you can tell me about yourself?
- ✓ What is your favorite color? Subject in school? Sports figure?
- ✓ Musician? Person? Pet?
- ✓ Who is your best friend and what would they tell me about you?
- ✓ If you could live anywhere, where would you live and why?
- ✓ Do you have a favorite pet? What do you like about your pet?
- ✓ Name two good things about your family? Your school? Your neighborhood?
- ✓ Who in your family are you most like? Why?
- ✓ Who do you admire most in your family? Why?
- ✓ What do you like to watch on TV? Why?

Examples of Solution-Focused Engagement Questions

The Solution-Focused Approach focuses on solutions rather than problems. Focus is on the families' strengths and abilities rather than their weaknesses.

These questions help family members define who, what, why,

- ✓ What happened when you decided to make this change in your life?
- ✓ Under what circumstances is this likely to occur?
- ✓ When this happens, what do you do?
- ✓ What are the positives for you continuing to stay in this relationship?
- ✓ Who else is concerned about this problem in your family?
- ✓ What would have to be different for you not to be afraid?
- ✓ How often did it happen last week?
- ✓ Who was there when it happened?
- ✓ Where were you when Johnny had his temper tantrum?
- ✓ When you decide to count to 10, what will you do differently?
- ✓ How will you make sure that your children are safe in the future?
- ✓ Where in the house do you feel most relaxed and calm?
- ✓ What part do you agree with and what part do you disagree with?
- ✓ What would your child say that he/she likes the most about the changes you've made in your life

21 Not Knowing Skills



Leading From One Step Behind

The purpose of using the Skills for Not Knowing is to have the customer recognize, identify and address their problems, strengths and solutions. Though you may actually know some of the things the customer needs, the best way to help them is to allow them to help themselves. Thus, you are **Leading from One Step Behind**. This is not one of the Skills for Not Knowing; it is the premise for the skills. Remember, the customer is the expert of their own life. Do not forget the **21 Skills for Not Knowing** are not designed to work with each customer. Just as with a bouquet of flowers, you choose, pick or arrange which one ones work best for each individual customer. There is no standard and/or set arrangement.



SKILL 1: LISTENING

Who and What is important to the customer? As you listen attentively to the customer you are focusing on the very things they identify as important. This keeps you focused on them and not what you are going to say next.



SKILL 2: FORMULATING QUESTIONS

Formulate your next question from the clients last or an earlier answer. This process is not easy but with practice, it will become easier.



SKILL 3: GETTING DETAILS

For the purposes of being a thorough child welfare worker, you need to get as much detail about your customer. With getting details you want to get as specific as possible. This is extremely important during your initial period of working with your customer. You want to ask questions that require a detailed answer. If the customer likes to use "don't know" you can ask them to share with you what they do know about the situation.



SKILL 4: ECHOING CUSTOMER'S KEY WORDS

You will notice as a worker that when you interact with your customer there are certain words that they will repeat. Some of them may be swear words but those are not the ones we want to focus on. When you echo you are doing just like an echo, repeating the keywords the customer has spoken.



SKILL 5: OPEN QUESTIONS

Very simply put, an open question is one that can not only be answered with a one-word answer. Yes and no, alone, are not responses you for an open question. An open question is designed to elicit a more detailed, complete, answer.



SKILL 6 & 7: SUMMARIZING & PARAPHRASING

Summarizing and Paraphrasing are similar but definitely not the same. **Summarizing** is restating the customer's words in a compact manner. There is no interpretation of the meaning of what they said, simply a summation of what they said. **Paraphrasing** is summarizing what the customer has said, but putting it into your own words or the way you understand what they said. You interpret the meaning.



SKILL 8 & 9: NON-VERBAL BEHAVIORS (CUSTOMER/WORKER) & NOTICING PROCESS

The **Non-verbal behavior** we are referring to is Body Language. Body Language says a lot about a person. It shows if a person is confident, scared, uncomfortable, inviting, etc. We

21 Not Knowing Skills

have to pay attention to the customer's body language when we talk with them but our own body language is important as well. The customer is observing us just as we are observing them. The **Noticing Process** is when you pay close attention to what the customer says and what they do. What you want to ask yourself is, do they contradict themselves. Is the customer telling you about an experience they had that was traumatizing to them, but they are laughing? You want to summarize and paraphrase what the customer is expressing so that you can get clarity on what the customer really means versus what you are observing.



SKILL 10: NOTICING HINTS OF POSSIBILITY

This skill is similar to "The Noticing Process". The difference is that for this particular skill you are trying to notice any solution talk the customer is saying. Solution talk involves any talk about a better future, successful past events and any steps they have already taken toward gaining a solution.



SKILL 11: THE USE OF SILENCE

It can be very difficult to be silent. Silence makes many of us uncomfortable. When talking with our customers, sometimes instead of allowing a moment of silence to pass we will jump in with a question or a comment. The truth is some of the most valuable information you will gather will come out of those moments of silence.



SKILL 12 & 13: COMPLIMENTING (Direct & Indirect Compliments)

When we are complementing our customer we need to be genuine. Phony compliments are not hard to pick up on. Identify a strength that the customer has and start there. There are two types of compliments; **direct compliments** are statements to the customer about something they have done well. **Indirect compliments** are questions that imply the customer has done something well.



SKILL 14 & 15: AFFIRMING CUSTOMER'S PERCEPTION & EXPLORING CUSTOMER MEANINGS

The purpose of **affirming our customer's perception** about their feelings, beliefs, experience's is so that they know in some way that you can relate to what they are saying. No one likes to talk with anyone who just does not understand them. Try to avoid "I would feel the same way" type of response. It's not about you. When we look at **Exploring Customer Meanings** we want them to think things through and draw their own conclusion as to why things are or what they mean. As the worker you don't want to give the customer solutions or resolve their thoughts for them because the customer may view you as being in a role of authority. They may ask you what you think or to interpret the reason for some of their issues. This skill is for you to know how to refer the customer to rely on themselves for their own interpretation.



SKILL 16 & 17:

NATURAL EMPATHY & SELF DISCLOSING

Seeing as that you are in the field of human services there is an assumption that your heart must be in this job. An assumption, however, is not a guarantee. Many people have to **learn** how to be empathetic with customers and their struggles. As the child welfare worker, you want to try to put yourself in your customer's shoes, in their shoes specifically, not "how you would deal with the situation if it happened to you". This is how you use **Empathy**. Sometimes you will come across customers who are having or have experienced something that you have also experienced. You may share your experience

21 Not Knowing Skills

with them believing it will help them to understand that you know what they are going through and can therefore relate and that if you made it, they can too. This is **Self-Disclosing**. Sharing is okay at times but sometimes it is best not to share your personal experiences, beliefs and ideals. Remember, we are being customer focused. If we spend too much time talking about ourselves the customer is not going to feel like they are being heard or valued.



SKILL 18: NORMALIZING

Though normal is a relative term, having this type of revelation can make you feel like you can get through it. Another thing it does is validate you. Normalizing lets you know that people do have similar experiences and that if someone else managed to get through it, it gives you hope that you can too.



SKILL 19: RETURNING THE FOCUS TO THE CLIENT

There are going to be times when a customer has a hard time identifying and taking responsibility for their actions or the situations they are in. Blaming is an issue you will have to know how to identify and address. You can do this by returning the focus back to the customer. Talk with them about their role in the problem regardless of what everyone else may have done. This is to help them take ownership.



SKILL 20: RELATIONSHIP QUESTIONS

There will be times when you will not be able to get your customer to truly see the areas they need help in or recognize their strengths. That's when you can use relationship questions. Ask the customer to explain how someone they care about views them. Or what kind of strengths does their mother or father say that they have? What will your friend see to let them know you have stopped drinking?



SKILL 21: AMPLIFYING SOLUTION TALK

You've done it? You have helped your customer begin to see that there is indeed a light at the end of the tunnel. They are not focusing so much on the problem but they are beginning to talk about the solutions to the problem. You want to encourage them to continue talking solution talk and in more detail. Therefore, you **amplify** the customer's solution talking.

Keys to Engagement

Keys to Engaging Families



Engagement Skills:

KEYS TO ENGAGING FAMILIES:

- ⇨ Listen for needs, interests, and concerns
- ⇨ Assist family members in identifying connections and strengths
- ⇨ Demonstrate warmth, empathy, and genuineness as a foundation for engaging family members around concern for child safety and building parental capacity
- ⇨ Use active listening skills
- ⇨ Tune into self and others (empathy)

KEYS TO ENGAGING FAMILIES:

- ⇨ Define terms of working together with the family using full disclosure
- ⇨ Manage the use of power and authority
- ⇨ Provide concrete and clear information to support the change process
- ⇨ Motivate and support participation
- ⇨ Assist families in making their own case for change

Keys to Engagement

<p style="text-align: center;">EMPATHY</p>	<p style="text-align: center;">PARTIALIZING</p>	<p style="text-align: center;">PAST SUCCESS QUESTIONS</p>
<p>Empathy is tuning in to the way the other person sees and feels about her experience and communicating to her both your attempt to understand and your compassion.</p> <p>Example(s): <i>Worker:</i> Megi has been in foster care nearly six months and she needs to be someplace where she can grow up. <i>Mother:</i> I know she needs a home for good. I am trying! You try kicking this habit. It is, like, so hard! <i>Worker:</i> I know it's been tough for you. <i>Mother:</i> : Do you? Do you? <i>Worker:</i> (pause) You have always told me that, even during the worst of times, you keep Megi in your heart and she is your reason to keep trying to kick your habit.</p>	<p>Partializing is helping clients deal with one problem at a time or breaking down complex problems.</p> <p>Example(s): <i>Mother:</i> I can't believe you guys want me to do all this stuff right away! <i>Worker:</i> Well, let's go over it to see the different parts—it's probably not as much as you might be thinking. First, we need to be sure that Leroy is never left alone. So, let's go over the plan for that again. What are your plans? <i>Mother:</i> I'll take him over to this new day care on my way to work everyday. <i>Worker:</i> OK. And how about if your car breaks down like last week?</p>	<p>Past success questions are intended to help the client to describe specific times when s/he has had success in a situation that could be applicable to a current concern.</p> <p>Example(s): It's not easy to raise three children on your own. How did you do it? After having been through what you've been through, how did you find enough strength to keep pushing on? What do you need to do so that you'll feel good about yourself and in control again? What would it take for you to bring back the confidence you had when you were in high school?</p>

Keys to Engagement

REFRAMING	RECOGNIZING STRENGTHS	SCALING QUESTIONS
<p>Reframing helps clients change their way of looking at problems so that the positive aspects can be more clearly seen.</p> <p>Example(s): <i>Parent:</i> So, there you have it. I guess what I am telling you is yes, I hit Andy with that strap and yes, that is how he got the bruises on his back. So, I guess you think I am worse than the wicked witch of Oz.</p> <p><i>Worker:</i> No. I think from what you told me that you are trying to find a way to keep Andy from touching his sister in a sexual way. I think you are concerned about both of your kids. I want to help you find a way to help them—and punishing Andy in this way will likely not stop him from doing it again. He needs a different kind of help.</p>	<p>Recognizing strengths involves identifying and emphasizing what the client can do to control safety concerns and reduce risks.</p> <p>Example(s): <i>Father:</i> Well, yes, I do have some other ways that I discipline Rory. I send him to his room and I use that chair over there—I face it to the wall.</p> <p><i>Worker</i> : Tell me about a time you used one of these ways.</p> <p><i>Father:</i> I tried sending him to his room just before I had to spank him—but he tore up some books and that’s when I had to spank him.</p> <p><i>Worker:</i> I can see that you have tried a different method and that is a real strength.</p>	<p>Scaling questions are a clever way to make complex features of a client’s life more concrete and accessible. Scaling questions can be used to assess self-esteem, self-confidence, investment in change, perception of hopefulness, etc. They usually take the form of asking the client to give a number from 0-10 that best represents where the client is at some specified point. Ten (10) is the positive end of the scale, one is lower.</p> <p>Example(s): Let me ask you, on a scale of 1 to 10, with 10 standing for ‘as determined as anybody can be in your circumstances to get your daughter back,’ how close would you say you are to 10?</p> <p>Okay, now this time 10 stands for ‘as confident as anyone can be that you will get your child to come back to live with you.’ Where would you put yourself on the same 1 to 10 scale?</p>

Keys to Engagement

OPEN-ENDED QUESTIONS

When you ask questions that are an open invitation to say whatever is on the person's mind, it is sometimes amazing what people will share. Solutions often begin to emerge from this type of processing out loud. This applies to any question for which "yes" or "no" or "I don't know" are not likely responses.

Example(s):

What else can you tell me about that?
Tell me about your family when you were young.

"WHEN..." RATHER THAN "IF..." QUESTIONS

"When" implies trust that the person is going to do something. "If" implies that they may or may not. "When" presumes a desire for, and the possibility of, a positive outcome. (Revisit your strength-based language list.)

Example(s):

When... (you're not drinking), how do you feel in the mornings when it's time to get the children off to school?
When you are in control of your temper...
When you go to your drug treatment program...

QUESTIONS THAT BEGIN WITH "HOW"

These questions tend to be more solution-oriented, and less likely to call for blame or defensive responses than "why" questions.

Example(s):

How can you tell? How do you know this?
How did you do it before?
How would that be helpful to you/ your family?
How long have you felt this way?

Keys to Engagement

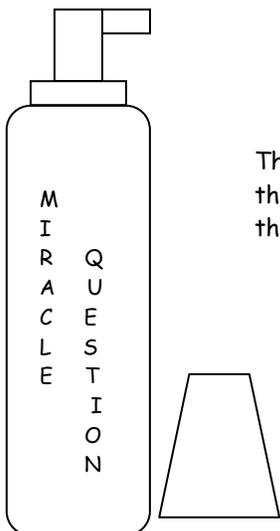
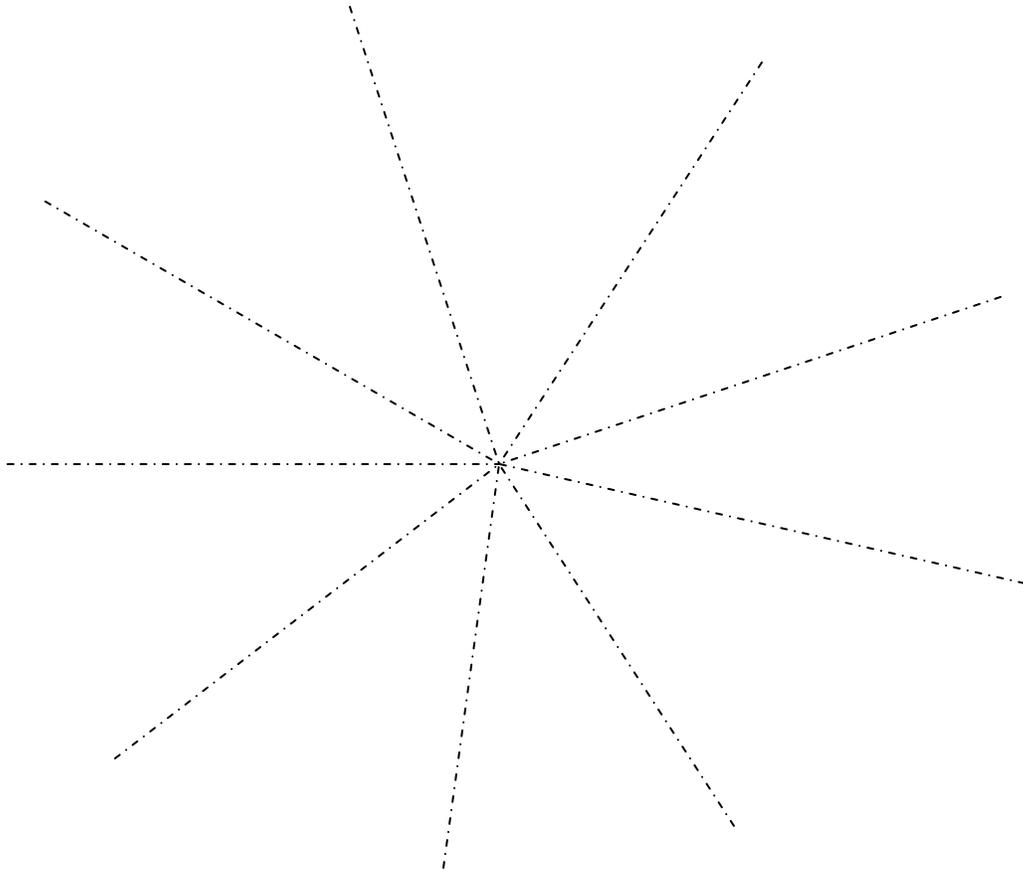
<p>QUESTIONS THAT BEGIN WITH “WH...”</p>	<p>STRENGTHS CHAT</p>	<p>EXCEPTION-FINDING QUESTIONS</p>
<p>These questions are solution-oriented and imply the person’s ability to solve problems.</p> <p>Example(s): Where is the best place for this to happen? What would your children/mother/friend say to you about this? Who helped you when...? What difference would this make to you? What would it take...? What are your thoughts about this? What part of this do you agree with, and disagree with? Who can you call when you are feeling that way? Where can you go when you decide you want to get help for that?</p>	<p>This is a normal, informal conversation seeking information about the family’s “Positive Family Processes.” Responses to these questions can reveal strengths the family can rely on when times get tough or when there is a crisis.</p> <p>Example(s): What do you do for fun? What does your family do together? What is one of your comforting family traditions? What are some things you like best about your children? How do you blow off steam? How did you meet your spouse/significant other? What is one thing each week that you really look forward to doing? How do you picture yourself and your family five years from now? What is something that makes you smile when you think about your family?</p>	<p>Elicit information that addresses how a problematic situation might have been different. These questions allow the receiver to talk about their successes (strengths). Exceptions are the building blocks of success. They shrink the problem. Exceptions focus on the possibilities.</p> <p>Example(s): Tell me about the times, in recent days, when you could have hit Tommy (screamed at him, called him names, etc.), but somehow managed to handle it differently? When you are... (not drinking...), what is different at home? Let’s talk about the days when you do feel safe and hopeful. What is it you are doing differently on those days? Tell me about the most recent time when you could have gotten stoned, but you didn’t. How did you manage not to?</p>

Keys to Engagement

<p style="text-align: center;">COPING QUESTIONS</p> <p>When dealing with difficult behaviors or situations, ask questions in a way that demonstrates empathy and compassion. This acknowledges your understanding of the pain, fear or frustration they may be experiencing.</p> <p>Example(s): I imagine these children are a real handful. I'm sure they keep you on your toes all day. What seems to help? That's very clever! How do you do it? Who do you turn to when you feel you need help? How did you manage to stay sober for a whole week? Considering how tough this week has been for you, it must have been hard to do.</p>	<p style="text-align: center;">MIRACLE QUESTIONS</p> <p>These questions ask for families to disregard their current troubles and for a moment imagine what their lives would be like in a successful future. It creates a vivid image or vision of what life will be like when the problem is solved and hope that life can be different. These questions are inspirational because they help to remove hopelessness.</p> <p>Example(s): Suppose one night there is a miracle while you were sleeping and your problem is solved. You don't know the miracle has happened. What will you notice that is different the next morning that will tell you that the problem is solved?</p>	<p style="text-align: center;">ETHNOGRAPHIC INTERVIEWING</p> <p>Interviewing people about their cultures helps us to understand a significant part of what influences their goals, values, problem-solving approaches, and child-rearing behaviors. This means focusing on their view of their culture first and only secondly on their view about how they are similar or different than their culture.</p> <p>Example(s): Tell me about how your _____ view physical punishment of children? Most groups of people have ideas about what children ought to be doing at various ages. Tell me what people in your group think about how children ought to act by age 10?</p>
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ASSESSMENT SECTION

CHARACTERISTICS OF WELL FORMED GOAL



THE MIRACLE QUESTION

The Miracle Question is used to get the customer to think outside of their usual boundaries. This type of question requires the customer to think of a "miraculous" change that would take place. The customer

The worker may have to present the question in a way that does not encourage the customer to go too far away from reality however, giving them a context for the question.

What's important to know is that, as the worker, you do not have to

J:\Child Welfare \07 Foster Care New Worker\DHS & CPA\ Engaging the Family\Characteristics of Well Formed Goals Job Aid EF 04/11/07 Reference: "Interviewing For Solutions" By Peter De Jong and Insoo Kim Berg



IMPORTANCE TO THE CUSTOMER

Who and what are important to the customer will be the motivation factor for them. When something is important to them, they may do more to make sure that thing or person has what is needed.



INTERACTIONAL TERMS

This characteristic is about how a person connects with others. Ask them, "How would your goal affect the other people in your life?" Those people that are important to them. The customer does care about what those particular people think about them.



SITUATIONAL FEATURES

Narrow down a goal so that it's manageable. Pick a particular aspect to deal with. We don't want to overwhelm our customers.



PRESENCE OF SOME DESIRABLE BEHAVIORS RATHER THAN THE ABSENCE OF ROBLEMS

The goal is to help the customer change their way of thinking; to focus on the solution and not necessarily the problem. "What would you like to do instead?" would be a good way to help the customer focus on a solution.



A BEGINNING STEP RATHER THAN A FINAL RESULT

In the beginning, when working with customers, you want them to have quick tiny successful steps. This will help build their confidence.



CLIENT'S RECOGNITION OF A ROLE FOR THEMSELVES

As it relates to CPS and FC, many of our customers may feel or believe they are victims and that they are in their situation due to someone else's actions. This way of thinking can make them feel powerless, like they have no control over their lives. We have to help our customers recognize that they do have a role in how they have lived their life.



CONCRETE, BEHAVIORAL, MEASURABLE TERMS

This part of a goal helps a customer recognize when they are making progress. Anything concrete is something that is tangible, easy for them to point out. Behavioral means a change in their behavior pattern. Measurable is something they can measure or scale.



REALISTIC TERMS

This aspect of the goal is to help the customer establish the goal so that it is actually attainable. The customer needs to have realistic expectations about their goals. Interacting with the customer will help you determine if you need to work on this area with them.



A CHALLENGE TO THE CUSTOMER

If the customer does not see the achievement of a goal as important, then it won't be. There has to be investment of their part in order to make the goal worthwhile for them.

The Rationale and Purposes for Case Planning

1. ROADMAP FOR PERMANENCY

Provide a roadmap for what needs to be done in order to achieve the permanency goal for the child or youth. The order of preference of permanency goals is:

- Remain safely in own home
- Return home (reunification)
- Adoption with siblings
- Adoption
- Legal Guardianship with Relatives
- Legal Guardianship
- Long-Term Foster Care with Relative
- Long-Term Foster Care with non-Relative
- Stable foster care with emancipation (older youth)

2. TAILOR THE INTERVENTIONS

Ensure that the “intervention reasons” and the “contributing factors” (i.e., why the child or youth is in the child welfare system) are addressed adequately. The safety concerns, the risks, and the related needs of the family must be the basis for the objectives, interventions, and actions described in the plan. The need for a case plan indicates that the parents’ ability to provide the minimum sufficient level of care (MSLC) is a concern.

3. S.M.A.R.T.

Ensure that the interventions and actions are prioritized and SMART:

- a. **Specific** (meet the needs of this family given their concerns, strengths, and culture; includes who is responsible for what)
- b. **Mesurable** (vis à vis the objectives)
- c. **Attainable** (reasonable for family to accomplish; doable)
- d. **Results-oriented** (success of interventions and actions is a pathway to the permanency goal)
- e. **Time-limited** (within the legal deadlines)

4. FAMILY INVOLVEMENT

Ensure that the family and the family’s team have opportunity and support for being involved in developing and implementing the plan, evaluating progress, and revising the plan as needed.

5. SPECIAL PLAN COMPONENTS

Ensure that special aspects of planning are completed:

- a. In the case of removal and placement of children or youth, a placement plan (including visitation) and a concurrent plan (an alternate permanency goal and a

The Rationale and Purposes for Case Planning

plan for achieving it, usually involving placement of the child in the home of the family who is identified in the concurrent plan) can be created.

- b. In the case of youth 16 and older who reside in out-of-home care, a Transitional Independent Living Plan (TILP) can be created.

Parent & Foster Parents Working Together To Create A Bridge Back Home

What is shared parenting?

- Shared parenting comes from the recognition that it is critical to reunification for parents to continue to be parents even if their children are not living at home.
- Shared parenting is a continuum of activities.
- Shared parenting is a commitment between the worker, the foster parent and the birth parent to work together to share the day to day and long term parenting responsibilities of children in care from the day they enter to the day they return and beyond.
- Shared parenting starts with an icebreaker meeting and sometimes evolves into a lifelong family type bond between parents and caregivers.

Examples of Shared Parenting

- Attend the icebreaker meeting
- Share information about the child's adjustment in foster care
- Share information about parenting, grooming, the child's food preferences, etc.
- Ask questions about the child's adjustment in foster care
- Attend Family Team Meetings
- Talk on the phone, Exchange photos
- Send a snack or activity to a visit
- Share copies of school work with parent
- Tell foster parent about school progress or challenges
- Exchange letters
- Foster parent can encourage the parent's progress: verbally, in meetings, on the phone, in letters
- Talk with each other at the beginning or end of a visit
- Foster parent can help the parent find community resources
- Set up times when parent and child can talk on the phone
- Ask for the worker to support the development of a shared parenting plan
- The foster parent should learn about understand and respect the birth parent's culture.
- Offer to host a sibling visit, Take or pick up for visits
- Offer transport to meetings when needed (go together to MTM's)
- Attend child appointments together (when possible)
- Attend school events or sporting activities together
- Take training to be a visit coach, Serve as a mentor
- Debrief before and after visits

Parent & Foster Parents Working Together To Create A Bridge Back Home

- Welcome the parents into your home (Sunday dinner, a visit, a movie night)
- Attend parenting classes together, Have joint family activities
- Help develop reunification plan
- Serve as a support following reunification
- Provide respite care after reunification
- Include the parent in farewell activities/reunification celebration

INITIAL GUIDE TO ASSESS POTENTIAL RELATIVE CAREGIVERS' SAFETY AND PLACEMENT POTENTIAL

OUTCOMES

- Child's need for safety, stability, continuity of care/relationships, nurturance and opportunities for growth and developmental well-being are met.
- Child has a caring environment, which supports family continuity through the delivery of a child-centered, family-focused system of practice to ensure permanency.

FAMILY IDENTIFICATION

- Can you identify the members of your family who have a healthy/positive relationship with you and your child or children?
- Who in your family do you think can care for your child or children?

INITIAL ASSESSMENT OF FAMILY INTEREST (Willingness of family member(s), length of relationship with family member(s), quality of relationship with family member(s), relationship with child or children, full disclosure of family circumstances)

- How have these family members helped you in the past?
- Has your child or have your children ever stayed with these family members over an extended period of time?
- What kind of relationship does your child or children have with these members of your family?
- Do these family members know the circumstances and conditions that have led to the need for your child or children's placement?

INITIAL ASSESSMENT OF ISSUES RELATED TO ENSURING A SAFE ENVIRONMENT -

(ability to meet child's physical and emotional needs: does any person in the home have a history of abuse or maltreatment; willingness to work with agency; health of family member; protection from abuse or maltreatment; ability to develop a plan with the agency)

- Is the family member willing to share personal information about their past and present circumstances by being part of the family study/assessment process?
- Can the family member meet the child's physical and emotional needs?
- Does the family member or any member of household have a history of abuse or maltreatment?
- Is the family member willing to work with the agency to protect the children and provide for their developmental well-being?
- Will the health of the family member impact on their ability to care for the child/ren?
- Will family members be able to protect child or children from further abuse? Do parents believe this to be so?
- Do any of the family members have an interest/capacity to become a licensed foster parent or to assume responsibility of the child without becoming a foster parent?

INITIAL GUIDE TO ASSESS POTENTIAL RELATIVE CAREGIVERS' SAFETY AND PLACEMENT POTENTIAL

- Are family members willing and able to provide short-term care and support family reunification efforts if they are required?
- Are any family members willing and able to provide a permanent legal home for the child or children as adoptive parents or legal guardians if this should become necessary?
- Will the family member work with the agency to develop a safety plan

CLINICAL ISSUES FOR THE RELATIVE CAREGIVERS

Loss

- Interruption of life-cycle
- Future plans
- Space, privacy
- Priorities

Role/Boundary Definitions

- From supportive to primary caregiver
- From advisor to decision-maker
- From friend to authority

Guilt

- Fearful of contributing to family disruption
- Becoming a primary caregiver and raising child
- More committed to meeting the child's needs instead of parent's needs

Embarrassment

- Due to birth parent's inability to remain primary caregiver

Projections/Transference

- Unresolved issues- with birth parent transferred to the child
- Difficulty perceiving the child's personality as different from the birth parent

Loyalty

- Usurping or replacing birth parent's role
- Fear of hurting parent's feelings and being rejected

Child Rearing Practices

- Updating and recalling techniques and methods
- Need to learn non-corporal techniques of punishment and discipline

INITIAL GUIDE TO ASSESS POTENTIAL RELATIVE CAREGIVERS' SAFETY AND PLACEMENT POTENTIAL

Stress Management/Physical Limitations

- Developing coping skills and support in managing children and additional responsibilities

Bonding and Attaching

- Establishing a parent/child relationship instead of a relative/child relationship

Anger and Resentment

- Birth parent's absence
- Birth parent's attempts to regain custody or continue contact
- Birth parent's sabotage or competition for child's loyalty to birth parent
- Agencies and professionals
- At/with "themselves" for becoming a surrogate parent

Morbidity and Mortality

- Concerns of illness/death triggered by previous losses and separations
- Who will take care of me if grandma gets sick or dies?

Fantasies

- Many parents fantasize about reuniting with their children
- These fantasies can be sometimes unrealistic
- These fantasies may cause to maintain unrealistic expectation about reuniting with the parent

Overcompensation

- Caregiver may try to make up for the parent's failings or mistakes
- This reinforces child's experience of life as "extreme" and not balanced
- Challenge for caregiver is to provide balance and consistency

Competition/Sabotage

- Parent can sabotage the placement by undermining the authority of caregiver
- Parent may challenge, defy, or not comply with agreements regarding visiting, curfew
- Parent may give child permission to defy caregivers and professionals

**FAMILY ASSESSMENT OF NEEDS
AND STRENGTHS**
Michigan Department of Human Services

Household Name:
Primary Caretaker:
Secondary Caretaker
DHS FC Worker Name:
DHS FC Worker Load #:
POS Agency Name:
POS Agency Worker:

Check One:

- Initial Service Plan
 Updated Service Plan

Date Completed: _____

CHILDREN INFORMATION:

Child's Name:

Child' Case Number:

Rate the caretaker(s) on all items, except for Item S14. Select the score that applies to each caretaker under each category. For items where the foster care worker is unable to obtain information at the ISP, Record US for Unable to Score. If a parent refuses contact at the 1st USP, "US" may be used with prior supervisory approval.

	Primary Caretaker	Secondary Caretaker	Most Serious
S1. Emotional Stability Behavior			
a. Exceptional coping skills+2			
b. Appropriate responses.....0			
c. Some problems.....-3			
d. Chronic depression, severely low esteem, emotional problems-5			
e. Unable to score.....US	_____	_____	_____
 S2. Parenting Skills			
a. Strong skills+2			
b. Adequate skills.....0			
c. Improvement needed.....-3			
d. Destructive/abusive parenting.....-5			
e. Unable to score.....US	_____	_____	_____

- S3. Substance Abuse**
- a. No evidence of problem0
 - b. Caretaker w/substance problem/current treatment issues -3
 - c. Caretaker with serious problem-4
 - d. Problems resulting in chronic dysfunction-5
 - e. Unable to score.....US

- S4. Sexual Abuse**
- a. No evidence of problem0
 - b. Caretaker has failed to protect child(ren) from sexual abuse -4
 - c. Caretaker has abused child(ren) sexually-5
 - d. Unable to score.....US

- S5. Domestic Relations**
- a. Supportive Relationship+2
 - b. Single caretaker not involved in domestic relationship0
 - c. Domestic discord, lack of cooperation.....-2
 - d. Serious domestic discord/domestic violence-4
 - e. Unable to score.....US

- S6. Social Support System**
- a. Strong support system+2
 - b. Adequate support system0
 - c. Limited support system-2
 - d. No support or destructive relationships-4
 - e. Unable to score.....US

- S7. Communication/Interpersonal Skills**
- a. Appropriate skills0
 - b. Limited or ineffective skills-2
 - c. Isolating/hostile/destructive-4
 - d. Unable to score.....US

S8. Housing

- a. Adequate housing..... 0
- b. Some housing problems, but correctable..... -2
- c. No housing, eviction notice..... -4
- d. Unable to score..... US

S9. Intellectual Capacity

- a. Average or above functional intelligence..... 0
- b. Some impairment, difficulty in decision making skills..... -2
- c. Severe limitation..... -4
- d. Unable to score..... US

S10. Literacy

- a. Literate..... 0
- b. Marginally literate..... -2
- c. Illiterate..... -3
- d. Unable to score..... US

S11. Resource Availability/Management

- a. Strong money management skills..... +1
- b. Sufficient income to meet needs..... 0
- c. Income mismanagement..... -2
- d. Financial crisis..... -3
- e. Unable to score..... US

S12. Employment

- a. Employed..... +1
- b. No need..... 0
- c. Unemployed but looking..... -1
- d. Unemployed, not interested..... -2
- e. Unable to score..... US

- S13. Physical Health Issues**
- a. No problem 0
 - b. Health problem or physical limitation that affects family -1
 - c. Serious health problems or physical limitation -2
 - d. Unable to score..... US

- S14. Child Characteristics**
- a. Age appropriate, no problems..... 0
 - b. Minor physical, emotional, intelligence problems -1
 - c. One child has severe/chronic problems that result
in substantial dysfunction -2
 - d. Children have severe/chronic problems that result
in substantial dysfunction -3
 - e. Unable to score..... US

Child(ren)

Based on this assessment, identify below the priority needs and strengths of the household below (indicate S code only). Address the priority items in the Treatment Plan and Service Agreement and any needs scored under Substance Abuse:

Household Name: _____

PRIMARY NEEDS

- | | | |
|---------------------------------|----------------------------------|----|
| S1 Emotional Stability Behavior | S8 Housing | 1. |
| S2 Parenting Skills | S9 Intellectual Capacity | |
| S3 Substance Abuse | S10 Literacy | 2. |
| S4 Sexual Abuse | S11 Resource Availability / Mgmt | |
| S5 Domestic Relations | S12 Employment | 3. |
| S6 Social Support System | S13 Physical Health issues | |
| S7 Comm. / Interpersonal Skills | S14 Child Characteristics | |

PRIMARY STRENGTHS

- | | | |
|---------------------------------|----------------------------------|----|
| S1 Emotional Stability Behavior | S8 Housing | 1. |
| S2 Parenting Skills | S9 Intellectual Capacity | |
| S3 Substance Abuse | S10 Literacy | 2. |
| S4 Sexual Abuse | S11 Resource Availability / Mgmt | |
| S5 Domestic Relations | S12 Employment | 3. |
| S6 Social Support System | S13 Physical Health issues | |
| S7 Comm. / Interpersonal Skills | S14 Child Characteristics | |

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: P.A. 280 OF 1939
 RESPONSE: Voluntary.
 PENALTY: None

TEAMING SECTION

THE FACILITATOR

Three most important responsibilities for the facilitator:

- Building the team
- Directing the process
- Resolving differences

Ways to carry out the above responsibilities:

I. Building the Team:

- Help each participant in the meeting to see the value and worth of each team member
- Encourage team members to be honest and open with each other
- Ensure team members demonstrate respect for each other
- Make sure the team has a common purpose and goal
- Express empathy for the pain and concerns communicated
- Use solution-focused questions to keep participants viewing opportunities for change
- Help the team work through differences

II. Directing the Process

- Encourage participants to talk directly to one another
- Cue the group so its efforts develop a plan that will work for the family and team
- Use reflections to let the family and team know what is being expressed both verbally and non-verbally
- Refocus discussion toward the positive, toward the task and toward solutions
- Use interruptions only to maintain ground rules and, when necessary, to bring the group back to task
- Use summarization purposefully to focus the group and reinforce agreement
- Use solution-focused questions to draw out options and help the team use solutions that have worked in the past
- Add key points of information if the family member forgets
- Offer support

TEAM MEETING PREPARATION

SAMPLE QUESTIONS

The following are sample questions that may be used during

To the parent: (possible other team members)

- What would you like to have happen as a result of this meeting?
- What do you see as family strengths? What do you need?
- What are your child's strengths? What does your child need?
- Describe what success is for your family. What would you be doing differently to achieve success?
- Can you think about what you would like team members to know about your family story, including how you got involved with the agency?
- Who are the people who care about you....your family...you children?
- Who would you want to be at your Team Meeting/
- If we invited all the people who care about your family to come to a meeting, what would be some good things that might come from their participation?
- Where would be the best place for the meeting?
- These meetings can be emotionally charged. What might be some of your concerns?
- Considering we are bringing together a lot of folks, what are some of your concerns?
- What is the family doing at this time that may help the family achieve its goal?
- Can you identify strengths now (possibly jot them down in preparation for presenting them at the meeting)?
- Can you be prepared to discuss the needs of the family?
- Do you have any concerns about your participation on the team?
- What value do you see yourself bringing to the team?

TIPS FOR PREPARING CHILDREN FOR FAMILY-CENTERED MEETINGS*

Below, you will find several tips and guidelines for preparing a child to attend a Teaming meeting.

How old is the child?

- How does the child WANT to participate?
- What special needs are there? (physical/mental health)
- Explain the purpose, what is going to happen, what it will look like to them, what to expect. Who will be present, where the meeting will occur, and designated support person.
- Anticipate the questions and provide answers. **(See Common Youth Questions Handout)**
- Allow ample time for child to ask what he wants to know.
- Help find an understanding that his opinions will be extremely important but that it may not always turn out exactly how the child would like.
- Once you feel the child understands the process, you may ask:
 - ✓ Do you want to come?
 - ✓ Who do you want to come with you? Who do you not want to come with you?
 - ✓ How do you think it should go?
 - ✓ What would you like everyone to know? What would you like to tell your family?
 - ✓ What will help everyone feel comfortable?
- Acknowledge that it may not be easy to hear some things and provide reassurance for his safety.
- If possible, give the child enough time to think about and prepare what she would like to say. Allow opportunities to rehearse, role play, and practice.
- Reassure child that you will do everything possible to make sure she feels comfortable and safe.
- Present many options and alternatives for attending, especially if child changes his mind about being physically present.

JOB AID:

Common Youth Questions

A Question and Answer guide for Youth to help

What is a Team

Meeting?

It is a meeting that helps make decisions and a case plan about what is going to happen to you. People who are supportive of you are invited to attend and help make important decisions about things such as entering foster care, placement in foster care and issues about your family.

Who is going to be there?

Multiple people who have an impact in your life may be invited. People such as your parents, relatives, teachers, therapists, friends, case workers and DHS employees will attend the meeting. You may request to have people at the meeting you find supportive. Please make sure your caseworker knows who you would like to attend the meeting.

Why am I going?

You have been invited to a Team Meeting to help make a major decision about your life. Depending on your situation, decisions may be made on where you will live, who will take care of you or how you and your family can be supported.

Why should I go?

Attending the Team Meeting will help give you a voice on your future. You will have an opportunity to share your feelings and experiences to help make a good decision. You are the expert of your life, so attending will help others understand your wishes, concerns and goals.

Do I have to attend?

Your participation is voluntary, but highly encouraged. This is YOUR future and you are important.

What should I bring and what should I wear?

Bring an open mind and lots of questions! Paper and pen will be available to you at the meeting. You may dress casual. This is a casual meeting, so come as you are!

Where is the meeting?

Meetings are held in a variety of locations throughout the County. Locations include churches, community agencies and DHS offices. You will be told where to attend the meeting.

Will I have voice? Will people listen to me?

JOB AID:

Common Youth Questions

Everyone at the meeting will be given an opportunity to speak at the meeting. Ground rules are given before the meeting. A facilitator is also there, supporting the meeting to assure EVERYONE has a chance to speak their mind, feelings and ideas. If you do not feel you are being heard or are being misunderstood, please make sure to let the facilitator know.

What if I am too scared to speak?

If you are too scared to speak, for whatever reason, please make sure to share these feelings with your DHS caseworker. You may schedule a private meeting with them, call them or email them. You may also write a note to your caseworker during the Team Meeting, letting them know you are uncomfortable. You have the right to have your feelings heard and feel safe. The Team Meeting is designed to make everyone feel as comfortable as possible, but it is understandable if some issues are difficult to express. We encourage you to reach out to someone to share your feelings and make certain you are heard and your needs are met. Remember, if you don't speak your problem will not be solved.

What is the Facilitators role in the meeting?

A facilitator is assigned to conduct each meeting. The facilitator's role is to make sure everyone has a chance to speak, that everyone feels comfortable, and that the group stays focused on making any recommendation(s) to develop a case plan.

Am I in trouble? Do I need to have a lawyer?

No, you are not in trouble. This is a meeting to help you and your family make important decisions, not to discipline, punish, criticize, etc. You do not need to bring a lawyer. This meeting is not a court hearing and they do not making any court orders. However, as a youth in foster care you do have a Guardian Ad Litem (GAL), an attorney, which you may request to attend the meeting on your behalf. Remember, you did not place yourself in foster care and being in foster care is not your fault.

PREPARING THE SUPPORT PERSON FOR A CHILD WITHIN FOR THE PPC

Explain the meeting purpose, process, and role of support person.

- ☞ Explain the importance of their role to enhance the experience of safety by a child before, during, and following the PPC.
- ☞ Understand their relationship to the child.
- ☞ Identify their specific support role (support, voice, message bearer, safety guide, etc.)
- ☞ Support people often have a dual role. Discuss the difference between supporting a child's presence or being a child's voice vs. expressing their own opinion. Assist them in differentiating these and help determine how they will reasonably achieve both.
- ☞ Provide tips for the inclusion of a child in a PPC or a child's voice in the PPC process.
- ☞ Prior to the PPC a support person should meet with a child to prepare for the meeting. Things they may discuss include:
 - What is the role of the support person (before, during, and after the PPC)?
 - What would you like to tell your family? Do you want help with that?
 - What will help you feel comfortable?
 - Do you want to come?
 - Where do you want to sit?
 - Do you want to have a cue to let me know if you feel uncomfortable?
 - What do you want to do if you feel uncomfortable?
 - Do you want to write down what is important for your family to hear? (Draw pictures, etc.)
 - Inform them that you will help them understand the decisions the family makes during the meeting.
 - Identify level and quality of contact you will have immediately after the PPC.

PPC Events and Timeframes Required

PPC Type (Event)	Trigger Date	Timeframe
PLACEMENT		
Emergency Removal	Date of child's removal	Next business day, prior to completion of preliminary hearing, when possible.
Considered Removal	Decision to consider removal-Referral for PPC	No later than 2 business days of PPC referral.
Change of Placement-Planned-Agency Requesting Removal	Decision/intent to change placement.	Prior to agency providing FP/Relative notice of intent (DHS 30) to move. PPC must occur prior to the child's change in placement.
Change of Placement-Emergency	Date of child's removal from FP/Relative	No later than the next business day
Change of Placement-Mental Health Hospitalization	Decision not to return to placement.	No later than 3 business days after the decision has been made not to return to previous placement.
Change of Placement-Planned-FP/Relative Requesting Removal	Date FP/Relative requested removal	No later than 3 business days after verbal or written request for the child to move.
REUNIFICATION		
Reunification-Planned	Referral for PPC	Prior to first multiple overnight visits.
Reunification-Unplanned	Court Order Date	No later than 2 business days after date of court order.
GOAL CHANGE		
Change in Permanency Goal	Consider changing the permanency goal. Immediate referral for PPC.	Prior to next court hearing or within 5 business days of PPC request
RETURN FROM AWOLP		
AWOLP	Date child returns to placement	Upon child's return to placement but no later than 2 business days after placement
CHILD IN CARE 9 MONTHS WITH GOAL OF REUNIFICATION		
Child in care for 9 months and has not progress to ensure reunification within 12 months	Date child has been in care for 9 months	ASAP after 9 month date but no later than 30 days after.
CHILD LEGALLY FREE FOR ADOPTION +3 MONTHS		
Legally free for adoption for 3 months w/o a permanent home identified.	Date child has been legally free for 3 months	ASAP after the 3 month mark but no later than 30 days
16+ ANNUAL TRANSITION		
Once a youth turns age 16 and annually. DHS-901 must be completed and goals discussed.	Age 16 and annually	ASAP once youth turns 16 and annually thereafter. Within 30 days of coming into care if 16 and older when removed.
90 DAY DISCHARGE		
Discharge of wardship	Age 18 or older and case closing	Within 90 Days before discharge or within 30 days if court dismisses wardship.

PPC referrals are made once a caseworker and the supervisor determines a need. Once a need has been determined, the PPC referral must be made immediately. After the PPC is held, the event must occur within 45 calendar days or a new PPC is necessary.

Appendix Section

Appendix A

DHS 987

Go www.michigan.gov/dhs

Go to Doing Business with DHS (Left side of screen)

Go to Forms and Applications

Appendix B

DHS 988

Go www.michigan.gov/dhs

Go to Doing Business with DHS (Left side of screen)

Go to Forms and Applications

Appendix C

DHS 989

Go www.michigan.gov/dhs

Go to Doing Business with DHS (Left side of screen)

Go to Forms and Applications

Appendix D

DHS 990

Go www.michigan.gov/dhs

Go to Doing Business with DHS (Left side of screen)

Go to Forms and Applications

Appendix E

DHS 991

Go www.michigan.gov/dhs

Go to Doing Business with DHS (Left side of screen)

Go to Forms and Applications

Appendix F

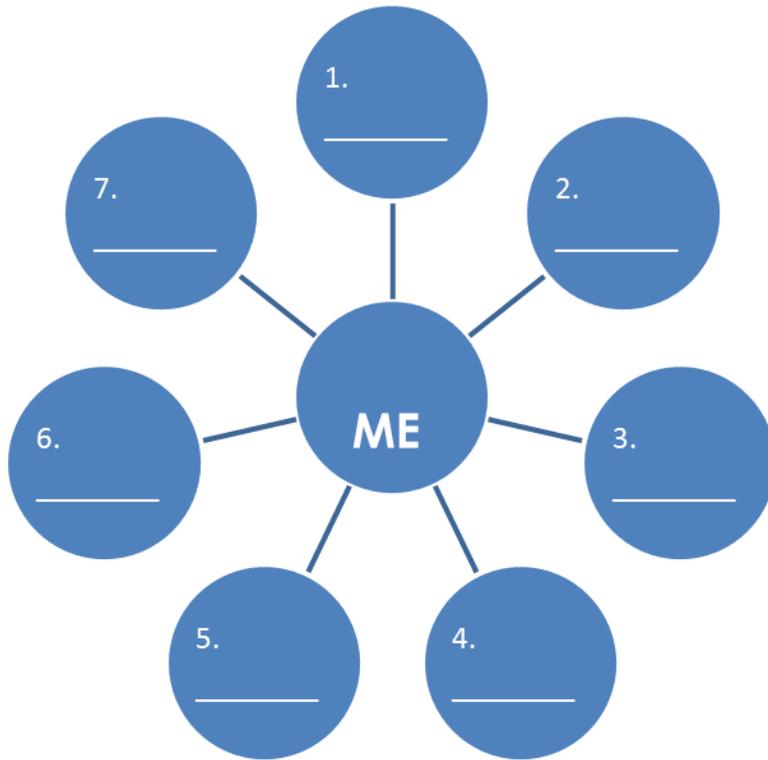
SUPPORT WHEEL

Ask Yourself The Questions Below. Then Fill In

1. Who Do You Talk To When You Want To Share Good News?
2. Who Do You Talk To When You Are Unhappy With Something In Your Life?
3. Who Do You Talk To When You Are Having Trouble Making A Decision?
4. Who Will Be The First People To Notice Positive Changes You Make?
5. Who Is Good At Helping You To Calm Down?
6. Who Gives You Good Advice?
7. Who Can Count On In Times Of Need?
8. Is Your Circle Full? Do You Need To Add More Circles? Do You Need To Expand Your Network Of People?

Appendix F

SUPPORT WHEEL



Appendix G

Team Meeting Preparation Tool for Specialists to Complete with Youth

Preparation Check List/ Review Meeting Logistics:

- Review case file
- Does the youth have transportation? Arrange transportation for the youth.
- Review School progress, should the Team Meeting be scheduled after School? If not, does the youth need a letter for school excusing them?
- Talk to relatives & invite relatives to the Team Meeting
- Explain the Team Meeting process to youth
- Discuss potential supports & participants with youth
- Ask the youth whom they would like to be placed with & invite them
- Connect youth with a Mentor
- Explore youth's interest & career goals
- Link youth with resources or Mentor that met those goals
- Contact former foster parents & invite to the Team Meeting
- Explore sibling visits with youth & relationships developed w/ siblings' caregivers and family
- Invite individuals' youth has connected with whom are caring for their siblings or are related to those caregivers
- Invite school-related individuals identified by youth as supportive
- Ensure the youth that the Team Meeting is his/her meeting and that their input is very important

Note: THE ATTACHED SPREADSHEET SHOULD BE COMPLETED WITH THE YOUTH

Appendix G

Youth's Name: _____

Team Meeting Date & Time: _____

Team Meeting Location: _____

List of relatives previously and presently involved w/ contact numbers	Youth's Mentor Name and/ or goals/ interests & potential Mentors, w/ contact #'s	List of individuals the youth identifies as their support inside and outside of placement, w/ contact numbers (including supportive people @ church)	List of former foster parents & contact numbers	List of individuals youth has connected with during sibling visits, & contact numbers	List of supportive individuals that work at the school the youth attends, & contact numbers

Appendix G

List of individuals the youth would like to be placed with, in order of preference, w/ contact numbers:

* Explain to youth that they can also include in this list anyone from the previous categories that they want to be considered as a placement provider e.g., previous foster parents, relatives, someone from the community, sibling caregivers, fictive kin, etc.

--

Appendix G

List of names, relationship and contact information pulled from case mining. Indicate efforts to engage them and if they were invited to the Team Meeting.

Youth's preference for permanency:

**** NOTE: DO A DILIGENT SEARCH ON ALL POSSIBLE SUPPORTS, TEAM MEETING PARTICIPANTS, & POSSIBLE PLACEMENT***

Appendix H

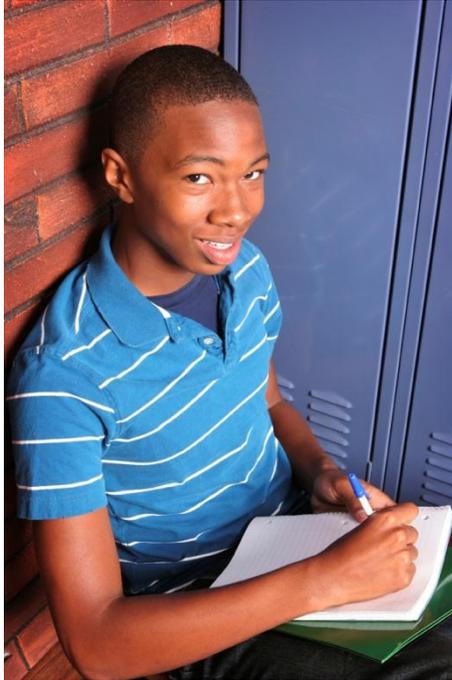
Overrepresentation of Children of Color in Michigan's Child Welfare System



- **Approximately 20,000 children are in foster care in Michigan. Although African American children represent slightly less than 18% of all children in the state, more than half of the children in foster care are African American, 1 of every 50 African American children in the state. This has resulted in a statewide disproportionality rate of nearly 3, which is higher than the national average of 2.43.**
- **African American families are more likely to be referred to child protective services and are more likely to have the complaint “substantiated”.**
- **In the last decade, the share of preschool aged children from racial or ethnic minority groups in Michigan rose from 1 in 5 to 1 in 3. These changing demographics call for a similar shift in state policies to ensure that all children have the opportunity to grow up in strong families and communities.**
- **African American infants are more likely to be placed in foster care shortly after birth. Nearly 19% of African American infants in Michigan under age 1 were removed from their homes, opposed to 16.5% of white infants. Initial drug testing at the prenatal visits appears to be equal. However after delivery, hospitals were 10 times more likely to inform Child Protective Services about African American women who tested positive for drugs than white women.**

Appendix H

Overrepresentation of Children of Color in Michigan's Child Welfare System pg. 2



- In one Michigan study, delinquency rates for children between the ages of 10 and 16 who had been the victims of child abuse and neglect were 47% higher than other youths. “For too many African American children there is a slippery slope leading from children’s protective services to juvenile detention-even prison.”
- Once in foster care, children of color far worse than other children. In every county in Michigan they are more likely to be removed from their homes; are less likely to be reunited with their parents; are more likely to be in multiple placements; spend more time in care; and are more likely to be adjudicated in the juvenile justice system, be placed in a residential treatment facility, or be waived to adult courts. Disproportionality rates vary by county, from 8.03 in St. Clair to 1.69 in Wayne County.
- More than $\frac{1}{2}$ of the youth leaving foster care have diagnosed mental health disorders, 1 in 5 has been homeless, $\frac{1}{2}$ have not completed high school, and $\frac{1}{3}$ lives below the poverty level.
- African American children are somewhat more likely to be placed with relatives. Of all children in relative care as of 2002, 33.2% were white and 59.7% were African American.

DAILY EVALUATION FORM

STRENGTHENING PRACTICE

DAY 1: ENGAGEMENT & CASE PLANNING

(All ratings are from the lowest/poor 1 to the highest/excellent 5)

I WOULD RATE THE CONTENT OF THIS SESSION:

1____ 2____ 3____ 4____ 5____

Comments: _____

I WOULD RATE THE DELIVERY OF THE CONTENT IN THIS SESSION:

1____ 2____ 3____ 4____ 5____

Comments: _____

I WOULD RATE MY PARTICIPATION DURING THIS SESSION:

1____ 2____ 3____ 4____ 5____

Comments: _____

THE MOST IMPORTANT PART OF THIS SESSION FOR ME WAS...

THE PART OF THIS SESSION I WOULD CHANGE WAS...

I ALSO WANT TO SAY...

DAILY EVALUATION FORM

STRENGTHENING PRACTICE

DAY 2: TEAMING & MENTORING

(All ratings are from the lowest/poor 1 to the highest/excellent 5)

I WOULD RATE THE CONTENT OF THIS SESSION:

1____ 2____ 3____ 4____ 5____

Comments: _____

I WOULD RATE THE DELIVERY OF THE CONTENT IN THIS SESSION:

1____ 2____ 3____ 4____ 5____

Comments: _____

I WOULD RATE MY PARTICIPATION DURING THIS SESSION:

1____ 2____ 3____ 4____ 5____

Comments: _____

THE MOST IMPORTANT PART OF THIS SESSION FOR ME WAS...

THE PART OF THIS SESSION I WOULD CHANGE WAS...

I STILL HAVE QUESTIONS ABOUT...

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