

NATIONAL RESOURCE CENTER FOR CHILD PROTECTIVE SERVICES

Technical Assistance Site Report



Prepared for Puerto Rico Administration for Children and Families
By Therese Roe Lund, MSSW,
National Resource Center for Child Protective Services

Dates of onsite technical assistance summarized in this report:
May 24, July 6 and 7, and August 29 and 30, 2006

Situation and Technical Assistance Request

Puerto Rico's Administration for Families and Children (ADFAN) requested technical assistance for the continuation of plans to develop, train and implement a safety decision making model. The Federal Regional Office approved up to 10 on site days.

Site Visits

May 24th site visit

Terry Roe Lund from NRCCPS met with the advisory group on safety during this site visit, working on the issues identified at the last site visit.

The first half of the day was spent clarifying and deciding on tasks, responsibilities of each of the implementation support workgroups (i.e., policy/procedure, program management, supervision, quality assurance, documentation and staff development). While much of the discussion centered on the benchmarks for evaluating progress in implementation of the safety model (a responsibility of the quality assurance workgroup), communication plans among the workgroups and time frames for drafts and final work products by all the workgroups were established.

Impressively, even though a government shut-down had temporarily caused challenges to moving forward, the workgroups had struggled to hold to original scheduled tasks. While some changes obviously had to be made in light of the shut-down, considerable work still had been accomplished.

As a result of an NRCCPS review of approximately 50 hotline reports as well as the long discussion during the April site visit regarding which cases should be served by the Department, a draft position paper was discussed. Prepared by NRCCPS for advisory group consideration, the paper helped the advisory group identify strategies and implications for successful implementation of the safety model. Improving the quality of hotlines, it was agreed, would have a positive effect on workload. Supervisory qualifications are also a critical area to revise.

The draft paper follows on page 3 of this report for further reference.

The next TA site visit was scheduled for July 6 and 7, with an agenda of helping with PIP issues concerning Homebuilders as well as practice and policy for ongoing services.

DRAFT

**Position paper regarding workload implications
Of
Implementation of a safety decision making model in Puerto Rico
May 24, 2006 Site Visit**

The decision to implement a framework or model for making decisions about child safety represents the *setting of standards for practice for child protection staff and supervisors.*

Standards have multiple benefits:

- Standards help regulate practice of staff AND for supervisors
- Standards help bring consistency to practice, and fairness to a process that intrudes in family life
- Standards inherently create measures and ways to evaluate practice and supervision
- Standards bring rigor, a professional and disciplined approach to a field (child protection) that has been subject to criticism for lacking precision in its approach
- Standards of practice bring a method to communicate about the minimum expectations of the job, and whether those minimum expectations are being met.

Creating and implementing standards of practice cannot occur successfully without a clear and pragmatic look at numerous issues. Standards are not meant to be a lofty goal: something that “would be nice if one has time to do it.”

Rather, standards are the minimum expectations of what must be done. Therefore, it raises the questions:

1. Who are the families that ADFAN must serve through its child protection program?
2. What are all the tasks, activities and responsibilities that must be carried out by staff and supervisors regarding each child protection case?
3. If each of the above tasks and activities were done *minimally satisfactorily* how much time would each case, on the average, take to carry out?
4. What are the minimum qualifications of staff and supervisors that must be met in order to carry out the job?
5. What kind of staffing pattern must be in place to a) achieve the tasks and activities; b) be consistent with the goals and objectives regarding how families should be treated, and c) assure quality safety decision making?

This draft paper represents a summary of observations and recommendations of the ADFAN safety model advisory group.

Intake

The hotline staff (Social Emergency Program) serves to identify those families that ADFAN has clearly stated it will/must serve. At this time, the advisory group recommends that the families to be identified (and screened in for an investigation) are:

1. Families where information received in the report leads to a reasonable conclusion that maltreatment is currently happening in the family.
2. Families where information received in the report leads to a reasonable conclusion that maltreatment will occur. This second category is *risk of maltreatment*, meaning the intake report does not help ADFAN make a reasonable conclusion about when the maltreatment might occur or how mild or severe the maltreatment may be.

3. Families where information received in the report leads to a reasonable conclusion that family conditions are out of control, and without intervention (an investigation) the children are or will be severely harmed in the immediate future. This category is about *threats to the children's safety*.

Categories of family problems that will not receive a child protection investigation (and will not be part of the standards for safety decision making) are:

- Adult services cases
- Institutional abuse
- Mental health issues (only) of children
- Physical, cognitive, medical problems or disabilities
- Peer on peer assaults
- Truancy
- Older children with behavioral problems (e.g. acting out behavior)
- Poverty if it is the only issue
- Custody disputes without allegations that concern safety

Implications for Intake

The contracted staff who perform the hotline or intake function serve to identify which reports have information that appears to “fit” with the families who should be served by ADFAN. Information at the point of intake is less certain because it is coming from a reporter and cannot be verified.

Yet by establishing *standards for information collection* at the point of the hotline, greater precision in decision making can occur. Families should not be subjected to a child protection process on the basis of a rationale that merely amounts to “just in case.” Likewise, the standards for practice regarding child safety decision making cannot be met on ANY case, if staff are unnecessarily going out on ALL or most cases reported to the hotline.

The advisory group recommends that:

The contract requirements for the hotline function clearly articulate that information collection is an assertive process, and that all reporters are asked the following:

- Client demographics
- Maltreatment including
 - Specific caregiver behavior indicative of maltreatment (e.g. leaving a child; harsh punishment)
 - Details about caregiver behavior associated with the maltreatment (e.g. substance use)
 - Events and circumstances associated with/accompanying the maltreatment
 - Effects of maltreatment or caregiver behavior on child; child's condition resulting from the maltreatment
 - Qualification of the severity
 - Seriousness and limits of caregiver behavior
 - Seriousness of conditions/situation in family
 - Vulnerability of child
- Child(ren)
 - General condition and functioning
 - Location
 - State of mind/emotion; specific fear

- Proximity to threat
- Access to those who can help and protect

Caregivers

- General functioning
- General state of mind/emotion
- Current location
- Habits, routines
- Violence or acting out
- Community relationships
- Employment
- Use of substances
- Mental health functioning
- Unusual stress or coping problems
- Caretaking interests and abilities
- Attitudes toward/perceptions of child(ren)
- Openness/awareness
- Previous relevant history
- Likely response to CPS

Family

- Unusual stressful circumstances
- Living arrangements
- Household composition
- Household activity – including people in and out
- Condition of physical environment

Documenting the above information (and clearly indicating that these issues were explored with the reporter, even if the reporter does not know this information) should be a routine expectation of hotline staff. Quality assurance measures should include this essential component of the purpose of the hotline function.

July 6th and 7th site visit

Although this site visit (involving Terry Roe Lund from NRCCPS and a workgroup from ADFAN) had originally appeared to be an agenda devoted to issues not connected to the safety model work being done, the discussion and decisions had a tremendous impact on:

- Increasing the understanding and appreciation of ADFAN staff regarding how safety concepts apply throughout the case process and
- Helping establish a foundation for the safety model the Department would like to implement post-investigation at some point in the future.

The help requested from TA for this site visit concentrated on the work ADFAN was doing to establish a case flow or model of intervention (and accompanying policy and procedures) for ongoing services (using a Generalist Model). This case flow document shared with NRCCPS for review and consultation was adapted from the Homebuilders' Program. The question for the TA visit: would this intervention model, with its expectations of staff and supervisors, work in ongoing services with caseloads of 17-32 and a supervisor/worker ratio (given vacancies of supervisory positions) of 1 to 8 or sometimes higher?

NRCCPS facilitated a discussion and helped the workgroup consider the following in establishing a framework for ongoing services:

- The homebuilders model as adapted, is likely not going to be successfully implemented given workload issues
- More importantly, the model as adapted, does not offer clarity regarding the worker's role and responsibility
- While it is too early to attempt to "implement a model of intervention" for all post-investigation services (efforts must be concentrated on the model for front-end services first), policy, procedures and a case delivery flow can be established that provides consistency with the concepts of the model for the front end of service delivery (i.e., the safety model).

In order to make decisions about how to proceed, the group discussed their reaction to the following ideas as a general framework for ongoing intervention:

- The definition of child safety that is used at investigation should be the same in ongoing services: children are safe when there is an absence of threats or sufficient protective capacity to control/manage any threats.
- Families are served by ongoing services (intact families or those with children in placement) due to concerns about safety
- Services are provided to supplement or substitute for the fact that the caregiver currently cannot protect the child him/herself.

- The outcome wanted is for the child to be safe, with the caregiver returning to their protective role
- The strategy (case plan tasks, goals, etc) then is to work to reduce safety threats by increasing caregivers' protective capacities.

The group considered some of the “certainties” of the work: involuntary clients, intrusive interventions in people’s lives; the characteristics of the workforce, the ever-present issues of workload and the very severe issues confronted in the work.

These certainties demand, the group agreed, that their case delivery flow has to provide workers and supervisors with precision and clarity about their roles and responsibilities, with a focus on safety.

Using resource materials provided by NRCCPS for further discussion and consideration, the group deliberated and decided the adaptation of the homebuilders’ model would not be used as the framework for case flow. Instead, the staff will use draft materials from NRCCPS on policy and from ACTION for Child Protection on a safety intervention model in order to develop their own framework for intervention.

Finally, the group decided that after training on the safety model, staff and supervisors should use the concepts of safety to examine open, ongoing cases for the purpose of seeing if some cases can close. Not only does this decision have a potentially positive impact on the concerning issue of staff workload, it reflects a deepening understanding by the ADFAN management of the implications of using the framework for safety intervention to manage the program.

August 29th and 30th site visit

The final two days of TA in the 2006 fiscal year were spent in preparation for safety model training and implementation. Through contracted work with ACTION for Child Protection, a train the trainers session was scheduled for September, and a practice session for the trainers was scheduled for October. This site visit returned to the work of the implementation workgroups, as well as the logistics of the September and October trainings.

In addition to practical and logistical work, a review/discussion of each workgroup’s focus included the following ideas:

- When implementation is failing it is essential to analyze what is contributing to the failure. The system supports around which the implementation team workgroups are built are the primary sources of how/where to begin to conduct an analysis.

- Policy and procedure
 - How is policy communicated?
 - Is policy clear? Does it provide a step by step “roadmap?”
 - Is policy consistent with the concepts?
 - Does policy cover not only what must be done but also how it must be done?
 - Are there adequate short-term policies that will support the short-term “developmental” milestones of implementation?
 - Does policy support supervision needs and requirements?

- Staff development
 - Is staff development thought of as different strategies and multiple audiences, or is it limited to classroom training for line staff?
 - Are there short-term staff development strategies to match the QA benchmarks?
 - Are there staff development strategies to support the expectations held for supervisors?
 - Are there staff development strategies to create greater expertise among the implementation team?

- Documentation
 - Is documentation easy, clear, and logical?
 - Are there current (pre-implementation) documentation requirements that now (given the implementation of the safety model) are duplicative and can be taken away?
 - Are there current documentation requirements that are inconsistent with the safety model’s concepts and/or practice standards that should be taken away?
 - Are there local office documentation requirements and/or “traditions” of how things get documented that should be examined for it’s a) value and b) effect on workload?

- Quality Assurance
 - Are the “right” benchmarks targeted?
 - Are the benchmarks logical, reasonable?
 - Do the QA reviewers have sufficient expertise to accurately judge the quality of practice and decision making?

- Program Management/Leadership
 - Are multiple methods of communication used to ensure everyone is updated and has the correct information?

- Is communication repeated in recognition of how people process information and “listen?”
 - Are all meetings used as a way to discuss implementation (understanding that child safety decision making links reasonably to any other business of child welfare)
 - Is managerial focus sustained on this initiative?
 - Is there adequate effort and demonstrated skill in coordinating, managing and leading the implementation team?
- Supervision
 - Early in implementation: are there expectations that supervisors will be competent in the basic process of safety decision making (e.g., knows the 6 questions and what would be sufficient answers)?
 - Does the supervisor know and use methods to direct the safety decision making work and the learning objectives in the unit?
 - Does the supervisor know and use methods to assess what staff need to learn in relation to the new practice standards?
 - Does the supervisor know how to and does use conferences and unit meetings to support implementation?

A longer discussion ensued regarding supervision, given how essential this position is regarding implementation success. Helping supervisors learn how to assess for competency of staff was identified as a critical need. The implementation team identified methods that can and should be used by supervisors to assess staff competency:

1. observation of interviews
2. review of written work
3. unit meeting participation, leadership demonstrated in front of peers in discussing casework, safety practice standards
4. individual conferences

A discussion of a general framework for helping the supervisor with assessing and addressing competency issues followed. The importance of helping the supervisor track trends within the unit in order to inform everyone of progress was stressed.

The last topic for the TA involved the work underway by the implementation team regarding the Hotline. Efforts had begun to revise the response time criteria and categories to match with the safety concepts. Decisions were made to have 4 categories for response time with appropriate levels of urgency (still to be determined). These categories are (note: the names may not be precisely accurate, but the ideas behind each category are accurately reflected):

1. Present Danger Response Time: the report contains information which, if true, suggests that the child is currently in danger and unsafe.
2. Impending Danger Response Time: the report contains information which, if true, suggests that the child is or will be in a very short time frame, in danger and unsafe.
3. Maltreatment Response Time: the report contains information which, if true, suggests that no safety threats exist but maltreatment has occurred.
4. Risk of Maltreatment Response Time: the report contains information which, if true, suggests that no safety threats exist, no maltreatment has yet occurred, but based on information about child functioning, parenting and discipline and caregiver functioning, a *reasonable conclusion* can be made that risk of maltreatment exists.

Next Steps

The August site visit concluded the technical assistance available to ADFAN in the 2006 fiscal year. Plans for a new request for technical assistance in fiscal year 2007 are underway to ensure that the training and implementation can continue seamlessly.