Center for Family Resource Development

Engaging Child Welfare Families: A Solution-Based Approach to Child Welfare Practice
By Dana N. Christensen, PhD & Becky Antle, PhD

"Outcomes, outcomes, outcomes!" is what many family caseworkers will tell you is the new rallying cry of their protective service agency. Regardless of the state, caseworkers are hearing and feeling the effects of the Adoption and Safe Families Act (AFSA). If asked what this new mantra is meant to convey, many front line staff may react in a rather cynical way when they first encounter the new system expectations. Some have complained that it means that they don't have time to do casework anymore, that they have to get the family to change quickly, and that they have to case plan and case manage under the constant pressure of hearing the permanency clock ticking. These impressions, though a sure sign of the stress related to the sweeping changes in child welfare, are at least partially grounded in the reality of the new expectations. Family caseworkers don't have the unrestrained time limits they used to have, they are under much closer scrutiny to see that risk is actually reduced, they are expected to spend more of their time coordinating a collaborative team of partners, and they really do need to think about permanency issues as early as the first meeting with the family.

Practice paradox: Hurry up and change!
However, if the new focus on time-referenced outcomes goes no further than a simple "hurry-up offense", the sad paradox is that real change can actually be slowed down due to the lack of family ownership. The more the worker bypasses efforts to engage the family in a partnership for change, the less hopeful and motivated the family becomes. Without an alternative conceptual map or practice model to guide them, the worker is at risk for responding to the systemic pressures they feel, rather then to building a consensus for change with the family. This usually results in the worker taking control of the case, trying to draw the family's attention to the seriousness of the problems or deficits, then trying to secure quick cooperation with what the worker thinks needs to be done on the case plan. There is considerable evidence now that this effort to speed things up usually results in a lack of engagement and a high potential for the family to resist, either openly or passively. This client resistance to losing control and being forced to accept a negative picture of themselves often confirms the worker's worry that the family doesn't want to change and therefore "the case" is not making adequate progress. If the caseworker then becomes discouraged or worried about the lack of progress, or even client cooperation, their response can be an escalation of hierarchical action, i.e. do even more of the same in an attempt to better get their message across. In some worse case scenarios, this interaction can lead to a downward spiraling relationship with barely masked antagonism creeping into worker attitudes. As one such worker put it, "*I don't have time to engage my families, to be all nice and understanding of my clients, I need to get across to them how serious all this is,... I don't have time to fool around, and neither do they*". When asked if this approach was working she said candidly, "*I don't really know, a lot of the time I don't know if they hear me or not, or if they care or not. They just close off and play the game just well-enough to get by, or they try for awhile and then go back to their old ways. It is like you can tell them over and over again and they just don't get it, or don't want to.*"
Such discouragement can be related to the new time pressures, but it can also be exacerbated by a conceptual practice model that doesn't

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>
> ...family *caseworker*

see the critical connection between family engagement and partnership on one side and risk reduction, well-being, and permanency planning on the other. If downplaying engagement is viewed as a sad but necessary sacrifice to the pressure of meeting outcomes, then paradoxically, the outcomes become harder to reach. Conversely, recent research (*see Engagement Outcomes section*) may indicate that taking the time to make engagement and partnership the cornerstone of family casework may produce more rapid and extensive goal attainment.

How we think effects how we work.
In the latter half of this century, casework practice models have been heavily influenced by physical and mental health treatment models, and therefore placed a significant emphasis on the assessment and diagnosis of dysfunction. The theory was a straightforward one; if the proper diagnosis of the problem or deficit was made at intake, then the prescribed corresponding treatment (or service provision) would provide the expected outcome. In such a model, families were viewed as recipients of treatment services rather than *partners in change*. Client compliance with the case plan became a common issue of contention, as well as a relied upon measurement for decision making. In this deficit based model, the client was viewed as having the need for expertise, not as a source of expertise. The workers job was to assess, diagnose, and prescribe the needed service and the client's job was to make themselves available to receive the needed expertise. The adoption of this model in child welfare led to caseworkers learning proper deficit based assessment and service delivery skills, however family engagement was relegated to the role of insuring compliance. Furthermore, case progress tended to be measured by service compliance and completion, versus measurable change in the self-management skills of patterned risk behavior.

More recently, mental health models have been developed that have sought a cooperative partnership with client families, seeking to utilize the families own resources. These models have sought 1) to define problems as challenges in family life (Carter & McGoldrick, 1998), to empower families to utilize their competencies and solutions (White, 1986; Berg, 1994; O'hanlon, 1989; deShazer, 1985; Durrant, 1993; Jenkins, 1990), and 3) to help family members learn cognitive and behavioral self-management skills (e.g. Goldstein & Glick, 1987; Marlatt & Gordon, 1987; Pithers et al, 1983; Meichenbaum, 1977). Although these models have contributed significantly to redefining treatment services in mental health, they have found slow application within the child welfare field. However, in the era of AFSA outcomes and timelines, these models have much to teach about partnership and change. To meet outcome criteria, caseworkers must 1) quickly build a clear consensus with the family and service providers on what needs to happen to reduce risk, 2) help organize and focus the teams efforts, 3) begin to document a reduction (or lack there of) in risk, and 4) be able to document that the specific risk factors have been (or not been) managed. To accomplish these tasks, a conceptual model is needed that allows the caseworker to engage the family, extended family, and community partners in a joint effort to target and document change.

A Family Centered Model of Practice
If best practice reflects a commitment to work in partnership with families and their resource network, then our conceptual practice model (our way of thinking about what we do) should provide us the conceptual reasoning to guide this practice. Because prior practice models have largely been deficit based, new models were needed that could encompass the worlds as diverse as the family, the court, and the mental health community. Solution Based Casework (SBC) has been developed in response to this need for a common road map.

The model utilizes concepts from family development theory, solution-focused therapy, and relapse prevention theory (cognitive behavior). The brief description of this approach follows.

Solution Based Casework anchors itself around three basic tenets; 1) problems are defined within their specific developmental context, i.e. the everyday family life tasks that have become challenging 2) outcomes are kept relevant and measurable by focusing the casework partnership on those everyday family life challenges, and 3) collaborative teams are utilized and facilitated to keep safety, well-being, and permanency solutions in focus.

The commonality of family life challenges. Families confronted with cyclical discouragement, disappointment, and even fear regarding their future need a hopeful way to think about the problems they face. Caseworker's also need a non-pathological frame for locating the family's struggles so that they can approach the family with respect and understanding. To accomplish this, the model draws heavily on the family life cycle literature (Carter & McGoldrick, 1988; Walsh, 1982) that presents the argument that all families face similar challenges and tasks in order to meet the needs of everyday life. Whether one is a third generation welfare client or a supervisor of social services, one can appreciate the difficult and all too real struggles over toilet training, or how to keep siblings from fighting, or what rules teens need to follow for curfew. This acknowledgment of the universality of family life does not diminish the significant differences that exist between families, it simply reminds client, worker and provider alike that it is within these daily life dramas that everyone must live and work out the meeting of family needs. So if a mother explodes with physically hurtful anger at a child over soiled clothing, the caseworker is trained to help the family come to a consensus that they are struggling with the challenge of teaching their child to successfully use the toilet, rather than her pants. It is only after reaching this non-blaming consensus (a step toward partnership) that the caseworker helps the family explore the details of that challenge. It is within this task exploration and non-accusatory frame that the mother's temper will be discussed as a potential obstacle. By thinking about the problem in a way that doesn't trigger additional personal defensiveness; the caseworker is better able to commiserate with the family's frustrations and team up with them to try some alternative methods of toilet training. There is no doubt that the mother in this case will need to get control of her anger, but her motivation will be much better if it is for the purpose of helping her child learn something new, rather than because the social worker thinks she is a bad mother. The goal in this stage is to separate the developmental intention from the high risk behavior that is holding up developmental progress.

Outcomes should track family life tasks. The second basic tenet of Solution Based Casework is that it is critical to maintain focus on the pragmatic accomplishment of the developmental challenges facing the family in everyday life. This means that casework planning must anchor itself in the identified risk areas and then maintain that focus even as other issues and needs come up and are addressed. Family casework is vulnerable to losing sight of the risk-related problem and its developmental context due to additional problem areas that come up once working with a struggling family. The Solution Based Casework model helps the family team organize, prioritize, and then document the steps they will take to create safety, improved well-being, and stable permanency. Because family's often have issues that go well beyond the initial child safety concern, caseworkers often have difficulty differentiating what is an issue in the here-and-now from what is critical long-term. Small crises can take precedence over larger family integrity concerns. Modern casework often necessitates working on two potential permanency options concurrently, one to follow if the

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safety issues are resolved, the second if they are not. However, when children are in out-of-home care, there is a constant danger for here-and-now placement issues to draw center focus and the original family–of–origin risk issues to fade into the background. Although the specific techniques for assisting a pragmatic focus are beyond the scope of this article, it should be emphasized that maintaining family engagement over the long haul is closely related to the treatment teams ability to keep casework anchored in the everyday life challenges the family (and originally the court) considered relevant.

Collaborative teams fuel the search for solutions. Families involved in child protection agencies typically are suffering from what Michael White (1986) called "problem-saturation". They have suffered a number of setbacks and defeats and often exhibit a form of collective learned helplessness (Seligman, 1975). Although they may be engaged enough to agree that change needs to occur they may not have the confidence and hope that anything will really change. The best the family may be able to bring to the formidable change process is an attitude of forbearance, an attitude consistent with their past view of what is possible. Although the desire for change may be present, it may have to do battle with a protective shield that grows out of perceived failure. Without outside input of hopeful resources, this defeatist view may dominate, particularly at times of slow progress or setbacks. Therefore it is critical for the caseworker to assemble a larger team from which the family might draw needed strength. This collaborative team can be made up of extended family, concerned others in the neighborhood, treatment providers and others from the church or social community that may contribute resources.

So often a family in trouble is also a family estranged from its larger kin and social network. This estrangement occurs for a variety of reasons, sometimes it is because the extended family has tried to help in the past and has been discouraged or defeated by the persistence of problems. Sometimes it's because the client family has current or past conflict with their extended family, often feeling they are trying to run their lives or break them up, and sometimes it is due to physical isolation brought on by economic circumstances. The age-old wisdom of seeking help and guidance from one's elders is not always as easy and simple as it sounds, particularly in emotionally troubled times. For these reasons, families may initially discourage workers from involving larger networks in their family assessments, and therefore their case plans. Engaging an extended family member in Family Team Meeting may require additional phone calls, home visits, or mediation sessions. However, once the process is started, new resources are often identified by those contacted. The creative power of families seeking their own solutions also influences the community providers and partners in a positive way. Rather than working in isolation they are now part of wider network that generates and celebrates change. And of course one of the primary benefits of tapping extended family involvement is the additional safety net created for vulnerable family members when the extended family can be assisted in organizing its efforts. When the inevitable setbacks do occur, kin networks and even communities are brought together for the purpose of mobilizing their energy, intent, and efforts to assist the family.

Research on SBC Engagement Outcomes

Several studies have been conducted to evaluate the effectiveness of Solution-Based Casework. Comparisons were made between clients with whom SBC was used and those for whom SBC was not used. Results of these studies indicate that SBC is effective for engaging clients in the child welfare system and promoting key outcomes. A summary of outcomes by category is provided below.

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Increased Partnership. Clients whose workers use Solution-Based Casework (SBC) are significantly more likely to work cooperatively with their worker in several areas. In one study, researchers found that clients were significantly more likely to follow through with referrals to collaterals (Antle, Martin, Barbee & Christensen, 2002). While 77% of clients in the SBC groups followed through with these referrals, only 35% of those in the non-SBC group did so. The same study found that clients in the SBC were also significantly more likely to complete tasks assigned by the worker. Approximately 75% of clients in the SBC completed tasks, while only 37% of clients in the alternative group completed such tasks.

In a second study, researchers found that clients with whom SBC was used were significantly more likely to keep scheduled appointments with the worker (Antle, Martin, Barbee & Christensen, 2002). 73% of clients who kept all scheduled appointments were in the SBC group. Finally, clients in the SBC were significantly more likely to follow visitation guidelines than others. While 33% of clients in the SBC group followed these guidelines, only 2% in the alternative group followed such guidelines.

Worker Effort. A second area of engagement for which positive SBC outcomes were identified was workers' effort. In one study, workers in the SBC group were significantly more likely to contact collaterals directly. While 88.9% of workers in the SBC group contacted collaterals, 61.9% of workers in the other group contacted collaterals directly. Workers who used SBC were also significantly more likely to schedule and attend appointments with collaterals. 31% of workers in the SBC group attended collaboration meetings, while only 19% of in the non-SBC group attended.

In a second study, researchers found that 100% of workers who attended meetings were using the SBC model, while 100% of workers who did not attend meetings were not using the SBC model.

Client Strengths. There was a trend in the difference between the SBC and non-SBC workers in the number of strengths identified, $t(46)=1.68$, $p<.10$. The mean number of strengths identified by the SBC group was 2.63, while the mean number of strengths by the LTG was 1.67.

Removal of Children from the Home. One study on SBC found that when SBC is used, children are significantly less likely to be removed from the home. While 90% of workers in the non-SBC group removed children from the home, only 59.3% removed children when SBC was used. The type and severity of maltreatment, as well as presence of co-morbid factors and chronic involvement with the system, was the same for these two groups. This indicates that clients in the SBC were more engaged with the system and therefore able to maintain their children in the home.

Client Involvement in Case Plan. Clients for whom SBC was used also showed much higher levels of involvement in the case planning process. For example, clients in the SBC group were significantly more likely to have signed the case plan. 76% of clients in the SBC group signed the case plan, while only 24% in the non-SBC group signed the plan.

There was also a higher rate of completion of the family's genogram for the SBC group. This indicated family involvement in providing detailed information about the members of the family to inform the worker. A genogram was present in 60% of SBC cases and only 40% of non-SBC cases.

Finally, workers were significantly more likely to use the family's own language in the construction of the case plan with SBC. The family's own language was used for 82% of cases in the SBC group and only 18% of cases in the non-SBC group.

Client Success. Clients for whom SBC is used are much more successful in their casework. Clients in the SBC group achieved significantly more case goals and objectives than those in the alternative group. The average number of goals/objectives achieved by the SBC group was 6.00, while the average for the non-SBC group was 1.09. This difference represents approximately a 500% increase in goal attainment. An interaction between the use of SBC and chronic involvement with the child welfare system was also identified. This indicated that clients who had previous involvement with the system and for whom SBC was used achieved even more case plan goals/objectives than others. This finding suggests that SBC is particularly effective for engaging and assisting the previously unsuccessful, chronic clients.

Organizational Outcomes. A third study on SBC examined the link between the use of SBC and organizational outcomes of child safety, permanency, and well-being as measured by state data systems for federal reporting (Barbee, Antle, & Martin, 2003). In the area of child safety, this study found when SBC is used the number of recidivism referrals during a six month time period is significantly less than that of a group not using SBC. The mean number of recidivism referrals for the SBC group was 350, while the mean number for the control group was 538. For permanency, there was a significant negative correlation between the number of strengths identified and the number of placements for the child. As the worker identified more strengths in the family, children experienced more placement stability (fewer changes). In the area of child well-being, there was a significant difference in frequency of contact with biological parents while in out of home care and better medical care. The mean length of time since last contact with biological parents for children in the SBC group was 1.17 months, while the mean length of time since last contact for the non-SBC group was 2.17 months.

RECOMMENDATIONS
These findings on the effectiveness of SBC for promoting client engagement in the child welfare system have led to the following recommendations:

A strengths and solutions perspective on clients is needed for those involved in the child welfare system. This system has traditionally adopted a deficit approach to clients due to the alleged maltreatment of children. However, when family strengths and solutions are identified and exceptions to problem patterns are utilized, clients are much more likely to work in partnership for change. The strengths and solutions identified can be used for achievement of case goals and objectives.

Partnerships with clients that focus on solutions tend to increase both worker and client investment. Worker effort promotes client effort. Workers using the SBC model were more likely to contact collaterals directly and attend these sessions with clients. This resulted in greater client compliance with these collateral services and achievement of case goals and objectives. Client use of collateral services is essential to the protection of children and well-being of families. In order to clients to use these services, workers should provide the positive example of involvement.

The family should be actively involved in the development of the case plan. When SBC was used, clients were more likely to provide language for and sign their plans. Client involvement in the case plan promotes family ownership of the plan and subsequent achievement of the goals and objectives of the plan.

Solution-Based Casework (known in Kentucky as Family Solutions) was developed in cooperation with protection workers and supervisors in the Cabinet for Families and Children, Commonwealth of Kentucky. See Christensen, D., Todahl, J., & Barrett, B. (1999). *Solution-Based Casework: An Introduction to Clinical and Case Management Skills in Casework Practice.* New

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4

TRUST EXAMPLES		MISTRUST EXAMPLES	
▪ Admit weaknesses and mistakes ▪ Ask for help		▪ Conceal their weaknesses and mistakes from one another ▪ Hesitate to ask for help or provide constructive feedback	
PI/Worker	Family	PI/Worker	Family
Write your examples here.	*Write your examples here.*	*Write your examples here.*	*Write your examples here.*

A records review not only gives you information about the incident and family; it can be used to motivate you for the engagement with the family.

Questions to ask:

- What mental picture do you have of the family? (E.g., Is the maltreatment episodic or are there deep underlying factors? What stressors are obvious? To what degree is the family cohesive? Is the family integrated within an extended family or community organizations?)

- What filters does the case "fire" in you? What filters do the family members display?

- What emerges as the strongest issue about the case?

- What strengths are evident at this point?

- What would the family see as the most important issue? How would you find this out?

- Who would be the most influential person in this family, and how would you enlist this person's assistance?

- Did a previous caseworker do something that was particularly helpful for the family? What could have been done differently?

- What do you still want to know about this family?

Records to Review

CPI

- Prior reports – maltreatments on those reports and more detail reviewed on verified reports and their indicators

- Previous services – what was done and what was the degree of compliance

- Existing court orders

- Reporter and source information

Case Management

- Current assessment

- Current case plan and prior case plan (as applicable)

- Last six months of chronological notes

- Talk to people – prior case manager, teachers, counselors, etc.

GENERAL GUIDELINES:

- Focus on the people the family includes as family members (or former family members).
- Use circles to represent females; squares for males.
- Use a solid horizontal line to indicate marriage; dashed for non-married.
- Add children by drawing a solid line below the solid/dashed parental line, left to right following birth order.
- Add explanatory symbols to a line, as necessary: Divorced: D/year; Separated: S/year; Adopted: A/year.
- Ask questions about family members while adding them to the map (e.g., What kind of work do you do? Other than school, how does Tony spend his day? How are your children different from one another?)
- Share some information about yourself (hobbies, what you do when not working, issues you face with your children, etc.) to promote a conversation rather than an interview.
- Add short descriptive notes by people (don't add interrelationship or dynamics notes when the family's anxiety level is high).
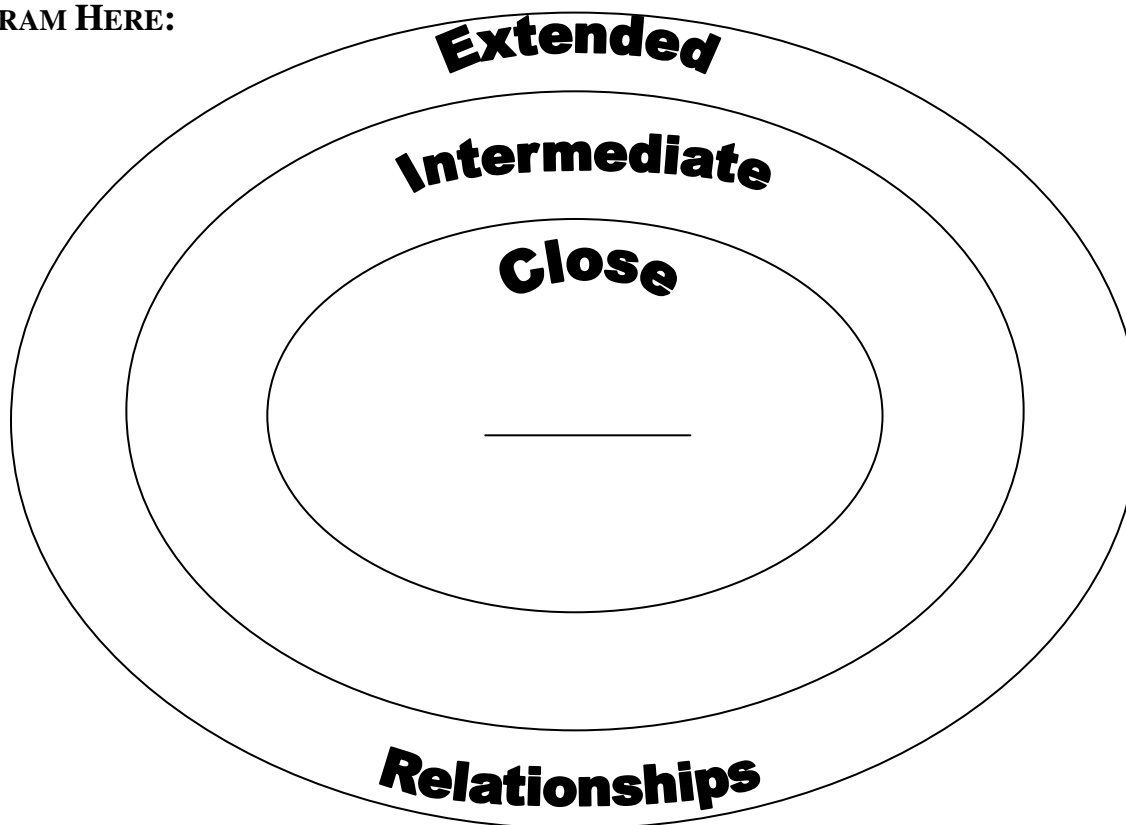
DRAW THE FAMILY MAP HERE:
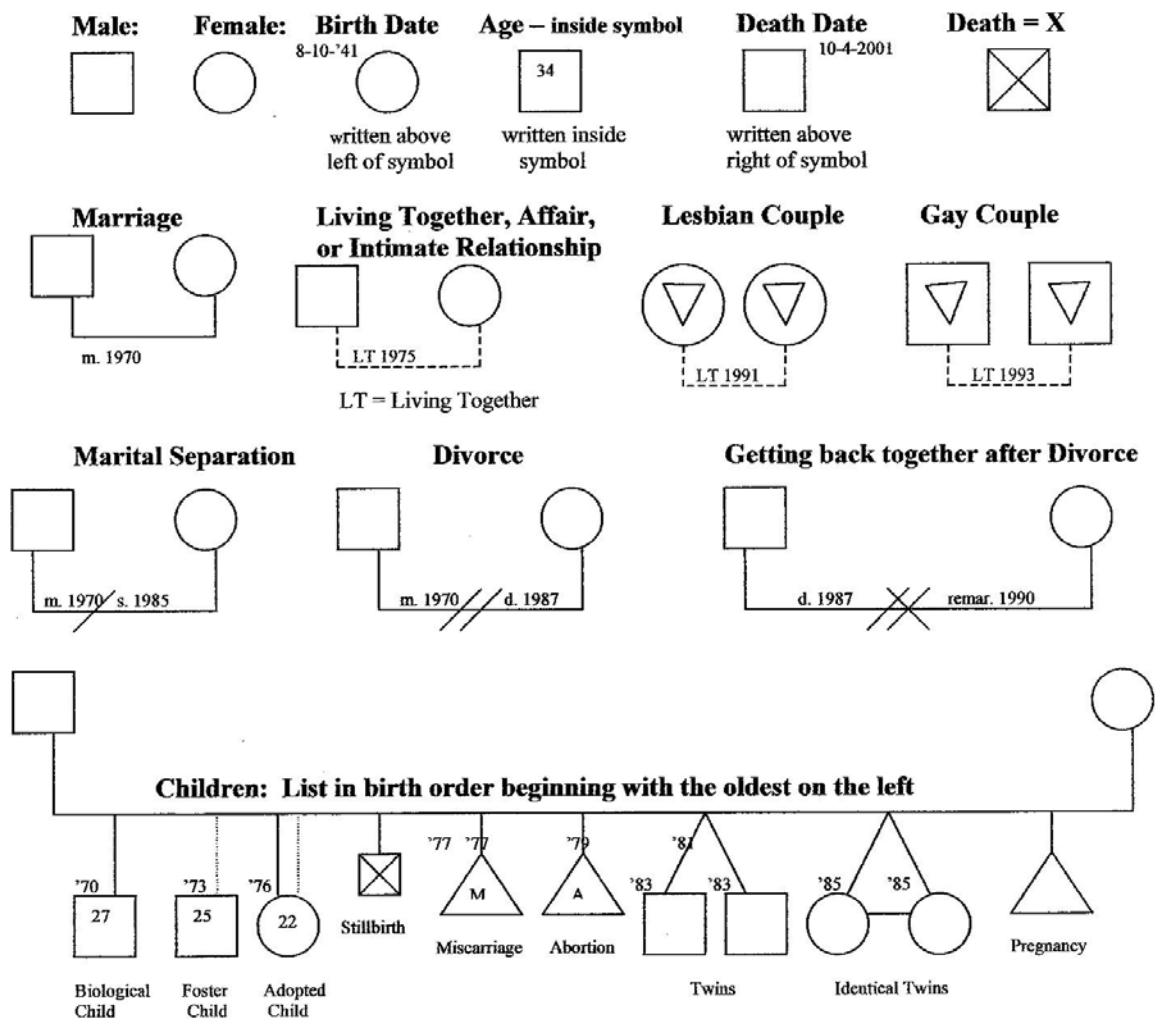
- Two people who are married are connected by lines that go down and across, with the husband on the left and the wife on the right.

- Couples that are not married are indicated with a dotted line.

- Children are drawn left to right, going from the oldest to the youngest.

GENERAL GUIDELINES

- The connections diagram may be filled out for the family as a whole, or for a particular member (usually the child, especially if the child is in out of home care).
- Put the family's or person's name in the center.
- Ask the family to identify who they are very close to . . . who are the extended family members or friends that they would turn to first for help or to whom they would offer help? Or, who do they enjoy being with the most? Write the names of those people in the Close circle.
- Next, ask who they would put in the next circle, Intermediate. These are people they probably know well or fairly well, but are not their closest friends or family members. The family may ask these people for help, but most likely they would not be the ones they ask first. Write the names in the Intermediate circle.
- Finally, ask about people they know, most likely less well, but may be in a position to help the family in some circumstances. For instance, the family may go to church, but are not active members. They know the pastor, but have not talked with him about anything of any consequence before. Write the names in the Extended circle.

- As you work with the family to fill in the circles, ask them to tell you more about the people, especially in the close and intermediate circles. For example: How they met; What they have done together before; What they like about the person.

## DRAW YOUR CONNECTIONS
DIAGRAM HERE:

GENERAL GUIDELINES

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DRAW A CONNECTIONS DIAGRAM FOR A FAMILY ON YOUR CASELOAD:
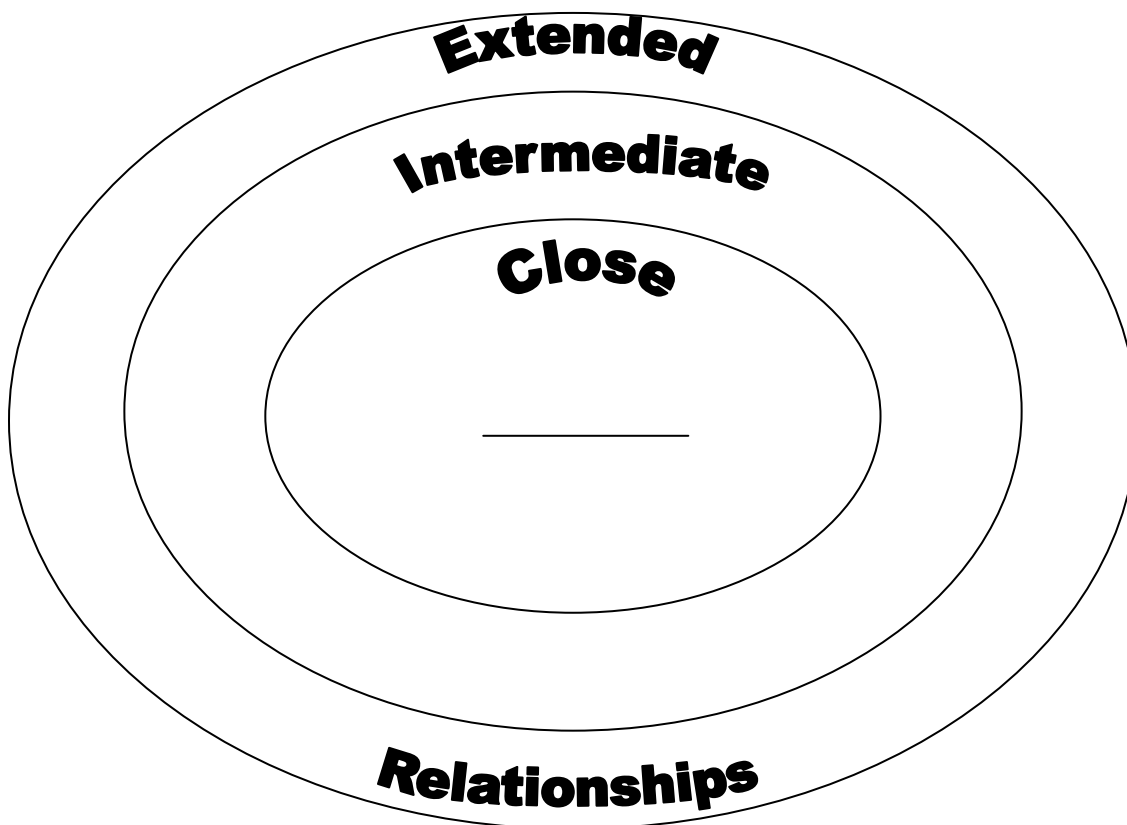
CRITICAL DECISION:

Have I established a trust-based team with the family that motivates the family and me to participate in the intervention?

CRITICAL THINKING SELF-ASSESSMENT QUESTIONS

1. Diligence of Inquiry
- Was I able to review records/reports before meeting with the family to get a mental picture of the family, identify potential strengths and concerns, and anticipate what the family might see as the major issues?
- Was I able to make contact with all family members who would have influence on how the intervention will proceed?

2. Level of Responsiveness
- Was I able to respond well (from the family or child's perspective) to the initial child or family concerns?
- Was I able to convey the purpose of my visit (agency involvement) and my authority in a nonthreatening manner?
- Was I able to demonstrate empathy, respect, and genuineness during the visit?
- Would the family state that I seemed willing to work with them in a helping partnership?

3. Depth of Understanding
- Did I get initial perceptions of family and individual strengths, risks, protective factors, and needs?
- Did I get a preliminary understanding of how this family interacts with the broader community?

4. Avoidance of Undue Influence
- Did I do a self-assessment of any personal filters that may adversely affect my working with the family?
- Was I able to "check my filters at the door" as I met with the family?
- Did I maintain a sufficient amount of professional distance?
- When encountering cultural differences, was I able to note my questionable understanding and seek help from someone more knowledgeable (including family members)?
- Did I engage with all family members and not let the opinions of any one person distort my view of other involved persons?

5. Discernment
- Do I have sufficient information to make an evaluation of my level of engagement with the family and its members?
- Have I reflected (thought about) my trust level with each family member and their trust level with me?
- Can I identify actions/statements that convey trust or lack of trust from family members?
- Does my thinking lead me to believe that I have at least a trust foundation that motivates the family members and myself to proceed with the intervention?

6. Heart/Gut Check
- Does my heart/gut feeling lead me to believe that I have at least a trust foundation that motivates the family members and myself to proceed with the intervention?

7. Confidence in Decisions Made
- Am I engaged with the child and family?
- Are the child and family engaged with me?
- Am I feeling at least moderately optimistic that the intervention will be successful with this family?

DIRECTIONS:
As you finish your self-assessment for a case activity, rate yourself on the seven critical thinking factors. To rate, consider your overall performance across your recent caseload. The rating scale is:

+   strength
-        need improvement

CASE ACTIVITY	1	2	3	4	5	6	7
ENGAGEMENT							
ASSESSMENT							
PLANNING							

LEGEND	
1. Diligence of Inquiry	5. Discernment
2. Level of Responsiveness	6. Heart/Gut Check
3. Depth of Understanding	7. Confidence in Decision
4. Avoidance of Undue Influence	

IMPROVING CRITICAL THINKING

DIRECTIONS:
Review your self-assessment ratings for strengths and areas that need improvement. Identify 1-3 areas you would most like to improve. Write down a few actions you will take to improve your critical thinking skills and the date by which they will be completed. (Think over the resources that have been mentioned in Strengthshares; they may be useful for you to review.)

Areas of strength:

Prioritized improvement skills:

Actions I will take and completion dates: