

The Purpose of a Formal, Written Treatment/Case Plan

Treatment is not a process of trial and error, it is a logical process of problem identification, goal setting, and strategic problem-solving. Case planning provides both you and the client with an organized, realistic method of seeing the interrelationship or logical connection between a problem and how to resolve or lessen that problem. Planning makes you accountable, and enables you to understand the reasons for your success or failure and to learn from your successes and failures. Through careful planning, you are able to minimize unanticipated consequences; both you and your client know what to expect as a consequence of what either of you do or do not do.

A written treatment/case plan serves many purposes:

1. A written plan is concrete proof of your commitment to the client and of the client's commitment to engaging with you.
2. The plan communicates to colleagues, supervisors, and other professionals what is happening in the case.
3. In Ontario, a written treatment/case plan must be presented to the court if the child protection agency seeks court intervention. Section 52 of the Child and Family Services Act (1985) states in part, "the court shall, before making an order...obtain and consider a plan for the child's care prepared in writing by the society..."

Contents of the Treatment/Case Plan

A well written case plan clearly specifies:

- a) treatment goals, in order of priority,
- b) the problems that will be addressed by each goal,
- c) how each goal will be addressed,
- d) what resources and services will be utilized to achieve the goals,
- e) a timeframe within which each goal or portion of goals will be attained,
- f) who specifically will perform specific tasks, when, how often, etc.,
- g) a prognosis for each of the goals,

- h) the criteria that will be used to assess the degree to which each goal is attained,
- i) when and how you will decide when each goal has been reached,
- j) alternative methods and services which may be utilized if original plans do not work,
- k) the criteria for terminating the case plan and/or protective service intervention.

Important Characteristics to Treatment/Case Planning

1. Goals must be attainable!
2. Goals must be specific and concise vs. vague and unclear.
3. Goals must be stated in terms of specific behaviours that the client is expected to perform.
4. Goals must be clearly and directly related to a problem or behaviour that is to be changed or corrected.
5. The goals of the treatment/case plan must reflect the client's perception of the problem(s) and the client's sense of priority.
6. Goals must be measurable.
7. The consequences of what will occur if the goals are not met must be made clear to the client during the initial phase of negotiating a plan for treatment with the family members.
8. The treatment/case plan must be flexible.

SERVICE CONTRACT TRAINING INFORMATION

Numerous case management models exist to assist the social worker in formulating and focusing the treatment approach. One concept that repeatedly appears as an essential treatment tool is the process of contracting. Contracting happens at numerous levels and in many different ways. Informally, even in the most casual conversations, a contract exists, usually unstated but nevertheless understood, as to what the mutual expectations of the participants are. On the other hand, the contract may be formal written documentation of every detail, duly notarized.

Contracts between clients and social workers can fall anywhere along a continuum. The treatment dilemma occurs when the contract is vague and both social worker and client are uncertain about what is being undertaken. Consequently, it is preferable for contracts to be written and signed by both client and social worker. Ideally, the whole family is involved and thereby all would be expected to sign.

Contracting is important in achieving the following:

1. Parents and children are brought together and recognized as integral parts of the treatment process.
2. Goals are mutually determined, unless they are non-negotiable. This is because the change in behaviour must be made if it involves the safety and well being of the child as defined by the C.F.S.A.
3. Demands and consequences are clarified. For example, exact changes required of the family if the children are to remain in home are specified, as well as the requirements by the family of the agency's services and resources, and the agency's responsibility for their delivery is agreed upon.
4. Expectations regarding meetings, time limits to meet goals and the family's commitment to be active participants in the treatment process are specified.

It is crucial that you build into your agreement some problems/goals/tasks which can be very quickly and successfully resolved. Nothing will encourage and motivate the client - and the worker - like a bit of success near the beginning of the process!

Like many other techniques which you will use in your work, this one requires practice to perfect. Once you have mastered the basic requirements of the task-centered approach you will learn how to adapt it to suit the needs of the wide variety of client families which you are likely to encounter during your career in Child Welfare.

1. Goal planning is the process by which an agreement is reached between consumer and practitioner that each will perform certain tasks.
2. A Behaviourial Contract is a contract which is written in behavioural terms and has, as its goals, specific consumer behavioural changes.
3. Contracts may be of short or long duration.
4. A series of behavioural contracts and their evaluations provides a specific and measurable record of client progress.

Writing the Contract

1. Involve the consumer from the beginning. By involving the consumer in selecting the goals, he/she feels that you are working with him and this will increase his motivation.
2. Use the consumer's strengths to set goals which help with his/her needs. Attention, praise and the feeling of success in accomplishing the goals will help to maintain the consumer's motivation. These should be part of any goal planning procedure.
3. Use small steps to reach the goal. Small, attainable steps bring rapid success.
4. State clearly who will do what and when.

Formal signing strengthens the commitment of all involved.

Contractual agreements clarify and specify just exactly who is responsible for what, by when. One approach to identifying the need for contracting is to survey participants regarding the following:

<u>Questions for Client</u>	<u>Questions for Social Worker</u>
1. Why were you first in contact with this agency?	1. What was the presenting problem?
2. Has the agency been of any assistance?	2. What has been accomplished to date?
3. What are you presently working on with your social worker? Be as specific as possible.	3. Specify your current short term goals?
4. What do you hope to accomplish before concluding your involvement with this agency?	4. What long term goals are necessary for termination?

Ideally, the correlation between the two responses would be high, indicating a clear process of communication and a successful contracting of the working relationships. If the correlation is low, the need for a more formal written contract is indicated.

Two important additional features of contractual agreements are that they facilitate decisions regarding alternate plans, as well as substantiate the agency's cases which may result in court action.

Errors to Avoid in Contracting:

Some common errors which can predispose to lack of success include:

- . setting goals which are vague, general, and unmeasurable
- . setting goals which are not clearly related to specific identified problems
- . setting goals which are not realistically attainable by the client
- . failing to "partialize" the large problem into manageable pieces
- . making statements which place the client in a negative light
- . using language/format inappropriate to the client's education or intellectual level

Contracting Guide

When formulating a behavioural contract, it is helpful to go through the following steps:

1. Identify the goals that must be achieved in terms of safety and those that are not negotiable.
2. Identify what behaviours have to change to achieve this (these) non-negotiable goal(s).
3. Identify the additional behaviour you and the client wish to bring about.
4. Describe all identified behaviours, both negotiable and non-negotiable, so that they may be observed.
5. Write the contract so that everyone can understand it.
6. Measure success by observing the behaviour.
7. Troubleshoot (review and revise) the system if measurement does not show improvement. (Don't be afraid to check everything).
8. Continue to monitor, troubleshoot and, if necessary, rewrite the contract until the objectives are met.
9. Select another need to work on.

There are Five Basic Steps in Goal Planning

- FIRST Actively involve the client from the beginning.
Initiate an assessment of the person's strengths and needs.
- A. Clients should participate in the assessment and development of Goal Plans as much as possible. Plan with the person, not at or for him/her.
 - B. Number each need.
 - C. Respect the client. Treat the person the way you would like to be treated. Be certain you understand what he or she is feeling and saying.
 - D. Encourage other significant individuals to participate in the planning.
 - E. Start where the client is NOW.

SECOND Select a reasonable, achievable goal.

- A. Initial goals should be meaningful to the person and achievable in two to four weeks.
- B. With the person, select several needs which appear to be meaningful. Explain the consequences of each need, including achievement and non-achievement of the goal.
- C. Help the person select any one need to work on. He or she is more likely to be committed to the goal if involved in making the choice.
- D. State a behavioural goal for this need and reference the goal by number from the index.

For example:

NEEDS

- 1. Friendships
- 2. Housing
- 3. Homemaker Service
- 4. Employment
- 5. Tutor for Child

Need Number 3. Homemaker Service

Goal: Obtain Homemaker's service by 9/1/90

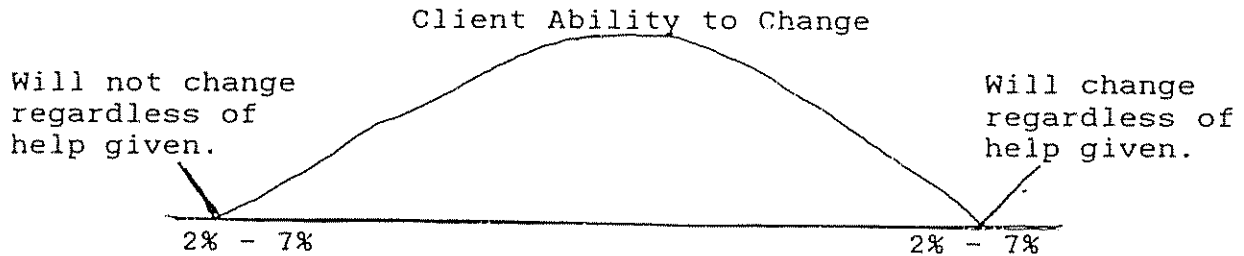
- THIRD Use the person's strengths and resources to plan the goal.
- A. Review each strength and list all the ideas which might be helpful in achieving the goal (ie. what he likes to do and other people who are willing to help).
- B. Review the ideas selected and agree on which ones are most likely to help reach the goal.
- FOURTH Spell out the steps necessary to reach each goal.
- A. Start where the client is now and select steps which can realistically be achieved in the amount of time given.
- B. The first goal should be achieved in about two to four weeks. Try to break it down into small, meaningful steps about a week apart.
- C. Each step should be considered as an achievement for the client.
- D. Be sure to include continuing plans.
- FIFTH Document who will do what and when.
- A. Describe what the client will do under the (client) section.
- B. Describe what staff or others will do in the worker section.
- C. Spell out clearly what is to be done so that a new person could read the plan if necessary and know what to do.
- D. List all the things that must be done to achieve each step. Be sure to include contingency suggestions when necessary. (This avoids depending on any one thing.)
- E. Include strategies for assuring that someone pays attention to each achievement made. (This avoids preoccupation with problems.)

ROADBLOCKS TO GOAL PLANNING

Goal Planning seems to be a very simple and obvious idea, yet many of us do not consistently use the five steps outlined. We have identified four basic reasons for this:

FIRST: We pay attention only to problems. Dealing with problems takes so much of our energy that we have no time to set goals and pay attention to what can be done.

There are some clients who will not improve regardless of the services provided and some who will improve without our help. Studies have found these two groups to represent between four per cent and fourteen per cent of most caseloads. The majority of the people we work with will make some improvement when help is provided.



Studies have shown that the majority of worker time is spent on these two groups of clients, while a minimum amount of time is given to the group most likely to use the services.

You may want to check your own caseload and time use, to see if this is true for you.

SECOND: We often do too much for clients. Many of the things we do for people, they could do for themselves. By doing for them, we often support their beliefs that they are inadequate and unable to take care of themselves.

This happens primarily because workers want to be helpful to clients, and clients often present themselves as very passive and unable to do things. Also, when we are busy it is often easier to do something for another.

THIRD: We label people as hopeless or unable to change. Labels can be useful to help understand a particular diagnosis or condition. However, many times we label someone and assume that with that label they will never improve. For example, labels such as "poorly motivated", "inadequate parent", or "child abuser" tell us little about what a person's potential is. When people are described by their behaviour, then we can more easily identify the steps necessary to make small, measurable changes, which may lead to larger and more obvious improvements.

You may want to review some of your case records to identify common "labels" used by your agency and staff.

FOURTH: We often choose goals for the client not with the client. The goals we choose may be too difficult, too large, or take much too long to achieve.

FIFTH: We often fail to check for the client's "fit" with his or her environment. Are there people or circumstances external to the client preventing achievement?

SIXTH: We often use vague language to define casework plans. Many of the terms we use to describe people and their needs are vague; they can mean many different things to different people. The result is that clients don't know what is expected of them, workers are unsure when they have achieved a goal, and casework records provide very weak evidence for court.

For example: the goal "needs to improve Parenting Skills" could apply to anything from a need to spend one hour of play time with a child to a need to provide clothing and meals on a regular basis.

CLEAR LANGUAGE EXERCISE

DIRECTIONS:

For each vague statement, write a possible goal. Remember - the best way to state an objective is to say what the person will be doing when the objective is achieved.

STATE OBJECTIVES POSITIVELY.

<u>Vague Language</u>	<u>Clear Language - Behaviourial Terms</u>
1. Improve family relationships	1. _____
2. Improve parenting skills	2. _____
3. Find adequate housing	3. _____
4. Dress appropriately	4. _____
5. Increase motivation	5. - <u>make appt. at family doctor by Fri.</u>
6. Show interest	6. - <u>read for 3 min. Mon., Wed., Fri.</u> <u>with your child.</u>
7. Respond appropriately	7. - <u>good news from school, praise child</u> <u>- notice 2 things child did this week</u>
8. Improve self concept	8. - <u>write down 2 strengths & 1 thing</u> <u>that needs to change. Treat self.</u>
9. Appropriate peer relations	9. _____
10. Decrease hostile attitude	10. _____

CASE PLAN EVALUATION

Introduction

Evaluation is a necessary and critical component of the case plan process. Evaluation is a continual process which necessitates that you repeatedly ask "how are we doing". In response, you make the necessary adjustments to your case plan.

No case plan is absolute. As circumstances and events occur in your families' lives, their priorities change; goals and objectives initially identified may have been achieved and/or may no longer be applicable or appropriate. Evaluation enables you to assess both what has been gained and what still needs to be achieved. More importantly, evaluation helps you to determine if the treatment plan is working or failing, and why.

Essential Considerations in the Evaluation Process

1. The case plan always reflects the client's priorities because the problems are his and, accordingly, the goals are for his benefit. Therefore, it follows that the client must be an active participant in the evaluation process. Your assessment of the client's perception of the case plan is critical:
 - a) Does the client seem committed to the plan?
 - b) Express anger?
 - c) Does the client express cynicism and pessimism about intervention being beneficial?
 - d) Seem disgusted?
 - e) Enthusiastic?
 - f) Frustrated?
 - g) Does the client appear apathetic and/or indifferent?

- h) Is the client showing signs of active involvement?
 - i) Is the client optimistic and hopeful?
 - j) Satisfied with the outcome of changes that have occurred?
2. Are the goals still clear to everyone, particularly the client?
 3. Are the goals still necessary, desirable or agreeable?
 4. Are the time limits realistic and clear to everyone?
 5. Is there any change in the client's motivation?
 6. Is the client still capable of making the necessary changes?
 7. Are all participants performing all of their assigned tasks?
 8. Is effective and continuous communication between all participants--the family, other professionals and you, occurring?
 9. Are the types, quality and quantity of services adequate?

Your Role and Responsibilities as the Evaluator

You are the individual who is primarily accountable to see that the treatment activities work because the ultimate responsibility for the case rests with the child protective services agency. As the person who is most familiar with the case or client, you have information about the client's progress, potential problems, and the need for revision of the existing treatment/case plan. Other professionals involved in the treatment plan are dependent on you for information and rely on your continual, objective evaluation. Though you will confer with the client/family and all professionals involved with the case regularly, you are the primary judge of whether the treatment goals have been reached or whether the treatment plan should be terminated or modified. In other words, you ultimately decide when it is safe to return a child home and/or to phase out treatment and terminate mandated intervention.

TERMINATING THE CASEWORK PROCESS

Termination is the seventh and final step in the casework process. You have been preparing for this final step from the beginning because, after all, it was the ultimate goal of your intervention.

As you contemplate termination of the casework process, it is important to keep in mind that the client/family may not have achieved the level of change that you sought but the change may be sufficient enough to warrant termination of mandated intervention. Often, the very most we can hope for is a minimal acceptable level of child care. In other words, the situation may not be as good as we had hoped it would be, but it is better than it was.

Specific Criteria for Phasing Out Treatment and Closing the Case

The criteria for termination was formulated in the goals of your treatment/case plan, and ongoing evaluation throughout the casework process has provided you with indicators of the level of progress that has occurred. To further assist you in assessing the appropriateness of termination, the following criteria should be considered:

1. There has been a reduction in the social and environmental stress experienced by the family.
2. There have been changes in the parents' individual functioning; the parents derive greater satisfaction and pleasure in their lives both in, and apart, from their role as parents.
3. The family is less socially isolated; responsive lifelines have been established; the family has demonstrated that they are able to reach out for help in times of need.
4. The parents are self-initiating; they utilize available resources.
5. Changes in the parents' interchangeable relationships and functioning have occurred. For example, a stressful relationship may have been terminated, an abusive partner may no longer reside in the home, or an improvement in the quality of the spousal relationship is evidenced in their ability to handle conflicts constructively, and in their support and positive recognition of one another.

6. The parents see the child as an individual with needs, rights and desires.
7. The parents' expectations of the child are age-appropriate.
8. The parents enjoy the child and express positive affects to and about the child.
9. The parents have the ability to tolerate the child's negative behaviour; they can tolerate the child's expression of negative feelings toward them.
10. The parents have demonstrated impulse control.
11. There has been a reduction in the child's provocative behaviour; the child responds to the parent without fear and has the ability to elicit positive parental responses.
12. The parents can allow the child to receive emotional rewards from people outside the family.
13. An acceptable form of relief from the child is available to the parent.
14. The family recognizes that some/all of its members may require further ongoing treatment and they are committed to continuing treatment as may be prescribed, without protective services intervention.

These are just a few of the areas that must be assessed when you are considering terminating protective services intervention with a client-family. Other areas requiring careful assessment will be reflected in the goals of your case/treatment plan. Of critical importance however, is your thorough assessment of changes that have or have not occurred which initially warranted protective services intervention. While a family may no longer require protective services intervention, they may very well require continuing services from other service providers. The nature and anticipated duration of additional services must be carefully negotiated between the client-family, and the service-providers, and documented in your closing summary.

