Children's Aid Society of Metropolitan Toronto

PREPARING FOR PRACTICE

The fundamentals of child protection

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CHAPTER XII

Working with Clients

INTRODUCTION

Earlier we talked about the causes (or etiology) of the problems of the families you work with, and how they are played out in the present (the dynamics). Broad categories and classifications of people are useful to scientists and researchers who study large groups of individuals in order to identify correlations among them. However, terms such as "abusing parents" and "multi-problem families" have not provided us with effective methods of helping people.

The terms interfere with the child welfare worker's need to work with individuals who have special problems, and to understand and help them in their social context. Traditional methods of "treating" others by concentrating on their intrapsychic needs have not proved to be of much help in addressing the problems of child abuse and neglect. In the helping professions, our eagerness to maximize the potential of humans with emotional problems has often led us to set such broad aims, such vague and high goals that no one knows how to realize them. Human behaviour rests on many other things that happen to people than simply our "treatment", and the word itself implies something done to another who may have a quite different agenda from a worker's. (Epstein, 1980)

One newer method that attempts to address these difficulties is the TASK—CENTRED APPROACH. Sometimes people call this approach "contracting", however contracting is actually only one step of the task-centred approach.

The method allows you to address what have been identified as the two components of most people's troubles (Epstein, 1980):

- The lack of resources for alleviating a problem.
- The lack of skills for alleviating a problem.

These two components are analogous to the environmental and personal aspects that have been identified by others. Your action in a case is called intervention (getting between the client and a situation to cause changes) rather than treatment (doing something to a passive recipient).

One of the leading authors on the subject is Laura Epstein. She identifies the major qualities of the method as:

Structure:
A strategy that pins down how you start, what you will work on, the terms and conditions of your interventions, the end goals and the results.

Specificity:
Sharply defined goals and actions for each of the people involved that are always clearly connected to the problems each identifies.

Congruence:
A coming together of worker and client opinions about problems and interventions that cuts down on the drop-out and failure rate.

The current research has found these three characteristics of interventions the most likely to produce effective outcomes. The same characteristics are beginning to be used in other, more traditional, social work approaches also.

There are some situations in which it is more difficult to use an oral or written contract. These include extremely disturbed people, very retarded or brain damaged people and intoxicated people. All of these can be expected to distort verbal information, making it difficult to reach agreement on terms. (you may also try and find others involved and responsible for the client with whom you can contract.) Some clients cannot read and written contracts cannot be used. Some methods of dealing with these situations will be described later in the chapter.

CONTRACTING IN CHILD WELFARE:

Over the past decade the method has been widely and effectively used in a variety of voluntary settings, and there is now information about how to adapt the model to work with involuntary clients such as in the field of child welfare. (Seabury, 1979).

It is not easy to effect changes in parents' behaviour that are the result of differing attitudes toward their children's care. Most of the parents you will see did not request the service you are bringing. Abusing or neglecting parents tend to be emotionally inaccessible. They often break appointments and it is difficult to empathize or like them when you know what is happening to their children. At least at first, they are usually resistive to social work contacts and can be very hostile and angry about any attempts to intervene.

Your expectations in these cases will have to be much more limited than with voluntary clients who come asking for help. The goals are limited and gains may be small throughout your work with them. In the field, there is high anxiety because there is little certainty about how to control actions that are dangerous to children. Unrealistic expectations and ambiguous goals are quite pervasive among both the professional and public sectors. These work anxieties can be better coped with by adopting realistic expectations and by clarifying and specifying goals. Using a more specific framework will help you, the client and other people understand what can and is being done, and to judge whether it has value.

A certain percentage of your clients will show some improvement in response to the authority of the community and the legal structure you represent. When parents change their behaviour only in response to this authority they are merely being compliant, and may require the constant supervision of others to continue to comform. Although authority is always an inherent **PART** of your approach, you will want to aim for your client to change behaviour because he has achieved some **INNER** conviction that the new standards have better consequences for him than the old ones. Used correctly, the contracting method is effective in producing more involvement on the client's part, because it ensures that you listen to him and what he experiences as problems.

Using the contracting method is more difficult with involuntary clients than voluntary—but so are all methods. The principles are especially important in this field, because of the relative powerlessness of a client in the face of a mandate that can be used punitively by others. The method stresses honesty, clarity and respect for the client on your part.

ENGAGING THE CLIENT:

This material is summarized from a chapter by Brett Seabury in the *Handbook of Child Welfare Services*, to be published by Free Press, New York City; editors, Laird and Hartman.

During the **INTAKE PROCESS** you went into a case to investigate the situation. You had to:

– establish the presence or absence of abuse or neglect.
– assess the severity.
– assess the present danger to the child.
– make some immediate decisions about whether to remove the child or leave her at home while you intervene.

In the process, you will have made beginning judgments about the parents' situation and their responsiveness, willingness, and ability to work with you.

Now that you have an open case, your task is to engage the family in a working relationship in order to define the problems and set goals.

In child welfare services a working relationship cannot be taken for granted. Social work literature (Biestek, 1957; Perlman, 1979) tells you that the ideal conditions for a good working relationship are:

- trust
- mutuality
- acceptance
- respect
- caring
- positive sentiments

YOU are expected to be empathic, sensitive, non-judgmental and the client will then feel secure and willing to share his innermost feelings and thoughts with you. Under these conditions, plans can be made together and work on the goals will proceed because you have achieved a "good working relationship".

In child welfare services, you are not likely to have the ideal relationship of a voluntary therapeutic encounter. Instead your initial contacts are likely to be characterized by:

- guardedness, (reluctance to share information)
- avoidance, (desire to leave the relationship)
- strong negative feelings, (anger, hostility, suspicion, guilt, despair)

You may well begin by not liking each other and it is probable that you will not develop a very high degree of mutuality and strong positive feelings about each other. Although in some cases these may develop, it is more realistic to expect only that at best **HONESTY** and **CLARITY** will be the essentials of your working relationship.

To achieve even these two, you will need to address certain practice realities that will be part of all your child welfare practice with clients. There are five major sources of conflict and confusion in building this relationship:

- common negative feelings
- clarification of purpose
- potential role problems
- authority
- demographic barriers

COMMON NEGATIVE FEELINGS:

The sources of the negative feelings have to do with what people feel about giving and receiving any kind of help and the feelings that people have about the removal of children by an outside agency.

Giving and receiving help in North American culture:

The **HELPERS** often like their role. They feel responsible, respected, valued, and more powerful when they give help. The **RECEIVERS** often feel guilty, helpless, scared, or unworthy. It really is "more blessed to give than receive" in our culture.

Removal of Children:

Removal, or even the threat of removal, may generate feelings of loss, failure and guilt, or anger and rage in parents. These are real and expectable reactions for parents in this situation. The feelings are compounded by any previous difficulties with self-esteem and self-worth the parents may have.

If the "helper" is punitive the probability of a working relationship is lessened.

How do you get past these negative feelings to begin to engage your client? First, it is necessary for you to assume responsibility to recognize ar[illegible]al with these feelings as they come up.

You need two basic skills to succeed:

— A "thick skin": the ability to take the brunt of negative feelings in the beginning.

— Empathy: the ability to recognize some subtle and not so subtle expressions of these feelings and to help clients express them.

Don't:	**Do:**
— become defensive	— allow and facilitate the ventilation of negatives
— counter attack	— recognize them as appropriate under the circumstances
— avoid confrontation about the negatives	— tell parents you still want to work with them when they have expressed anger

In so doing, you will demonstrate that you understand and accept the parents, and that you're still willing to work with them even though the negative feelings are there.

CLARIFICATION OF PURPOSE:

Purpose is the "why" issue in child welfare practice. Why are services offered or imposed? Why do you choose certain interventions?

There are four general purposes that usually apply to your cases:

— **Permanent families.** A primary purpose is to ensure that children have a permanent family in which to grow. Ideally, this is with the biological family but if this cannot work out, it will be with a **SUBSTITUTE** family. This means your services are not designed to break up families, but to strengthen and reinforce them.

— **Protection:** Protection is important but it is a temporary and narrower purpose because it should always be accompanied by a plan for permanence for the child who has to be removed.

— **Problem solving interventions.** Problem solving interventions should also be used to answer the "why" you're there. Helping the family identify problem areas, improve linkages to its environment and its own internal relationships not only helps them find answers now but also strengthens the unit for the future handling of stress.

— **Prevention.** Prevention is another reason for working with these families. Hopefully the experience of working with you will make the family better able to cope without the need for child welfare services.

When you are seeing families for ongoing work, state explicitly why you are there, state it positively and state all aspects. For example:

"I am here to help you see that Jinny doesn't get hurt (or go hungry), (or to deal with what led to Jinny being removed). I want to help you change those so that she can stay at home (go home), I want to help you identify the problems you are experiencing and to help you find and use whatever resourc[illegible] would help."

The family may not believe you at first. Look for their reactions and allow them to say what they feel and why they think you are there. It may take several interviews and you may have to actually demonstrate it by doing something helpful before they believe you have any **BENIGN** purposes.

POTENTIAL ROLE PROBLEMS:
The third source of conflict and confusion is in potential role problems. The parents may be very unsure of what is expected of them, you, and others (such as foster parents), or their expectations may be very unrealistic.

When you clarify expectations they may disagree with your view. Research has shown workers and clients are often far apart in their role expectations, and clients may terminate service early because of the confusion, anxiety and dissatisfaction they feel. This is even more likely when you do not bring these expectations to the surface and clarify them.

You can get past this difficulty by paying attention to it early in your contacts.

Since each of the people involved has a view of herself and the other, there are four sets of **EXPECTATIONS** that must be clarified in each 2 person interaction.

	Parent's Expectations	Your Expectations	
of herself	— unsure of what her role is — deny she has any role in it (it was your idea, you tell me) — or may be apathetic — or passive	— the parent will share problems with you — or be actively involved — or visit placed children — or help solve problems	of the parent
of you	— fears of your power to remove child or to find other things wrong — or may think you're a paper-pusher, a court clerk — or you can cure the problem magically	— you will be helpful connecting family to services — monitor progress — report to court — facilitate problem solving	of yourself

Role clarification involves three steps:

- spelling out the different expectations.
- comparing and identifying the discrepancies in expectations.
- negotiating, compromising and reaching agreement on them.

In the first step, it's important to ask the parent first to state (or write) what she expects of you and what she expects to do herself. Help her get clearer about what she is saying.

Once the parent has stated her understandings, you state yours of yourself and the parent.

In the second step compare quadrants 1 and 2—what the parent expects of herself and what you expect of the parent. Then compare quadrants 3 and 4— what she expects of you and what you expect of yourself.

This should uncover any conflicts and confusions between your viewpoints. Acknowledge the differing views, bring them clearly into the open. You can't move to the next step until the differences are clear. Do not allow parents to "sell out" to your authority by accepting only your view. Legitimize their view; help them to express it and accept it from them. For example:

"I hear you saying you don't agree; am I right?" "Let's look at how **YOU** see this." "I see what you mean".

The final step in role clarification is to obtain some degree of mutual agreement about the roles of each.

Sometimes the parents will have few expectations of themselves **OR** you. If this happens, **EDUCATE** them in what to expect. Even if this is all you achieve, it is valuable in clarifying potential confusions. When there are court orders or certain administrative details that are already a part of the case, let them know those parts that are **NOT** negotiable. Some items are negotiable, but you may have to impose eventual time limits. For instance #1, below, cannot be negotiable ad infinitum.

Separate the legal issues from the negotiable items. On negotiable items it is always preferable for the parents **NOT** to simply accept **YOUR** perspective. For example:

Negotiable:

1. How fast to work on the problem.
2. What problem to work on to gain stability.
3. How often visits take place and where.

Non-negotiable:

1. Worker has to report to court.
2. Child will be in care until family is stable.
3. Child will be in foster care.

When you use this matrix, you can repeat it with each parent separately or ask the parents to discuss their views and put down one common view.

You can also extend the matrix to include another column when a third party such as a foster parent is involved, and ask each of the parties to state their role expectations.

AUTHORITY:
A fourth practice reality that will make it difficult to engage your clients is that of authority.

Your clients recognize that you hold some authority in your position. You can "snoop around" and "tell" on them to an even higher authority. They also may not distinguish between your authority to monitor and the court's authority to make decisions. Many of them have had experiences with other public service organizations that made them feel harrassed and embarrassed.

They may well have more severe problems with authority than most of us. Your intervention is the final insult; it is viewed not as a resource for help, but as an interference, a social control.

Don't expect **THEM** to take responsibility for dealing with this issue. You are going to have to help them cope with it. To do that, **YOU** must have some degree of comfort with authority yourself. You must be able to recognize you represent some authority and you will use it fairly. Remember the "honesty and clarity" when you discuss it.

Some common tactics workers use with the authority issue are:

- — Denial that the worker **HAS** any authority. (I have no decision making power, I'm totally for you, I don't decide anything, the judge does it all).
- — Blaming or ordering the parents—insisting on compliance to worker's rules only. (You have to visit every week, you must go to a clinic).

Of the two, it is easier for clients to deal with the second approach than the first. At least the second is honest.

Don't promise that you don't hold any authority. You know your recommendations and reports and your oral evidence in court will at least influence the decisions made.

Be cautious—don't promise complete confidentiality. Your discussions may surface later in court actions; material they have shared with you may be used against them. Remember the principle of honesty and clarity applies here. Clients should **NOT** hear you testify in court about anything you have not already discussed with them. (See "Court" chapter.)

DEMOGRAPHIC BARRIERS:
The fifth area of difficulty in achieving your working relationship will be the demographic barriers between you and your client.

Differences in age, sex, race, culture and social position create strain in establishing rapport with clients, especially at first. The visual ones spark off stereotypes immediately, before anything is verbalized. It is not likely th[illegible] matching" of client and worker will always be done and it is

therefore important to address the differences early; don't ignore them. (See "Cross Cultural Counselling" chapter.)

Check out how **MANY** differences there are between you in these areas: race, sex, age, family position, and ethnicity, or culture.

Follow through on clues the parent gives:

Parent: "Are you married?"
"Do you have children?"
"I didn't expect someone so young."

Pursue these:

Worker: "No, I'm not. You must wonder how I can know anything about it then."

If the parent doesn't mention the differences between you, bring the ones up you think are most critical—age, sex, or race, for example.

Worker: "Sometimes it's hard to work with someone who seems very different from yourself. For instance, maybe you were surprised to get a Chinese worker."

Try to find out what kinds of impressions the parent has about your differences—what will happen because you are different. Supply any information that might help them alter their impressions.

If the attitudes remain on their part, it may be prudent to get the parent better matched with another worker.

DEFINING THE PROBLEMS:
Defining target problems is part of the task centred approach and other contracting approaches in the recent literature. Laura Epstein says:

"Practitioners are decision makers who need to have a practical plan so that they can carry it out and help people cut down on their problems."

Before you can begin to set goals and plan practical interventions that have effective outcomes, you will need to have identified the problems that will be worked on. These are called target problems.

In child welfare services, there are two important sets of target problems:

- — mandated problems that you bring to the client's situation from the agency or court.
- — client's definitions of his problems.

The interventions that work best are tied to the problems that the **CLIENT** defines. He really only has much motivation to work on those problems **HE** targets. They are the ones relevant to his life system, where he is connected and grounded. Unfortunately, you can't work only with those; you have mandated problems that need attention too. Your task is to bring the two kinds together and aim for some degree of merging or [illegible]erlap of them. You want to allow the client as much self-determinati

as possible while you are involved; you want to offer a service that has real value to him; and you want him to have as much parity as possible with you in working on the problems. All of those mean that you will need to understand **HIS** context and the problems **HE** will define and target, as well as the mandated problems.

When you work with a voluntary client it is not difficult to get him to state what problems he believes he has and what he is willing to work on changing. You may have to help him clarify target problems he wishes to work on, but a voluntary client can almost always come up with reasonable definitions of problems that the two of you can agree to try and change. If your client proposes to change a problem in a way that you believe is trivial, immoral, or illegal, you can refuse to go along with his suggestion.

In child welfare cases, however, agreement about what problems to work on is more difficult to come to. Your clients are faced with certain mandated problems that you present to them. They do not have a choice about dealing with these in some way, but they may not agree that they are really problems and may have their own differing views of what is wrong in their lives.

You say:

"You cannot leave your young children without supervision."

The client says:

"I can't stay home all the time. The kids ought to be better behaved and take care of themselves and not cause problems for me."

There are certain steps you can take to acknowledge both sets of problems and gain some understanding and congruence between you. When the client is faced with a mandated problem, it is up to you to first help him see what the consequences will be if he does not choose to do something about it. Then help him draw up a list of actions he can take to avoid the negative consequences. For example:

Consequences:

— The children will keep getting hurt because they aren't watched.

— Neighbours and others will keep calling the agency.

— I may have to recommend to the court that the children come into care.

Actions:

— You can watch the children yourself.

— You can get someone else to watch them.

— I can help you make day care arrangements for them.

The mandated problems must be clearly identified by you, but you can see the parent has problems he is identifying also. Don't ignore or deny them. Draw up two parallel sets of target problems—one mandated and one as the parent sees them:

Mandated Problems:

— The children are left unsupervised for hours.

— The children do not attend school.

— The children are not fed and clothed adequately.

Parent's Target Problems:

— I can't stand being shut in the house with them all the time.

— I can't get them to school.

— They must behave better.

Once the parent has stated his definition of the problems, help him phrase them in a very concrete way so that they can be developed into statements of what is to be changed.

For example, "the children must behave better" is too broad and abstract a statement to plan actions for. Instead, "the children fight too much with me" allows for changing a concrete situation.

"I can't stand being shut in the house all the time" is also too abstract a statement. Instead, "I have to have some time away from the children each week" is a concrete description of a problem that can be tackled. It allows for goals and tasks to be set as you go on.

After you have explored them with the client, his problems can be stated very specifically. The two lists now read:

Mandated Problems:

— The children are left alone for hours.

— The children do not attend school.

— The children are not fed and clothed adequately.

Parent's Target Problems:

— The children fight with me too often.

— I can't get up in the morning to get them to school.

— I have to get out of the house without them sometimes.

In the process of defining target problems with clients, you will do a great deal of discussion. During that discussion you will be exploring the problems and finding out information about the social context of the problem and the client's characteristics. These will shed light on who these clients are, what socio-economic conditions they live in, and how much these are responsible for the problems. Most of the information about the client that you need can be found in your observations of his behaviour. Is he timid or aggressive, trusting or suspicious, calm or angry, logical or irrational? You are looking for gross indications of what behavioural characteristics and environmental stresses are bearing on the immediate problems.

You can find out also what previous problem solving has been attempted recently by the client. All of these explorations will give you a rough gauge of what opportunities exist for problem solving.

SETTING PRIORITIES AMONG PROBLEMS:

In the task-centred approach, it is suggested that you settle on not more than three problems to be worked on at one time. This limit is recommended in order to keep the tasks to a manageable number and to structure them according to the highest priorities of the mandated and client problems.

Whether you stick to the rule of three or not, keep in mind that you will want to keep your list to a feasible and manageable one. It is confusing and overwhelming to work on too many things at once. You can always start to work on another set later if it is indicated.

For example, using the two previous lists of mandated and client's problems, pick some (with the client) from each that have the highest priority. Keep your most important mandated ones and include the client's most important. Your combined list could now read:

— The children are left unsupervised often.

— The children are not fed and clothed adequately.

— The parent does not have time alone away from the children.

You now have three target problems that are clearly specified and can lead to agreement on goals and determine the interventions and the tasks that each of you will do.

The goals follow logically when the problems are clearly stated:

— To provide supervision for the children at all times.

— To provide the children with winter clothes, two nutritional meals a day, and clinic appointments.

— To arrange for the father to have time each week away on his own.

You can now move on to making a contract, or agreement, about what will be done and by whom.

CLUES ABOUT SETTING GOALS:

There are several types of goals in any social work setting: agency goals, professional goals, personal goals, and client goals. You will need to understand and differentiate between them in order to use goal strategy effectively with clients. Epstein describes them and their characteristics in the following way:

Agency Goals:
These are related to your agency's formal structure. They are the broad and abstract goals of the organization as a whole and reflect political aims,

Professional Goals:
These are long range, philosophical opinions by professionals in the field about what is of value to people and society.

Personal Goals:
These are your own opinions and biases about what you want to do.

Client Goals:
These are aims your client wants to achieve. They may be congruent with some of the agency, professional, or personal goals you hold, but they may conflict with many of these too. Even in mandated or non-voluntary agencies you can usually get some congruence between the client's goals and mandated goals. It is easier to achieve this if you understand that unless client goals entirely violate the broader goals of the other categories they **MUST** help determine the individual case goals. This implies that while you will not lose sight of the other goals, you may well have to relinquish many of them if the client wants something different. If your client's goal is in contradiction to yours, get the conflict in the open and discuss this. If it is in contradiction to a mandated goal that cannot be altered, make that clear and see if by discussion you can get the client to alter his goal.

In addition, goals must be:

- directly related to an identified problem.

  Wrong: Bobby needs counselling.
  Right: Bobby's fights with his mother are to be cut in half.

- stated positively.

  Wrong: The G. family needs assessment of their problems.
  Right: The G.s are to be supplied with pick-ups for special school and the clinic for Terry.

- stated from the client's viewpoint rather than the agency's.

  Wrong: Supervision or placement of the children may have to be in place for the children while their mother is away.
  Right: Temporary foster care is to be available to Mrs. L. in case she has to have emergency surgery.

- stated clearly and very specifically.

  Wrong: Improve client's social functioning. Help family get along better. Work on marital relationship.
  Right: Increase social contacts outside the home. Discipline Johnny verbally rather than physically. Arrange one evening a week when parents get away from rest of family and talk together

- be measureable

"Increasing the client's social contacts outside the home" is something you can both measure.

- be realistic.

Setting, or allowing to be set, unattainable goals is a real disservice to you and your client. Your clients often have a history of failure to achieve. You also need to experience success in this difficult field. It is better to err on the side of slightly too easy goals than too difficult ones.

In their enthusiasm to help, new workers sometimes set goals for clients that reflect their own biases or idealism about potential and achievement. Don't promise things in your agreement with the client that you cannot do, or a resource that you cannot provide—remember it is important to be consistent and dependable.

Partialize; break large global problems into small steps that can be tackled one at a time. Help clients rehearse what they will encounter in each step—make it real for them by acting it out in role plays—let them play themselves, you play the other person.

WHAT IS A SOCIAL WORK CONTRACT?

In direct service work, a contract is simply an agreement to do something. It's really only a modern version of the older and conventional practice wisdom that says you need to get some kind of client-worker agreement about what you are seeing each other for, and what will be done.

Written and oral contracts are both in use presently in a variety of settings.

Written contracts are useful when you are concerned about holding staff, clients, or collaterals to specific commitments and you believe it won't happen unless everything is clearly written down. The written contract can take more time in the beginning but some experienced workers believe they save time in the long run because the details are more fully worked out and there is less digression as the work goes on.

If you use written contracts with **INVOLUNTARY** clients, they must be told certain things about them. A written contract can be used to prove that a client has achieved a goal well, but **FAILURE** to achieve the goals of a written contract can be used against him. Failure to perform may be construed by the court, for example, as inability to perform as the court thinks the client should in order to return a child. This has happened at times.

Don't **ASSUME** your client can read and understand a written contract. Check out whether he can read and whether he knows what the contract means—if he can read, ask him to explain in his own words what you have written.

Written contracts should never be used by the worker as a rigid, unchangeable way of pushing the client to an unrealistic goal or a quick and abrupt ending of contact. they must be realistic and open for negotiation. Remember that involuntary clients tend to be more vulnerable, affected by a wide range of stresses, and powerless. If they agree to goals they cannot achieve in a contract they can find themselves punished for failure to carry it out.

Good oral contracts should and can be as specific as written ones. They are really semi-written because they are incorporated into the agency recording as an agreement between you and the client. Show your dictation on the agreement to the client before entering it in recording, your client can initial it to show he has read it.

You can use oral contracts with the same advantages as written ones, and they are easier to adapt and revise than written ones, so long as you are equally careful about the clarity, specificity, and focus.

HOW TO MAKE A SOCIAL WORK CONTRACT:

In child welfare practice, primary and secondary contracts are both used. They are both equally as important for your results. Good working relationships with foster parents, placement institutions and other resources are a vital part of what happens to your client.

A primary social work contract is a working agreement between client(s) and worker(s) about the terms of interventions.

A secondary social work contract is a working agreement between the worker and the other people about services they will offer to the client. These may include foster parents, other staff or services inside your agency, or people outside the agency. (Seabury, 1982).

Ideally, the contract agreement you make will have some elements of the mandated problems you bring to the situation and some of the client's own targeted problems. If you can get this degree of mutuality, work for it. The ideal contract is a mutual agreement.

This may not be possible because the client simply defers to your authority, or because the client really disagrees with the mandate the court makes about the care of his children. In the first instance, you and the client may never really know the client's wishes until he fails to carry through on some part of the agreement. Once he does fail, he may be better able to express his conflicts with you, and you can start to contract in earnest. In the case of client disagreement with a court mandated problem, you may still be able to work with the client on a contract that captures the terms of **HOW** that problem will be solved. Even court mandates often give the client some discretion about **WHAT** tasks and **HOW** tasks are to be done. For example:

> The court may decide the child goes into care until the child care arrangements are improved in the home. Your contract could negotiate and set goals for how that improvement will be achieved

Some child welfare projects have not used written contracts at all, but have adapted the principles in innovative ways. In one, workers used strategies similar to contracts by developing task lists or calendar check-offs with their families. (Knapp, 1980)

In another, the usual timing of contracting was modified. The workers used early contacts to develop a working relationship, to engage the client, and they helped them look at and understand better the reasons they had not used services and resources in the past. Once that had been done, they were able to establish formal contracts with the families. (Michigan Special Family Services Project, Michigan, 1981).

With clients who cannot read you might, for instance, develop a task list with cut out pictures (instead of a written list) for each task to be completed.

Be innovative about the ways you can adapt the principles of the task-centred approach.

In the actual contract, there are eight basic parts. (Epstein 1980).

The Contract Element	**Example**
1. Specify the priority target items.	The two participants are Ned, 14 and his mother. Ned is living in a group home at the time. Ned says: "My mother listens to my big brother too much and too many people tell me what to do when I'm at home." Mother says: "Ned keeps bad company; he stays out too late and he runs away when I make rules." Mandated: (by court) Minor needs supervision; (by agency) mother is too strict, has unrealistic expectations of teen age behaviour.
2. State the specific goals that the clients want and you can agree to.	Mother and Ned both want him to live at home. Worker agrees. Ned is to be returned home and to enroll in school. Ned and his mother are to agree to a set of rules for him. Brother's interference is to stop.
3. State the client's general tasks.	Ned will decide what school subjects he wants to take and will start enrollment procedures. Mother will decide on latest possible curfew time and two other rules she feels are most important. Ned will tell her in return how he will report to her. Mother is to limit brother's interference.
4. State the practitioner's general tasks.	Arrange vocational aptitude testing for Ned. Get all available material on courses for Ned. Confer with brother about conflict with Ned. Prepare court recommendation for Ned's discharge from group home. Negotiate Ned's re-enrollment with the school.
5. State duration of intervention tasks.	Two months.
6. State schedule for interviews and locations.	For Ned: Eight interviews, once a week (dates); four in office, four at home.
7. State schedule and content of interviews.	Week 1 and 2: curfew planning and other rules. Weeks 3, 4: decisions and planning for school. Weeks 5, 6: decisions on extent brother will be involved. Weeks 7, 8: any parts of the above that show the least progress.
8. State parties who are to participate.	Ned, mother, brother, group home staff, worker.

CLUES ABOUT CONTRACTS:

Keep your target problems down to a manageable number.

Include any mandated ones that you cannot change.

Avoid jargon, use the client's language (well, within limits).

Keep your phrases re detail short—don't use explanations, descr

When you have several participants, get each person's view of problems, separately first, then work together in the group to get consensus on the problems. (Air the conflicts about them, work them through, get some agreement).

GENERAL tasks are those stating the direction of the action: "Ned will start enrollment procedures". They do not spell out exactly how they are to be done. A general task may include more than one action. A general task **MAY** be the same as the client's goal—it will **ALWAYS** lead you directly into the goal. The goal states what the condition will be when the task is done. "Ned will be enrolled in school."

OPERATIONAL tasks are those that say **EXACTLY** what is to be done. They are sub-tasks of the general tasks. "Ned will go to school and talk to the Principal", or "Keep his appointment for testing."

When you are planning tasks, find out from the client what s/he thinks s/he could do to resolve problems. Clients will usually state sound ideas when they feel their ideas will be respected.

You will be responsible for introducing ideas if the client can't seem to think of any, and to help modify the client's ideas to be more realistic if necessary. If you have had experience with someone else in a similar situation doing something that worked, say so to this client. Help the client think through the steps to a task. "What will happen when you talk to the Principal? What then?" Walk him through it so he becomes more familiar with what will happen. Role play and rehearse the sequence with him to help him anticipate and prepare.

William Reid has devised a "task implementation sequence" that is a very effective way of helping a client rehearse an agreed upon task. It can help assure that tasks are completed. There are five steps:

1. Enhance commitment.

   Ask the client to tell you what good things will result from carrying out the task. Reinforce the benefits she thinks of and add any she misses.

2. Plan the implementation.

   Ask the client to tell you how she will carry the task out—help her develop an exact plan, encourage and suggest other steps along the way.

3. Analyze the obstacles.

   Ask the client to consider problems she may encounter along the way. If she can't think of any, suggest by saying "What if (this) happens?" In this step you may also probe for possible negative consequences the client may face and suggest psychological obstacles that may interfere. Clarify all these and suggest ways of handling obstacles.

4. Model, rehearse, and practice.

   Ask the client to rehearse what she will say or do in the steps she takes. For example, you play the clients's boss, and the client practices asking you for time off. Then switch roles, and model ways to ask.

5. Summarize.

   Restate the task and plan. Make sure the client has a clear idea and indicate you expect the client to try to do it.

Contracts should be kept to fairly short time periods. They can be extended if it is necessary. Don't push unrealistically short times, but be aware that shorter time periods tend to mobilize people earlier.

A WORD ABOUT EMERGENCIES:

You may ask "why make a specific and structured plan when so many things happen that make it impossible to see it through?"

One difficult aspect of child welfare work is the number of emergencies and ultimatums that clients go through. Your best laid plans, where you thought you had agreement and things were rolling along toward goals, are apt to suddenly fall apart.

A teenager runs away just as he is about to be placed back home, a resource you have lined up falls through, a parent calls to say "I'm not taking that kid back home after all", or a judge adjourns all his cases for a month's conference away. You can't always foresee the difficulties, but you can expect they'll be part of your work.

Your work on the target problems and attention to the client's goals will help to forestall a lot of them. The structure of the contract will help point you and the client back toward what can be done now rather than lengthy, discouraging analyses of **WHY** it happened. You can refer to the contract when you talk to the client:

"What didn't I understand that you were telling me?"
"What did you want to happen that you didn't tell me?"

A contract helps keep you and the client focussed on the **WHAT** and the **HOWS**—action questions, rather than the **WHYS** that represent inaction.

Remember that setbacks are common in most plans with clients. A contract doesn't guarantee that they won't happen, it only facilitates your staying on track and getting back on track when derailments occur.

Cases on a monitoring status only, or follow up, often have emergencies. Your schedule should include some leeway to allow for attention to urgent problems. Use quick problem specification, short but intensive activity to arrange for lessening the stress, and terminate the episode, going back to monitoring only.

SPECIAL PRACTICE TECHNIQUES IN CHILD WELFARE:

If you are using the task-centred approach in your work, you will want to adapt it to some of the things we know about situations in this field. Don't "throw out the baby with the bath water" when you turn to a newer approach. The more businesslike approach of the task centred method can help keep you focussed, but it does **NOT** mean you should become brusque.

As has already been mentioned, you can adapt the method of contracting to oral contracts that are well done, or you can use the problem defining and the task setting parts to make a modified form of contracts: time limits and goal setting. Once you have more familiarity with the very structured method, it is not hard to modify and adapt it. The **PRINCIPLES** are important; however used, they are the same. It is very important to understand the reasons why a step is used and structured the way it is before you change it in order not to lose the whole meaning and direction of the approach. One way to become familiar with it first would be to use it with one or two of your simpler cases and use **ALL** the steps. You can then begin to adapt it to some of the more complex cases.

Aside from adapting the model to your particular situation, there are some things that have been developed or discovered that have become a part of the practice wisdom of this field. They are not mutually exclusive to the task centred approach. Many of them are techniques that can be used along with contracting.

The timing:
It is generally accepted that the more difficult cases in the field need a longer intervention time period than the two to three months that the task centered approach advocates. Nine months to eighteen months is a time period often named as most effective. If you do not feel that making a contract for that time is a good approach, break the segments of work into smaller time periods of tasks and goals, complete the first part and move on to contract for the second section. You can tell the client you are doing this:

> "We won't get everything taken care of in the next two months; probably it will take longer but let's take these three problems first before we try to get the others worked out."

Partializing the enormous problem this way is known to help contain anxiety and have a mobilizing effect; and it gives you and the client a chance to experience some success. The problem is not so overwhelming this way.

Techniques that have been used successfully:
Alex Zaphiris, of the School of Social Work, Houston, Texas, speaks of the value of using a **"foresight increasing"** techniques with clients who have abused their children. Rather than trying to get "insight" (the process of gaining understanding about one's intra-personal problems that cause actions) using this technique enables parents to gain some controls on abusive behaviour. For example:

"Mr. J., What happened just before Bobby got hurt?"

"What happened fifteen minutes before he got hurt?"

"What happened an hour before?"

SAY IT NON-PUNITIVELY.

Keep doing this consistently through your contacts each time you see n[illegible]juries. After several months of working with a parent and using

this "re-ordering" of the past experience, clarifying it over and over, a parent is often able to make connections and say:

> "I am striking out at the child when other things happen that get me angry or upset."

This kind of admission and connection leads to a self-awareness that has much more lasting effects than your telling him what he is doing.

Expect some **dependency** on you. Once a client accepts and trusts that you have given some help, you may well find a somewhat dependent, clinging or demanding behaviour from the parent. You will need to tolerate some of this for some time before this stage can be dropped. Do not promise actions or appointments that you cannot fulfill. If an emergency arises and you cannot keep an appointment or promise, call the client and tell him you are getting someone else to do that thing for him and you will be there just after, or the next day (as soon as you know you can make it thereafter).

Use Concrete Services With Clients:
Focus on concrete needs such as food, clothing, housing especially at first. You can't work on other problems when stomachs are empty.

Accentuate the Positives:
Find positive things clients do to praise, no matter how small they seem to you.

Be very organized and regular and dependable about your contacts, promises, and visits. Be persistent in the face of rejection on their part.

EVALUATING PROGRESS:

In order to evaluate the effectiveness of the interventions you are doing, monitor **WHAT** you did and the **RESULTS** of what you did. You will be trying to test, confirm, and substantiate the effects of the intervention. This is not the same as scientific research, but it does make for more efficient and accountable practice.

At each interview, check the following (Epstein, 1980):

- Task performance.
- Problem status, any changes for better or worse.
- Any new or revised problems.

This kind of simple, common sense approach to evaluating your work is not difficult in the task centred approach, which lends itself to easy monitoring.

AS YOU MONITOR:

Partial or minimal achievement is a signal to look at what obstacles there are to the planned intervention. Tasks may need revising if they have been attempted several times and have failed to be carried through.

Revise the whole contract if the progress is unsatisfactory, if new p[illegible]lems arise, or if the old problems take on significantly diff[illegible] characteristics.

Below is a simple case monitoring chart. (Epstein, 1980, p. 236).
(Use a check mark to indicate which applies).

1. task performance	complete	substantial	partial	minimal	no opportunity
task #1.	☐	☐	☐	☐	☐
task #2.	☐	☐	☐	☐	☐
task #3.	☐	☐	☐	☐	☐
2. problem status	**no longer present**	**considerably alleviated**	**slightly alleviated**	**no change**	**worse**
problem #1	☐	☐	☐	☐	☐
problem #2.	☐	☐	☐	☐	☐
problem #3.	☐	☐	☐	☐	☐
3. problem altered:			**Explain:**		
problem #1.	______				
problem #2.	______				
problem #3.	______				

In the chart problem **STATUS** means, 'is the problem that was targeted better or worse?' If it is considerably alleviated, you have success. Slightly alleviated is **NOT** a failure. If the problem status is "no change" or "worse" category, take a look at what is happening in the client's environment. Start with checking the client's health, deterioration around the client, hostile actions from the family, authorities or friends. Look for adverse effects of agency programs or the courts. If there are **NO** explanations that seem connected, and the problem is worse, don't keep using the same interventions.

When tasks don't get done, look for obstacles that occur to hold up their completion. Some of these are:

- — the client lack resources: housing, child care, money, etc.
- — lack of reinforcement from peers, family.
- — lack of skills—not knowing how to do something effectively.
- — the client may hold adverse beliefs, may believe the task has little value or even negative consequences.
- — lack of skill on the worker's part, or biases that lead to negative attitudes by the worker handling the case, or other collateral staff attitudes.

A Word of Caution:
EXPECT to have slow downs, failures at times. You will not have spectacular results. Real and supposed new problems are all **ORDINARY** occurrences during the process of your work.

Termination:
Be very organized and regular and dependable about your contacts, promises, and visits. Be persistent in the face of rejection on their part.

Once the situation is better, do not back out too quickly. There should be follow through for a time even if the child is not getting hit, because the child may well begin to act out himself. This stage could cause relapse in a case that has so far gone rather well. When you do terminate with a case you have been with, let the parent know he can call you if he needs to, even though you have stopped seeing him.

Your clients will normally have only come somewhere close to reaching the goals that were set in the beginning. This does not mean they cannot manage on their own. Short of having mandated problems that are still there, they will probably benefit from not extending the contract time but arranging for termination, with the provision they can come back if necessary.

Most clients will not be averse to leaving the contact with you. Some experience a natural degree of regret at termination because they have had some dependency on you as a resource for things they needed. Practitioners sometimes tend to overrate the value they have to clients in the relationship, and it is at times more difficult for the practitioner than the client to terminate. Unless you are prepared to take on a case with a more conventional therapeutic approach and see it through, it is not really fair to clients to induce a lot of dependency and expectations that you will always be there for them. The task centred approach is more businesslike in the beginning and lends itself to a more business like approach to ending. Leading the client to manage tasks and gaining skills as you go along will lead to more ability to manage on his own at the end of the contract sequence.

When you are ending, be sure to inform your clients fully about whatever other resources are available to them. Help them look at the things they have learned to do and how they have managed certain things on their own. Let them know they can touch base at times with you without becoming a "case" and that should the need arise they can come back for service.

If there are **LEGAL** requirements for monitoring, they can be structured by clearly informing the client of the need and setting up a schedule. If there is an agency or professional need to set up monitoring in order to detect early problems and put in preventive interventions, set it up only if the client is willing. (This kind of monitoring should be set up only if it is known that effective remedies are available.)

QUESTIONS FOR DISCUSSION

1. Using the attached case example, select three problem areas to target.
2. Then select the goals for the problem areas and the tasks (Be specific—what, when, where, how, with time limits).

3. Write out HOW you will achieve the goals. (For example, goal #1; (what) medical check up at (where) hospital, (when) today in the E.R., then HOW will this be done? By you picking up Mrs. Smith or giving her money for a cab?
4. Pick a partner to work with. Ask your partner to identify for you a real task s/he has believed s/he wants to do but has been procrastinating about. Go through the task implementation sequence described in this chapter step by step with your partner. End by asking for a time later you can check on whether it was done as planned.

CASE EXAMPLE

THE UNIVERSITY OF MICHIGAN
School of Social Work
B. Seabury, Professor

"PARTIALIZING" EXERCISE

You are a social worker in an agency store front office which is located in an inner city community. It is your day to handle all walk-in situations. A white, 25 year old woman enters the agency. She is wringing her hands and crying.

After seating this woman and fetching her a glass of water, she begins to explain why she is so upset. She states that she lives around the block in a condemned apartment. Upon returning home this afternoon, she learned from a neighbour that her six year old son had fallen off a broken fire escape and had been taken to the hospital. She called the hospital and talked with the doctor in the emergency room. Her son is in fair condition but must remain in the hospital for a 48-hour observation period. Because her son has been very upset, the doctor has requested that she spend as much time with him as possible. She wants to be with her son but does not know what to do with her other children (4 years, 2 years, and 3 months).

Mrs. Smith gives you her name and explains that she had left her six year old son to babysit for her other three children while she was out trying to "hustle" for more money because there is no food in the apartment. She is very short of cash this week because her husband, from whom she is separated, came two nights ago, beat her up, forced her to have sexual relations in front of the children, and then took what was left of her welfare money for this month. She explained that this was not the first time her husband had come in drunk and abused her. In fact she had separated from him because he was "abusing" the children, and about six months ago the parents had been brought into court by protective services in order to remove their children. But Mrs. Smith was able to keep the children on the understanding that she would not allow her husband to associate with them.

Mrs. Smith is concerned about the health of her two youngest children. The baby has been throwing up and has had diarrhoea for the past week, and the two year old has had a severe sore throat and ear aches for the last three days. She feels that they have come down with these "colds" because the weather has gotten colder and the only way she can heat her apartment is with an old electric heater and [illegible]hting the gas oven with the door left open.

Mrs. Smith states that she is not in good health herself because she has begun to have her "black-out" spells again. For the past few months she has found herself walking around on the street and not remembering how she got there. These "black-outs" happened before, after the birth of her second child.

Mrs. Smith is worried about her living arrangements because the building she is in is scheduled to be torn down in a few weeks. In her search for a new apartment, she has not been able to find a place which she can afford on her present welfare allotment. She has had to put aside as much of her money as possible to pay the funeral expenses of her mother who died about two months ago. Mrs. Smith would prefer to remain in her present neighbourhood because she has become close to a neighbour who is also on welfare, and this neighbour helps her with her bills and mail because Mrs. Smith cannot read or write.

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Children's Aid Society of Metropolitan Toronto

PREPARING FOR PRACTICE

The fundamentals of child protection

by Nancy E. Falconer
with Karen Swift

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CHAPTER XI

Assessments

In the previous chapter we discussed how to go about collecting the data for your assessment. In this chapter the focus is on:

— the specific information you need to make your decisions.

— the criteria to consider in the child's present safety.

— assessing whether continued involvement is necessary, and if so, deciding on the nature of the immediate intervention.

You will have several sets of factors to consider—information in all these areas has to be gathered, checked out and evaluated before your assessment can be completed:

- physical signs of injury or illness in the child.
- behavioural indicators in parents and children.
- information about the family's past and present mode of functioning.
- signs of neglect.
- evidence of intellectual or psychological problems in parents.
- indicators that suggest "high risk".

PHYSICAL OBSERVATIONS

Your first concern will be physical evidence of abuse or neglect.

Bruises:

Most typical of abuse are bruises or welts over large areas of soft tissue, or lacerations of the skin. (A child usually cuts or bumps HIMSELF on bony areas like elbows, foreheads, knees, shins). Remember also that sometimes racial characteristics of skin such as bluish discolorations at the base of the spine are confused by workers with bruising.

The shape of the bruises may indicate belt or buckle marks. A series of long narrow marks or cuts may indicate whipping with a belt or other objects. Poorly outlined bruises with swelling, covering more than one area of the body, may be indications of a beating.

Remember that bruises can be caused in many ways, including medical conditions such as hemophilia and vitamin C deficiency.

Burns:

Several types of burns may be seen. Thermal burns, resulting from immersion of the child in hot water, are usually on the lower trunk and

extremities. This type of burn is easily recognized by a physician and can be accidental (parent did not test bath water).

Scalding results from hot liquids poured onto the skin. You will try to determine, based on location of burns, child's age, and parent-child relationships, whether the burn was an accident (e.g., could child have pulled a pan off the stove?)

Burns resulting from cigarettes or matches may result from parent's attempts to teach child the danger of fire. This is obviously a questionable approach. Location and number of burns is important. Burns located on breasts or genitals indicate extreme pathological behaviour—consider immediate removal.

If a child has been burned on a stove or heater, consider whether parental supervision is part of this problem.

Burns that are associated with other injuries are suspect and require thorough assessment.

Fractures:
Many children, of course, sustain accidental fractures in the course of growing up. However, fractures in children UNDER 3 are suspect. If any unexplained fractures are present, a bone survey is required.

Internal Injuries:
Internal injuries can be difficult to detect. A child who shows no external damage but who is distressed, apathetic and seems generally unwell may have internal injuries and needs to be seen for medical examination right away.

Head Injuries:
Injuries which cause bruising or bleeding in the brain (subdural hematoma) can be caused by blows to the head or, in the case of young children, by shaking the child. These injuries, if serious, can result in brain damage or even death. Young children are more at risk because the brain is still developing and because of the large size of the brain within the head.

Symptoms of head injury are vomiting, irritability, general changes in the child's manner, and drowsiness which can lead to coma.

If you know that a child has sustained a blow or other injury to the head OR if the child displays symptoms related to head injury, s/he should be examined in a medical setting right away.

Exotic Punishment:
- stabbing
- hanging
- poisoning
- tying child up

These forms of abuse are unusual. If you do see them, recognize that they are the result of pathological behaviour, and the child should be removed.

IF THE CHILD IS ILL OR INJURED
If obvious physical injuries are present, if you have questions about the seriousness of the injury, or if the child seems unwell (ill or internal injury possible), you will want to be sure the child is seen by a physician right away. Do not wait for the parent to take the child. Make the arrangements yourself and try to get the parent to go with you. If the parent refuses, take the child yourself for a medical opinion. If you have questions about whether to leave a child at home call your agency and ask for a corroborating opinion.

If you work in an area where the hospital, doctors or nurses do not have experience with abuse incidents, make clear what your concerns are and ask if they will use x-rays or other diagnostic procedures to establish whether the injuries were likely not a result of normal childhood falls.

Either before or after the child is seen medically depending on the degree of urgency you believe is present, you will talk with the parent about the injury, how it occurred and what was done about it.

EXPLANATIONS:
Compare the parents' explanations with your own observations. Listen for INCONGRUITIES regarding:
- descriptions of child's behaviour out of keeping with age and developmental level.
- illogical explanations.
- attempts to tie the injury to a pre-existing medical condition, either real or imagined.

True explanations may be given by parents who really see nothing wrong with the action. They may be outraged at your intrusion; this absence of guilt and discomfort with their own behaviour can indicate a prognosis of slow or limited progress. Accurate explanations also will be given in cases of genuine accident. These parents will generally recount in the finest detail what occurred. You will be able to see and feel the incident through the explanation.

Ask parents what has been done about the injury. Were efforts made to treat wounds, was the child seen by a doctor? Evasion or inappropriate action taken will provide important clues to parents' competence and intentions.

Parents who have seriously hurt their children sometimes show characteristic behaviour about the event in the hospital. These parents often:
- are evasive or contradict themselves about the circumstances of injury.
- do not volunteer information about the circumstances, or the explanations don't fit the injury.

- show no open remorse or guilt about the child's injury.
- tend to be more concerned about what will happen to THEMSELVES than to the child.
- show little or no concern about the injury itself—the treatment, prognosis, or after-care.

The Child's Explanation:
The child's explanation of his injuries is often extremely accurate. Some children, however, will "parrot" the explanations given by parents.

Young children will sometimes withdraw from the abusive person or from all adults.

Children usually feel guilty about their injuries. They may see physical punishment as being deserved because of actual misbehaviour or poor self-concept.

If the child is fairly comfortable with you, you may be able to ask questions about specific marks. Can he show you how it happened? Be careful not to lead the child or force an explanation.

Children NORMALLY cry when they get hurt—except for those who have been repeatedly abused. Does the child respond to pain when being examined? Could the child's attitude be described as one of "frozen watchfulness"?

Always remember that children have only one set of parents and may grow protective if you are perceived as a threat.

FAMILY FUNCTIONING—BEHAVIOURAL INDICATORS
If the child has been in danger, you will have to delay gathering behavioural and other information until the child's safety is assured. If there is no apparent danger to the child the focus of your initial interview will be the collection of data about the family's functioning.

In either case, you will be attempting to establish whether further intervention is required and the nature of that intervention.

The following behaviours in the child and siblings MAY indicate a history of abuse or OTHER DIFFICULTIES if a large number of them are present. Use your observations of these to corroborate other evidence or to formulate your assessment. Be cautious in using any of the following lists—remember no one of the "indicators" is conclusively associated only with abuse or neglect.

Does the child:

- seem very different from other children physically or emotionally?
- appear unduly afraid of the parent(s), act vigilant, watchful?
- seem over-compliant, attempt to escape notice?
- pl[illegible] a very protective role with the parent, consoling or patting when [illegible]t is upset?

- exhibit behavioural extremes: crying often or very little, excessively fearful or not at all afraid of adult authority, overly aggressive and destructive or very passively withdrawn?
- seem wary of physical contact especially with adults, or apprehensive when an adult approaches another child?
- show attempts at self care inappropriate for age?
- miss school often (a child is sometimes kept home when injured or to care for other children) or does he come early and stay very late at school?
- exhibit inattention, self-absorption, appear tired or irritable often?
- exhibit behaviour inappropriate for his age?

Other abnormal symptoms in children are:

- habit disorders—excessive biting, masturbating, bed wetting.
- conduct disorders—rebelliousness, temper tantrums, lying and stealing.
- neurotic traits—extreme curiousity or imagination, speech disorders, sleep disorders, learning disabilities.
- psycho-neurotic traits—hypochondria, phobic obsessive-compulsive traits.

Look for signs of strength as well as for problems in the child's behaviour and circumstances.

Examine these factors in conjunction with any evidence of injuries. They will provide further material for your assessment and plan of intervention.

It is also important to observe the parents' attitudes toward and interaction with the child(ren). Do the parents:

- speak over-critically of the child; refer to him as bad or different or responsible for family problems?
- show signs of excessive rigidity; are they domineering or very compulsive in their interactions with the child?
- reverse roles with the child; expect very grown-up behaviour, or speak of the child as though he were an unloving, unsatisfactory parent?
- react with impatience at the child's crying or demands, or ignore demands; do they seem unable to feel empathy for the child?
- express belief in harsh punishment for children?
- scream or yell at the child; or is there little interaction between them?
- give inaccurate information regarding the child's medical history and any present physical problems?

Additionally, you may need to pay attention to the parents' general mode and level of functioning. Your interview, together with [illegible]mation

collected from collaterals and records, may uncover some of the following factors. Do the parents:

— appear distrustful of outsiders or help; are they isolated from family and friends and other possible supports?
— misuse alcohol or drugs consistently?
— consistently fail to keep appointments—with doctors, school personnel; is it often difficult to locate the parents?
— act impulsively about problems rather than talk about them?
— have a history of serious marital discord?
— have a history of abuse in their own childhood (studies show only about 20% of abusers do have).
— have many external stresses to cope with—low income, poor housing, problems associated with single-parent status, cultural or racial discrimination, illness, or a suddenly precipitated environmental or emotional stress?

ALWAYS note strengths you discover in these areas too.

ASSESSING NEGLECT:
Investigations of neglect often arise from a report specifying some particular type of poor care a child is receiving. Your first focus will be on the complaint you have received. Is it valid? If so, how serious is it and what are the contributing conditions? As you investigate keep in mind that neglect is generally characterized by the **PERVASIVENESS, CONSISTENCY** and **LONG DURATION** of poor care. As you observe and ask questions look for patterns of care and try to establish time frames; that is, how long various conditions have existed.

As in abuse investigations, you **MUST SEE** the child(ren) named in the report. As well, you must see any other pre-school age children in the household. Remember that the neglectful care is likely to affect more than one child in the family.

There are several different areas to observe and explore with parents:

House or Apartment:
— What is the general state of repair and cleanliness of the living quarters?
— Can the home be adequately and safely heated?
— Is the condition of the home similar or startlingly different from those around it?

Clothing:
— Does each child have enough clothing?
— Is clothing adequately warm and clean?
— Are there conspicuous differences in dress, e.g., parents well dressed while children wear skimpy ragged clothes?

Nutrition:
— Is there enough food in the house?
— Do parents have awareness of nutrition?
— Are regular efforts being made to provide children with nutritious meals?

Child Care Routines:
— Do children have regular routines for eating, sleeping and bathing?
— Do older children have a curfew that is enforced?

Safety:
— Are there obviously unsafe conditions in the home; e.g., toxic substances or sharp objects in reach of small children?
— Have parents made efforts to teach and enforce safety rules; e.g., street safety?

Medical Care:
— Are both routine and special medical and dental care needs readily attended to?

Cognitive Stimulation:
— Do parents show some interest and ability to provide age—appropriate stimulations; e.g., toys for small children (including home-made toys and safe household items), displays of paintings or school achievements, awareness of child's progress at school?

Discipline:
— Is there any consistent discipline?
— Do parents usually follow through on rewards and punishments?
— Do latency-age and older children have any regular responsibilities in the household?

Emotional Support:
— Are parents comfortable with giving and receiving displays of affection?
— Do parents mention positive as well as negative things about the child?
— Does child have friendships and ties outside the immediate family?

As you observe and collect information remember:
— You will need to make judgments during your visit about how far to pursue information on any one kind of care. For instance, if children appear bright-eyed, active and of normal size and development for age you will not dwell on nutrition overlong. On the other hand, if children appear thin, lethargic and unwell, you will pursue information concerning diet and other physical care even if the parent assures you no physical problem exists.

— In making your observations, keep in mind that your object is not to judge the housekeeping or parenting style but to protect children from serious deficiencies in child care. You must tie your observations to their effects upon the children. That the house is in a state of disrepair is not in itself an indicator of deficient care. That the baby eats flaking paint which parents consistently fail to sweep up does describe deficient care.

— One or two items of poor care do not constitute neglect. Parents who are willing and able to correct problems, given adequate resources, are not neglecting parents.

— Poverty and neglect are not the same thing. Subminimal child care may indicate that the family has insufficient resources. You may be able to play a role—through advocacy or referral—in assisting parents to obtain what they require. However, if care of children is below minimal standards, regardless of the reason, you will need to remain involved until the care reaches an acceptable level.

RECOGNIZING PROBLEMS:

In assessing the present functioning and potential of parents, you will need to be alert for signs of special limitations and problems that affect parenting.

Problems: Reactive Depression:

Reactive depression results from failure to experience and express grief immediately following a traumatic life event.

Lindemann (1965) has suggested points to look for in identifying reactive depression:

— Reaction to the life event is delayed or postponed. An individual seemingly retains morale for weeks or months but a reactivation may be suddenly precipitated by some other, less important event.

— An individual may adopt the symptoms shown by the deceased during his last illness or may show other medical problems.

— Withdrawal of attention to family and friends and general social isolation often occur, accompanied by general loss of initiative.

— There are outbursts of fury against specific persons such as doctors and surgeons. Almost anyone who becomes involved with the bereaved person becomes liable to attack.

— Powerful feelings of guilt occur. Sometimes a suicide attempt or other self-destructive behaviour occurs.

A parent who has previously given good care and suddenly shifts to neglectful parenting behaviour may be exhibiting the signs of reactive depression.

Problems: Psychosis:

Diagnosis should be done by a skilled clinician. However, several of the following symptoms found in combination should alert you to the possibility of serious illness:

Social withdrawal. This may show itself in marked shyness when around people, efforts to avoid social situations, or staying by oneself all the time like the mother who refuses to leave her bedroom.

Loss of contact. The individual seems unaware of what is going on around her, drifts in and out of focus in her conversation, stares aimlessly. Some dash around in a frenzy for no apparent reason. Silence is not the only expression of being out of contact.

Inappropriateness of mood. One version of this is called "lability" in which mood veers wildly from sadness to hilarity and back again. Another form is shown by the person who laughs in the midst of discussing something painful or smiles vacantly in the face of bad news. Most common is the individual whose mood is inappropriate because it never changes. This is called "flatness of affect".

Bizarre behaviour and grimaces. The individual may talk to himself, laugh wildly or exhibit strange movements with arms or legs or facial contortions.

Disturbances in the stream of thought. Talking gibberish, coining new words, and using malapropisms are sometimes indicative that a person heretofore intact is breaking down. Some persons also show an inability to break off a stream of speech, repeating the same thing over and over; related to this may be a need to mimic.

Delusional systems. These are sometimes hard to discern. Some of the distortions of reality are relatively mild. That is, we know that something is wrong, but is it wrong enough to indicate psychosis?

Hallucinations. Many psychotics are wise enough to refuse to admit having such symptoms except under highly skillful questioning. Therefore the presence of hallucinations is often inferred from bizarre reactions.

Severe anxiety. A great many psychotic individuals can feel themselves losing contact; anxiety is both the cause and the effect of this illness.

Some individuals whose behaviour and symptomatology fluctuate a great deal, may be "borderline psychotic". Assessment is difficult because at times the behaviour may appear quite normal. These people may function in more or less the same way throughout life. One characteristic is that they pull themselves together quite quickly when hospitalized, creating obvious complications in planning for children.

HIGH RISK SITUATIONS:

One of the most crucial—and anxiety provoking—aspects of intake is the recognition of high risk situations. When you are working on a long-term

basis with families, you will usually have more information available to determine the degree of risk. But if you are seeing a family for the first time, you will need to be familiar with factors which, in the experience of others, have indicated that risk is great.

The term "high risk" implies:

- a substantial threat to a child's life or health.
- intervention is required to ensure that the child is protected.

Intervention does not necessarily mean removal of the child—you may also want to consider:

- close monitoring in the home.
- involvement of health resources, for instance a public health nurse.
- frequent contact with physician or clinic.

CRITERIA TO CONSIDER:

The HEW publication *We Can Help* lists the following situations in which a worker should consider immediate intervention to protect a child:

- — Maltreatment is such that the child could suffer permanent damage to mind or body if left in the home.
- — Child is in immediate need of medical or psychiatric care and parents refuse to obtain it.
- — The child is already physically and/or emotionally damaged and requires an extremely supportive environment to recuperate.
- — Child's age, sex, physical or mental condition renders him or her incapable of self-protection, or for some reason constitutes a characteristic the parents find completely intolerable.
- — Evidence that parent is torturing the child or continuously resorting to physical force which is not reasonable discipline.
- — The physical environment of the home poses an immediate threat to the child.

In cases where there is evidence of physical injury or neglect (unfed, no medical care, for example) the following symptoms may well signal that removal is necessary:

- — Parental anger from the investigation is directed toward the child in retaliation (find out by review of past behaviour and from statements in the interviews or reports from knowledgeable others).
- — Parents show evidence of being out of touch with reality and cannot provide for basic needs.
- — Family history indicates hiding child from others.
- — Parents are totally unwilling to maintain contact or cooperate with any agency or the investigator.
- — Family has history of previous incidents of serious abuse or neglect.

Should you decide immediate intervention is absolutely necessary, you must inform the parents of the reasons. Urge them to cooperate with a temporary plan if you cannot arrange in-home help.

All efforts to get the family to cooperate should be tried before using legal action to remove a child. It is also important for you to begin to build an honest contact with parents you may be working with later.

Whenever possible, it is helpful to discuss the factors determining risk with others (multi-disciplinary team, other agencies involved, inside agency supervisor, etc.) to decide the level of risk and to avoid the separation which can be so damaging to the child and his family.

IS THE CASE TO BE CONTINUED?

If you have, in the course of your investigation, observed injuries or other medical conditions requiring treatment OR if you have not been able to rule out abuse or neglect as possible causes of the child's condition, you will continue your involvement with the family.

Otherwise, your decision whether to remain involved will be based on the information you have assembled. Decisions will be guided by:

- — Child welfare legislation in your province—how is "child in need of protection" defined?
- — Policies of your agency—what mandate has the agency given you respecting cases which are not deemed dangerous enough to bring before the court?
- — Current social work practice and ethics, especially in regard to concepts of the "child's best interests".
- — Accepted community standard of minimal child care.
- — Your assessment of the family's ability (present and potential) and willingness to provide a minimal standard of care for the child.

In arriving at this assessment, remember there is seldom one factor which leads to a decision to intervene. Look for the PERVASIVENESS, DURATION and CONSISTENCY of a number of indicators over time before you confirm that a child requires protection.

Use your information to assess these critical areas:

- The nature, extent and seriousness of present circumstances as they affect the child.
- The effect on the child of maltreatment.
- Parents' awareness of problems.
- Family's potential for change.
- The next immediate steps.

Keep in mind that many of the families you will see can be classified as having potential for some change—intervention can be conducted with the child remaining at home or removed for short periods of time.

Although they are more rare, there are a few situations where the parents do not exhibit the controls necessary to alter abusive or potentially abusive behaviour to children. Some adults react to internal or external stressors with violence that is unpredictable. Some of the conditions in parents that can be seriously high risk for children are:

- psychotic parents who are also physically abusive or very neglectful.
- those who have organic central nervous system disorders that produce violence.
- those who are chronically alcohol or drug abusing and are also abusive.

If you observe behaviour that indicates these conditons are present, use consultation from psychiatrists or other trained medical personnel to assess the risk in the situation.

FINALLY:
Don't ignore your own instincts. Does the child "feel" all right to you, in spite of some indications of poor care. Or do you leave the house feeling anxious and fearful yourself? Try to locate in your data some basis for these "gut reactions", and be certain that your decisions are based on more than just your feelings. ALWAYS have facts to back up your judgments.

Decisions concerning intervention will usually be made with your supervisor or other agency personnel. Most agencies will have a system of categorizing open cases such as the following:

High risk:
Physical abuse verified

Serious neglect verified

High risk of abuse or neglect exists based on past instances

Child removed by court order.

Some degree of risk.

Opening mandated

Court-ordered supervision of child at home.

Low risk:

Opening mandated

Care below minimal standards but not immediately threatening to child.

Child at home or in care by voluntary agreement.

Agency mandated to provide protection.

Agency-mandated preventive services

Voluntary preventive and/or other services given upon request of parents.

When you have determined that a case is to be opened for ongoing service, you will probably be required to assist in decisions about classification of the case. This implies other decisions such as court involvement, placement of the child, and your own role. The following sections will deal with the activities, procedures, knowledge and skills you will need to perform these ongoing functions.

QUESTIONS FOR DISCUSSION

1. Review the steps in an interview situation.

   Discuss briefly with several others what factors would go into making a decision to remove a child immediately. Then role play how you would tell the parent(s) during your first visit.
2. Select a neglect case you are familiar with. What factors went into making the original assessment of neglect?
3. You have received a call from a Mrs. B describing an abuse incident next door. Mrs. B says others in the neighbourhood have witnessed previous incidents and gives you the name of a second neighbour, Mrs. N to check with.
   - How and when would you approach Mrs. N for substantiating information?
   - What questions would you ask?
   - What information would you give her about the investigation?

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