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- Washoe County Department of Social Services
- Action for Child Protection, Inc.
- The Ruth H. Young Center for Families and Children at the University of Maryland School of Social Work
- The Children’s Cabinet, Inc.
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1 BACKGROUND

History of the PII Project

The Permanency Innovations Initiative (PII) is a 5-year, $100 million initiative of the Children’s Bureau underway since 2010 that includes 6 Grantees, each with an innovative intervention designed to help a specific subgroup of children leave foster care in less than 3 years. The project combines requirements for purposeful application of implementation science, rigorous evaluation, and coordinated dissemination of findings. PII aims to:

- Implement innovative intervention strategies, informed by relevant literature, to reduce long-term foster care (LTFC) stays and to improve child outcomes
- Use an implementation science framework enhanced by child welfare expertise to guide technical assistance activities
- Rigorously evaluate the validity of research-informed innovations and adapted evidence-supported interventions (ESIs) in reducing LTFC
- Build an evidence base and disseminate findings to build knowledge in the child welfare field

This integration of implementation science and program evaluation in a coordinated framework is intended to build or enhance the capacity of child welfare agencies to develop, implement, and evaluate research-informed innovations and adapted ESIs and to provide evidence about program effectiveness. An overarching objective of PII is to increase the number of ESIs available to the child welfare community. To this end, Grantees follow a systematic approach (the PII Approach), focusing on clearly operationalizing the infrastructure needed to support practitioners’ implementation of the interventions as intended.

The PII Approach readies interventions for broad-scale use, which is more likely to be warranted and feasible when interventions have been well operationalized with specified core components, and implementation teams have documented necessary infrastructures to support, sustain, and improve implementation integrity over time. The PII Approach provides a model for child welfare administrators and agency directors to add evidence to the body of knowledge about what works in child welfare. Its systematic approach offers a guide for child welfare stakeholders to identify existing interventions or develop innovations to solve complex problems and evaluate them for effectiveness.

The federal government is supporting Grantees as they implement and evaluate their interventions through two offices within the Administration for Children and Families (ACF): the Children’s Bureau and the Office of Planning, Research and Evaluation (OPRE). The Children’s Bureau is providing training and technical assistance to Grantees to strengthen their use of best practices in implementation. OPRE is supporting rigorous within- and cross-site evaluations of Grantees’ interventions. Both offices are working together to disseminate the lessons learned from PII.

Purpose of This Manual

This program manual provides detailed information about the implementation process of the Safety Assessment Family Evaluation—Family Connections (SAFE-FC). Its purpose is to assist others in the field in replicating or adapting SAFE-FC for their local use. Replicating or adapting ESIs with fidelity to the interventions builds evidence in child welfare and expands the range of intervention effectiveness to different target populations and organizational contexts. These efforts to build evidence serve several purposes, including preparing an intervention for evaluation (either during implementation or later, depending on the organizational context in which an intervention is implemented) and building a base of replicable interventions that can serve the complex needs of diverse communities of children and families.
This replication manual is provided for informational purposes. Agencies interested in considering implementation of this intervention must contact the model developers, ACTION for Child Protection, Inc. (ACTION) and the Ruth H. Young Center for Families and Children (the RYC) at the University of Maryland (referred to as the purveyors), to discuss requirements for implementation. The manual includes examples and details from the experience of the Washoe County, Nevada Department of Social Services (WCDSS). As part of PII, WCDSS was involved in a random assignment study, which is referenced in this manual. Similarly, the systems referenced in this manual and some implementation decisions were based on the requirements of the State of Nevada, County of Washoe, or the PII cooperative agreement.

The intended audience for this program manual comprises potential implementers of the intervention, including child welfare administrators and staff, evaluators, and purveyors. This document contains background information about the explorative stage of implementation and detailed explanation of processes related to:

- Ongoing system readiness for implementation
- Teaming for implementation and communication
- Practitioner recruitment and selection
- Client recruitment and selection
- Operationalization of the intervention
- Training for practitioners to deliver the intervention
- Coaching
- Performance/fidelity assessment
- Use of data for decision making and improvement

It also includes lessons learned and other practical information based on the experience of the WCDSS executive leadership and implementation leadership team. The appendices include numerous program documents.

Description of Intervention
SAFE-FC is a permanency model based on two established interventions: Safety Assessment Family Evaluation (SAFE) and Family Connections (FC). SAFE is an assessment and intervention approach that results in decisions that move the family through the child protective services (CPS) process. FC is a community-based service program that works with families to help them meet the basic needs of their children and to reduce the risk of child neglect. SAFE-FC is a comprehensive CPS intervention system that incorporates a series of sequential assessments and interventions to respond when children are determined to be unsafe. There are two overall phases of SAFE-FC intervention: (1) Safety Assessment and Management and (2) Change Focused Intervention and Safety Management. The Safety Assessment and Management phase is designed to identify which families will be served by the agency (pre-SAFE-FC activities). Phase 2, Change Focused Intervention and Safety Management, reflects the SAFE-FC intervention, which addresses the changes required to restore caregivers to their protective role.

Components of Phase I: Safety Assessment and Management
To identify families and to respond appropriately to families with unsafe children who will be eligible for SAFE-FC intervention, the Safety Assessment and Management phase is implemented through the following components: (1) intake assessment, (2) the Nevada Initial Assessment (NIA), (3) safety plan determination, (4) safety planning, and (5) safety services. The primary emphasis of these components is to control impending danger threats so that unsafe children will be protected.

The intake assessment (IA) is the method used by WCDSS to receive and document reports from the community of child abuse or neglect. The IA is the first assessment directed at determining who will be served (i.e., whether a case will be opened for further
assessment) based upon safety concerns. The IA begins to identify caregivers who are unable or unwilling to protect their children from impending danger. The assessment includes consideration of present and impending danger, vulnerable children, and caregivers with diminished caregiver protective capacities. The NIA determines whether maltreatment is or is not occurring in a household and whether or not a family requires further services to prevent further maltreatment and to improve caregiver protective capacities. The NIA reaches conclusions about caregivers who are unable or unwilling to protect their children from impending danger. This includes the assessment and management of present and impending danger, the identification of vulnerable children, and the assessment of caregivers with diminished caregiver protective capacities.

NOTE: In Nevada, the NIA refers to the function or process commonly referred to as investigation or the IA process. The primary purpose of the NIA is to identify families in which children are unsafe and, therefore, in need of ongoing CPS. For agencies considering replication of SAFE-FC, the term NIA should be synonymous with the local investigation process and the IA synonymous with the local or statewide intake process.

Components of Phase II: Change Focused Intervention and Ongoing Safety Management

This phase represents the SAFE-FC intervention and focuses on working with families to change the behaviors and conditions that threaten the safety of children and contribute to the risk of LTFC. Components of this phase include (1) the caregiver Protective Capacity Family Assessment (PCFA), (2) case planning, (3) Change Focused Intervention and Ongoing Safety Management, and (4) the Protective Capacity Progress Assessment (PCPA).

The PCFA is a structured interactive process that is intended to build partnerships with caregivers in order to identify and seek agreement regarding changes needed to ensure a child’s safety and to develop case plans that will effectively address caregiver protective capacities and child needs. The PCFA is a “people process” emphasizing mutual discovery rather than an evaluation. SMART case plans become the end product of the “people process” occurring between a SAFE-FC worker and a caregiver. The PCFA concludes with a SMART case plan representing the end of the process to enhance caregiver protective capacities and to restore the caregiver to the role and responsibility of protecting his or her children.

The PCPA is a collaborative review of and conclusion about enhanced caregiver protective capacities. It includes input from the SAFE-FC worker, caregivers, and others who are a part of the remediation process. The PCPA, at times, will include case managers from private child welfare agencies when in-home safety planning is being considered. In Washoe County, the Children’s Cabinet (CC) was a private agency that provided case managers; this role is referenced throughout this manual. The purpose of the PCPA is to encourage, support, and facilitate caregivers in the process of behavioral change that enhances their caregiver protective capacities and restores them to their role and responsibilities concerned with protecting their children.

Target Population

WCDSS developed SAFE-FC to respond to two target populations at risk for LTFC, which included families with children who:

- Population 1—Are assessed as unsafe due to impending danger following the completion of the NIA process
- Population 2—Were in care for 12 months or longer (as of August 2012) and who, at the time of placement, presented with 1 or more of 4 risk characteristics: single-parent household, parent substance abuse, homelessness or inadequate housing, or parent incarceration with an available parent or caregiver to participate in the intervention.
Cases that are excluded from SAFE-FC assignment include those:

- With a single child over the age of 17½ because of the limited time available for intervention
- In which the children are legally half free or free, adoption is imminent, and the child is living in an adoptive placement
- Involved with family drug court
- That were not eligible for Population 2 and that have a new NIA approved with the child determined unsafe according to this new assessment

The WCDSS target population was determined in collaboration with ACTION and the RYC as part of the PII project described in the next section. The process in which WCDSS participated to identify the target population is important because this manual describes how SAFE-FC was implemented within the context of PII and the needs of Washoe County. Similarly, the evaluation of the intervention is focused on PII goals and strategies which may not be the same as those of an agency seeking to replicate or adapt SAFE-FC.

**History of WCDSS' Participation in PII**

The process to identify the target population and intervention, along with the theory of change and prior research, are directly related to WCDSS’s involvement in PII. The next four sections of the manual provide valuable context for the intervention as it was ultimately operationalized; however, these sections are not intended to guide future replication efforts.

**Process to Identify the Target Population**

Prior to the WCDSS application submission for the PII cooperative agreement, the RYC completed extensive survival analyses of administrative data from 2006 to 2010 and identified characteristics of children and families newly placed in foster care who might benefit from services to prevent LTFC (Population 1). The PII Evaluation Team (PII-ET) reviewed these analyses with WCDSS and its purveyors and also conducted tree diagram analyses to identify a population already in foster care that was at risk of LTFC (Population 2). Through these extensive data mining efforts conducted by Washoe County, the RYC, and PII-ET and through discussions with WCDSS to refine and understand pertinent risks for LTFC, four case risk characteristics were identified as risks for LTFC for Population 2: (1) parental substance abuse, (2) homelessness/inadequate housing, (3) single-parent households, and (4) parental incarceration.

The Children’s Bureau and the OPRE required that the target population be approved through the submission of a Target Population Approval Template, which required documentation of the target population and the evidence showing that this population is at risk for LTFC. This template required the Grantee to address children disproportionally represented in the county’s foster care population. Characteristics of this population that placed them at risk of long stays in foster care (e.g., specific child, placement, and family characteristics) and the evidence that each was associated with long stays were identified. Prioritization of the characteristics, according to their importance as risks for LTFC and to the results of the data mining activities (which demonstrated that such characteristics created greater-than-average risk of LTFC relative to other groups), was identified, as were the key systemic barriers to permanence that especially affect the target population.

Washoe County also conducted 2 separate sets of case reviews (15 cases reviewed in each set), in addition to survival analyses conducted by the RYC and data mining conducted by PII-ET. It was concluded that child characteristics are not salient in predicting longer stays in foster care, but, rather, case risk characteristics and systemic factors are more related to long stays. The reviews found that contact with parents was not sufficient to engage parents either in the intervention process or in services and case
planning in order to reduce the length of time children remained in care. This inadequate engagement included infrequent visits between the caseworker and parents and a lack of focused parent-child visits. It was also determined that placement could have been prevented in many cases and reunification achieved within 12 months had assessments been more thorough, safety plans and in-home safety services been available, and case plans developed that focused upon the safety factors that caused removal. Prior research has documented the importance of identifying and understanding factors both in the placement and service process\textsuperscript{12} and in the organizational contexts\textsuperscript{13} that account for child welfare outcomes, independent from the preexisting differences in characteristics between children entering foster care.

**LESSON LEARNED**

Install a data-informed, decision-making process from the start. The Washoe project received exceptional support and guidance in this phase of the PII Approach, called Exploration and Installation. Having access to various data sources, such as the Adoption and Foster Care Reporting System and community demographic information, was only the start. The presence of highly trained and experienced purveyors, specifically ones experienced in research and data analysis, was instrumental to Washoe’s ability to apply data to the decision-making process around determining the final intervention approach for both Populations 1 and 2. Having purveyors so closely aligned in this phase of the process (versus using second-party analysis) set the foundation for the leadership team’s implementation work yet to come.

**Theory of Change**

The Theory of Change for SAFE-FC was adapted from the amalgamation of the two intervention models discussed earlier, FC and SAFE, which have overlapping and mutual concepts around the change process.

**FC Program Description**—FC was designed as a multi-faceted, community-based service program that works with families in their neighborhoods to help them meet the basic needs of their children, reduce the risk of child maltreatment, and strengthen overall functioning of the family and children. It operates from an ecological developmental framework using Bronfenbrenner’s\textsuperscript{14} theory of social ecology as the primary theoretical foundation. Developed primarily to prevent child neglect, the program conceptualizes the problem evolving when risk factors related to the child, caregivers, family system, and the environment challenge the capacity of caregivers and broader systems to meet the basic needs of children. FC uses a home-based, family-centered model of practice consistent with other home-based, tailored intervention approaches.\textsuperscript{15} Nine practice principles guide FC intervention\textsuperscript{16}:

1. Community outreach
2. Individualized family assessment
3. Tailored interventions
4. Helping alliances
5. Empowerment approaches
6. Strength-based perspective
7. Cultural competence
8. Developmental appropriateness
9. Outcome-driven service plans

Individualized intervention is designed to increase protective factors (e.g., social support) and decrease risk factors (e.g., parental depression symptoms) associated with maltreatment. The core components
of FC include (1) emergency assistance, (2) home-visiting family intervention, (3) outcome- and SMART-goal-driven case plans, (4) advocacy and service coordination with referrals targeted toward risk and protective factors, and (5) multi-family supportive and recreational activities. FC uses screening criteria as clear inclusion criteria for targeting and screening program clients.

FC initiates the therapeutic relationship through face-to-face contact with the family promptly (within 1 business day). An FC worker is assigned to work with the qualified family on an ongoing basis. The worker provides at least 1 hour of face-to-face, change-focused, purposeful services to families at least once per week for at least 3 months. Workers provide most services in the community, meeting families where they live. They use clinical assessment instruments to guide the identification of risk and protective factors associated with child neglect or maltreatment as part of the comprehensive family assessment. They provide emergency and concrete services to address both initial needs and ongoing specific services directed to achieve identified outcomes and goals on a continual basis. Workers conduct comprehensive family assessments to guide the service delivery process. They deliver tailored and direct therapeutic services through outcome-driven and customized service plans to help families reduce risks, maximize protective factors, and achieve service outcomes and goals. FC advocates on behalf of families in the community and facilitates services delivery by other organizations/individuals.

SAFE Description—SAFE is a comprehensive assessment and intervention approach. It is theoretically based, containing concepts and practice principles that guide the intervention. The key practice constructs for SAFE are:

- Caregiver protective capacities
- Impending danger
- Well-being, permanency, and family-centered practice
- Self-determination and mutuality
- The Trans-Theoretical Model (TTM)
- Solution-based intervention
- The involuntary client
- Systematic safety intervention process

Based on the data analyses and case reviews, WCDSS found that approximately 20 percent of maltreated children enter out-of-home care because the agency has been unable to protect children (i.e., manage safety) in their own homes. WCDSS identified the root causes of the problem as caregivers (parents) with inadequate protective capacities influenced by complex problems (e.g., substance abuse, neglect, housing problems, parental incarceration, single-parent households); the unavailability of adequate safety services; and the inability of the WCDSS to adequately assess and deliver focused, purposeful, change-oriented interventions to help families change the behaviors and conditions that threaten safety and led to the original placement.

Two theories of change guide Washoe County’s work with each target population. For families with children assessed as unsafe due to impending danger (Population 1), improved safety and permanency outcomes will be achieved if:

- Impending danger is adequately assessed;
- In-home safety services are provided when possible;
- Caregivers are engaged to address safety threats and to build protective capacities;
- Safety is managed through in-home safety services or temporary out-of-home placement;
- SMART case plans facilitate intensive, purposeful, change-focused services;
- Services are provided to change the behaviors and conditions that would otherwise lead to placement in LTFC; and
- Goal achievement and changes in behaviors are regularly measured.
For families with children currently in care for 12 months or longer, with one or more of the risk characteristics for LTFC, time in foster care will be reduced if:

- Children are reassessed for impending danger;
- Parents are re-engaged to change behaviors and conditions that led to the need for foster care placement;
- Parents receive a comprehensive assessment of caregiver protective capacities;
- SMART case plans facilitate intensive, purposeful, change-focused services;
- Services are provided to achieve goals that increase the likelihood of reunification;
- Change is regularly evaluated; and
- Concurrent planning is implemented if parents are unable or unwilling to participate or engage.

**Process to Identify Intervention**

Every 5 years, the Children's Bureau conducts federal Child and Family Services Reviews (CFSRs) nationwide to measure the effectiveness of child welfare agencies with service provision to children and families and to promote conformity in practice and compliance with federal regulations. These reviews are conducted in every state by creating teams to review a randomly selected sample of child welfare cases from each child welfare agency in the state and to interview case participants using specific review guidelines. The review process measures and compiles data to determine how well state and county agencies perform with ensuring that children in the community are safe; maintained safely in their homes whenever possible; and receiving necessary services to promote reunification, well-being, and permanency when the children have entered the child welfare system.

The last CFSR for Nevada was held during the week of August 31, 2009, and 18 cases in Washoe County were reviewed. The **Final Report: Nevada CFSR (January 2010)** documented that WCDSS was not successfully engaging parents in the intervention process, including participation in service provision and case planning, largely because the frequency and quality of face-to-face contact with the children’s mothers and fathers was not sufficient.

Using the data collected from CFSRs in Washoe County and comparing CFSR results from states using a safety model (specifically South Dakota, Wisconsin, Alaska, Alabama, Nebraska, New Mexico, Oregon, Nevada, Puerto Rico, and West Virginia), WCDSS, ACTION, and the RYC collaborated to initiate an application for funding through ACF to support a plan to assist WCDSS in improving the outcomes for children in its custody. While Washoe did speak with other jurisdictions implementing SAFE and FC, that did not drive the intervention identification process. The Project Management Team (PMT) reviewed and approved all aspects of the development process, such as the finalization of the theory of change, logic model, target population, and intervention approach.

**LESSON LEARNED**

Leadership must remain active, informed, and in charge throughout the implementation process. For the Washoe team, this was initially evidenced by a series of collaborative meetings with agency staff and the purveyors during the drafting of the original Children's Bureau application. Although the foundational concepts of the intervention approach were developed by the purveyors, agency leadership staff were clearly identified and involved with the final products. Furthermore, the identification and installation of a Project Director position (versus an added duty or part-time position) significantly added to the consistency, centralization, and timely completion of the implementation activities yet to come.
1 Background

Prior Research or Evidence
An FC demonstration study describes a comparison of 70 families who were assigned to FC intervention for 3 months and 84 families assigned to receive FC intervention for 9 months. Results for both groups demonstrated increases in protective factors (parenting attitudes, parenting competence, and social support), diminished risk factors (depressive symptoms, parenting stress, life stress), improved safety (physical and psychological care of children), and improved behavior (decreased internalizing and externalizing). There was no difference between the 9-month and the 3-month intervention with the exception of child behavior although all measures were below the clinical cutoff on the Child Behavior Checklist.

In addition to reviewing evidence from quantitative and qualitative research completed on FC, the agencies looked at the evidence base for SAFE. The safety assessment and safety planning components of SAFE were pilot tested in Anne Arundel County, Maryland. In an evaluation of 76 cases in which children determined to be unsafe were compared to cases served prior to implementation, two of the findings were that (1) use of the safety model was successful in reducing the rate of placement of maltreated children identified at CPS intake by 29 percent and (2) for 100 percent of the children in which a safety plan was developed, there was no further report of child maltreatment during the follow-up period.

They also looked at the South Dakota Department of Social Services, which had been implementing SAFE for both in-home and out-of-home cases for 10 years. The study noted that in its final CFSR report in 2008, the state had met the national standard for the safety data indicators pertaining to the absences of maltreatment recurrence and of maltreatment in foster care, as well as achieved overall ratings of strength for nine individual items. South Dakota had also met the national standard for the permanency data composite pertaining to the timeliness of reunification and permanency. A particularly noteworthy finding related to the case planning component of SAFE was the increased engagement of families and their increased satisfaction with services.
2 ONGOING READINESS FOR IMPLEMENTATION

Initial Readiness

According to Dymnicki, Wandersman, Osher, Grigorescu, and Huang (2014), “‘readiness’ refers to the extent to which an organization is both willing (motivation) and able (general and intervention-specific capacity) to implement a particular practice.” In a nutshell, readiness means that staff are “motivated (individually, as well as strategically) and capable of making the adjustments required.” The first step is to administer a readiness survey to capture an understanding of agency-wide views, values, and perceptions of organizational readiness for change. The survey results provide information about issues that need to be addressed within the competency, organization, and leadership drivers. In addition to the survey, key staff, including upper management, can provide insight to the implementation team about agency culture and possible points of difficulty.

LESSON LEARNED

This initial survey, and others like it to come, were conducted through lenses (e.g., National Implementation Research Network drivers) not previously known or used by the agency. In hindsight, the information was only partially helpful as the agency focus was often on day-to-day mission requirements, changes in leadership, and more internally driven demands. A primary area of need, identified early on and again in subsequent surveys, was that of stakeholder input and support—specifically, the legal system partners. Although never fully mastered during implementation, information from surveys remains an excellent resource for leadership even if imperfectly managed. The Washoe team continues to seek input from staff and stakeholders and is refining its use to support scaling-up and sustainability activities.

Consideration should be given to both internal changes to staffing responsibilities and to shifts in practice and to roles and responsibilities among the public and private child welfare workers and the various community service providers.

WCDSS EXAMPLE

The WCDSS child welfare worker and the the CC worker participated in the readiness survey. Results of the survey showed that both WCDSS and CC had the organizational and staff capacity to implement SAFE-FC. The SAFE-FC theories of change had a strong focus on locating and successfully engaging caregivers and on providing purposeful, change-focused services. Several existing organizational mechanisms and supports ensured fidelity to the program model and best practice standards. These included WCDSS and CC team meetings; weekly caseworker supervision; practice standards; fidelity assessments; feedback, coaching, technical assistance; routine quality assurance checks; and on-going monitoring by the project implementation and management teams. ACTION and the RYC provided support to Washoe County to build organizational readiness through their membership on the project implementation and the project management teams and through ongoing responsibility for developing a staff selection plan, SAFE-FC intervention manual, and standardized staff training curriculum; a coaching process with coaching provided by the purveyors; and fidelity measures and a performance assessment.
LESSON LEARNED

WCDSS and the CC found a positive readiness for organizational change and that the organizational climate was supportive of the project and related evaluation research. A challenge was in the legal community. Timely engagement with the legal community around the development of the intervention and frequent involvement along the way is a key hindsight observation.

The services to be implemented included safety services to control or manage impending danger to keep children safe during the time that change-focused services were put in place and for change to occur. These included hospitalization; emergency medical, mental health, and alcohol and drug services; in-home health care; supervision, daycare, respite care, and parenting assistance; basic home management; social and emotional support and crisis counseling; financial services; housing services; transportation; and emergency food and clothing. In Washoe County, the CC provides many of these services.

Following the assessment, gaps in needed services may be identified. Providers should develop a plan to identify specific service providers and to revise contracts as needed to align with SAFE-FC, including educating providers about SAFE-FC and developing protocols for communication between providers and SAFE-FC workers.

LESSON LEARNED

There is a need to clearly define roles and responsibilities when a public agency is contracting services from a private provider, as this created some difficulty in the seamless provision of timely services. It is also important not to avoid known communication or relational challenges. The work done to align the agency with its community safety service delivery partner was significant and ongoing. In an ever-intensive and demanding budget environment, building a seamless and mutually supportive working environment between public and private (or non-profit) entities is paramount. Matching agency cultures and philosophy was not easy and took dedicated leadership with formally installed and maintained teaming structures to succeed. Finally developed during full implementation, the project maintained the working expectations as defined early on during the “roles and responsibilities” work and has continued post-research as a regular business practice.

Ongoing Readiness

Implementation of innovations often occurs in a complex organization. As a result, the organization must pay constant and ongoing attention to readiness. Attention to ongoing readiness means paying close attention throughout the implementation process to the entire organization, both the people and the overall structure in which an innovation is being implemented. This can take multiple forms, e.g., administration of a readiness assessment before beginning implementation or targeted information gathering through meetings and outreach sessions. However, the information gathering occurs, it should include ongoing exploration of how an organization is currently operating and how it should or could be
operating to support the innovation more effectively. A readiness assessment could reveal that, in general, a certain innovation does not fit into the organization’s current mission and vision or that the organization needs to involve more partners. A targeted look could reveal that current hiring practices do not assess for the specific competencies needed for the innovation. Although assessment methods and results vary by organization and implementation stage, attention to ongoing readiness is crucial throughout the process.

One tool is the Readiness and Organizational Climate Re-Assessment Survey. The purpose of the survey is to assess the readiness of staff and organization climates at the implementing organization as they begin the initial implementation of SAFE-FC. In addition to gathering general information about the employment history of staff and identifying in how much SAFE-FC foundational training staff had engaged, the survey includes a scale of readiness for organizational change27 and measures of organizational culture/climate.

The Readiness for Organizational Change Scale gauges an organization’s readiness for change at the individual level. It measures the relationship between the content (i.e., what is being changed), the process (i.e., how the change is being implemented), the context (i.e., circumstances under which the change is occurring), and the individuals (i.e., characteristics of those being asked to change).28

The survey also consists of numerous aspects of culture, climate, and work attitudes. Culture and climate have been identified as key constructs in

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**WCDSS EXAMPLE**

The reassessment survey was administered twice during the 5-year project to individuals from the CC; the private providers, including SAFE-FC case managers, supervisors, and family therapists; and WCDSS employees representing various positions, including assessment staff, CPS supervisors, Emergency Response Unit staff, intake workers, SAFE-FC staff and supervisors, and several management representatives. The purpose of administering the tool a second and third time was to re-assess the perceptions of staff readiness and organizational climate at WCDSS and the CC as they continued implementation of SAFE-FC.

The respondents indicated the need for additional support when implementing SAFE-FC on issues of communication, expectations, training, workload, and coaching. They also identified needing additional information on data and progress sharing, service provision, and training on the intervention. They additionally identified workload and staff shortages, communication inconsistencies, lack of support from leadership, lack of availability of supervisors, burnout, and morale as problems facing SAFE-FC workers.

Workers were slightly satisfied with the selection process, which was determined by random assignment for evaluation purposes; generally satisfied with training; satisfied with coaching; and neither satisfied nor dissatisfied with leadership. Responses varied widely regarding satisfaction with supervision. They were dissatisfied with the agency’s administration of supports and conditions that make their work effective. This represented a continued decline in staff perceptions of management support. There was an increase in career commitment, personal competency, and supervisor competence and responsiveness.
organizational social context. Aspects of organizational culture included rigidity (i.e., structure and functioning subscales) and proficiency (i.e., responsiveness and competence subscales). Organizational climate included the following constructs: stress (e.g., emotional exhaustion, role conflict overload), engagement, and functionality (e.g., role clarity and cooperation/cohesion). The third aspect of the organization measured included work attitudes, such as dimensions of morale (e.g., career and organizational commitment, job satisfaction).

In addition to the internal organizational readiness and climate surveys, another tool, a Drivers Assessment, can be administered through a survey or facilitated onsite. The Drivers Assessment informs the implementing agency about competency drivers (e.g., staff training, staff coaching) and performance assessment and organization drivers (e.g., data-supported decision making, administrative supports, systems intervention). This survey should be administered multiple times to continue to inform decision makers of the effectiveness of implementation supports.

**WCDSS EXAMPLE**

Findings from the WCDSS Drivers Assessment indicated significant progress to facilitate efforts related to staff training, best practices in place in staff coaching, and performance assessment. The decision-supported data system was reported to not yet be fully in place, while leadership structures, processes and protocols, and strategies to address external issues that affect the ability to deliver SAFE-FC were largely in place.

When the Drivers Assessment was administered again about 1 year later, WCDSS found that staff training did not advance particularly around the use of training data to improve the process. There was improvement in the development of best practices in staff coaching, particularly around direct observation of frontline workers. There had, however, been significant progress in supports to facilitate performance assessment.

There was no change with the decision-supported data system. Processes and protocols that support facilitative administration had advanced, although there was a decrease in confidence that the leadership team will facilitate implementation of SAFE-FC. There was also a decrease in the belief about the extent to which external issues are important to the outcome of SAFE-FC.
3 TEAMING FOR IMPLEMENTATION AND COMMUNICATION

The implementation team guides the overall initiative by ensuring that the innovation is defined, operationalized, and implemented; ensures implementation supports are in place; identifies the measures for monitoring the initiative; and plans for sustaining the improved outcomes. A clearly defined teaming structure with defined communication linkages ensures that the implementation work is accomplished. The Terms of Reference (see Appendix A) provide important information about the linked teaming structure, purpose and responsibilities of each team, and role of each team relative to one another.

Teaming Structure

In WCDSS, the SAFE-FC structure included a Coordinator, 3 SAFE-FC supervisors, and 18 SAFE-FC workers evenly distributed among the supervisors. The WCDSS Director functions as the head administrator and provides executive oversight of the intervention. The WCDSS Division Director provides direct oversight and day-to-day managerial responsibilities by supervising the SAFE-FC Coordinator and supervisors.

Figure 1 illustrates how WCDSS opted to structure SAFE-FC. Implementing agencies can configure a teaming structure to best meet their own needs. Two teams are recommended to support the implementation: The Project Management Team (PMT) and the Implementation Leadership Team (ILT).

The ILT should comprise agency leadership, project leadership, and expert purveyors hired to help with the implementation of SAFE-FC. A community stakeholder advisory team should also be created to help identify needs of and services for the families within the county.

FIGURE 1: WCDSS PII TEAMING STRUCTURE

<table>
<thead>
<tr>
<th>Community Advisors</th>
<th>Community Advisors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Management Team</td>
<td>Project Management Team</td>
</tr>
<tr>
<td>Washoe County DSS County Director</td>
<td>Washoe County DSS County Director</td>
</tr>
<tr>
<td>Implementation Leadership Team</td>
<td>Implementation Leadership Team</td>
</tr>
<tr>
<td>Expert Consultants/ Purveyors</td>
<td>Expert Consultants/ Purveyors</td>
</tr>
<tr>
<td>Children’s Bureau Technical Consultants</td>
<td>Children’s Bureau Technical Consultants</td>
</tr>
</tbody>
</table>

Project Implementation Team

Work Teams
that come to the attention of the child welfare system. The PMT guides the process to ensure that SAFE-FC is defined, funded, operationalized, and implemented. Each team can have sub-teams with specific responsibilities.

As the purveyors, the RYC and ACTION’s roles are to provide expert guidance, training and technical assistance, and consultation related to SAFE-FC. Their staff participate on the PMT and ILT.

The implementing agency may have community-based partners that will also be active members of the PMT and ILT. Based on the state’s child welfare system structure, a state child welfare representative may also be a valuable member of the ILT. In Washoe County, representatives from the CC and the Nevada Division of Child & Family Services were involved.

Finally, an implementing agency may want to incorporate a group to provide feedback from a community perspective on issues that it anticipates need attention or on resources that are available to address barriers in the implementation process. WCDSS included the local Social Services Advisory Board, comprising community members, to keep informed of the ongoing implementation and evaluation.

Implementation Team Membership

The PII Project Director facilitates the PMT. Its mission is to serve as the steering committee responsible for decision making, overseeing and approving planning, evaluating and adjusting implementation efforts, overseeing activities, approving products, addressing community and system barriers, communicating and participating with stakeholders, and managing project funds. Membership includes senior leadership staff from the implementing agency, community partner organizations, and the purveyor(s). The PMT meets at least quarterly or more often when needed. It links directly to the ILT and Department Advisory Committee.

In Washoe County, representatives from the PII Training and Technical Assistance Project (PII-TTAP), PII-ET, and the Children’s Bureau were also involved.

The PII Project Director and ACTION Implementation Director co-facilitate the ILT. Its mission includes planning and installing implementation strategies as outlined by the PMT and directing the PII implementation teams or other ad hoc designated workgroups. The ILT meets at least monthly or more often when needed. It links directly to the PMT, Communication Team, and the Supervisors Joint Staffing Team. (See Appendix B for an ILT meeting protocol.)

Implementing agency leadership staff co-facilitate the Communications Team. Its mission is to facilitate communications internal and external to the agency about intervention activities. In Washoe County, the WCDSS and CC Supervisors Joint Staffing Team is co-facilitated by the WCDSS and CC SAFE-FC Coordinators. Membership includes all CC and WCDSS SAFE-FC supervisors. Its mission is to facilitate communication between the agencies and to coordinate intervention activities. The team meets monthly and links directly to the ILT, SAFE-FC Supervisors Team, CC Supervisors Team, SAFE-FC Staff Team, and CC Staff Team. (See Appendix C for the communication plan.)

The SAFE-FC Coordinator facilitates the SAFE-FC Supervisors Team, which includes all WCDSS SAFE-FC supervisors. Its mission is to facilitate SAFE-FC program leadership collaboration and coordination. The team meets weekly and links directly to the ILT, WCDSS/CC Supervisors Teams, and SAFE-FC Staff Team. The CC Coordinator facilitates the CC Supervisors Team and includes all CC SAFE-FC supervisors. Its mission is to facilitate SAFE-FC program leadership collaboration and coordination. Its focus is on the provision of safety, treatment, and change services to SAFE-FC intervention families. The team meets weekly and links directly to ILT and the WCDSS/CC Supervisors Teams.
The CC Coordinator facilitates the SAFE-FC Staff Team and includes all CC SAFE-FC staff. Its mission is to facilitate CC SAFE-FC program collaboration and coordination of staff resources. Its focus is on the provision of SAFE-FC intervention model service delivery to families. The team meets weekly and links directly to the SAFE-FC Supervisors Team, WCDSS/CC Supervisors Joint Staffing Team, and CC Supervisors Team. The CC Staff Team is facilitated by the CC Coordinator and includes all CC SAFE-FC staff. Its mission is to facilitate CC SAFE-FC program collaboration and coordination of staff resources. Its focus is on the provision of safety, treatment, and change services to SAFE-FC intervention families. The team meets weekly and links directly to the CC Supervisors Team and WCDSS/CC Supervisors Joint Staffing Team. Figure 2 depicts the linking of the various committees.

Teams are constantly evaluated. They can be added or disbanded based on changing circumstances and influences affecting the project. Teaming structure is a regular discussion of the ILT and is monitored by the

**FIGURE 2: LINKING OF SAFE-FC TEAMS**
Project Director. Based upon the stage of implementation, the Project Director oversees the monitoring of team functioning and develops recommendations for new teaming structures. Figure 3 shows a detailed chart of the WCDSS teaming structure and alignment.

As SAFE-FC moves from the Exploration and Installment Phase to Initial and later Full Implementation, the teaming structure should be reassessed to determine if it continues to align with the implementation of the intervention. For example, when Washoe County looked at the essential functions of its teaming structure, it became apparent that some teams had completed their work and were no longer needed (e.g., the Population 2 Case Review Team), while the Implementation Team had too many tasks

**FIGURE 3: WCDSS PII TEAMING STRUCTURE AND REALIGNMENT CHART (1-20-12)**

<table>
<thead>
<tr>
<th>Program Management Team (PMT)</th>
<th>Members: Schiller, Marsh, Durand, Sandoval, C. Holder, DePanfilis. Facilitated by: Durand. Mission: outlined in the original proposal. Meets at least monthly or more often as needed. Note: PMT members may attend any other team or workgroup as warranted.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation Leadership Team (ILT)</td>
<td>Members: Durand, C. Holder, T. Holder, DePanfilis, Cline, Negron, Kleinedler, Capello, Lynn (with focus on SAFE enhancement activities). Co-facilitated by Durand and C. Holder. Mission: to plan for implementation strategies outlined by the PMT and directs the implementation teams or specialty designated workgroups. Targeted to meet 2 times per month.</td>
</tr>
</tbody>
</table>
| Program Implementation Teams (PIT) | 1. **SAFE-FC Purveyor Team.** Co-leads are Cline and T. Holder. Focus is on installing SAFE-FC interventions (SAFE-FC & FC).  
2. **SAFE Purveyor Team.** Co-leads are Lynn and C. Holder. Focus is on installing ACTION SAFE model enhancements.  
3. **Intake Team.** Co-leads are Lynn and Capello. Focus is on installing enhancement to the IA structure/process.  
4. **Evaluation Team.** Co-leads are Negron and DePanfilis. Focus is on PII research and evaluation tasks.  
5. **FC Intervention Team.** Co-leads are Kleinedler and DePanfilis. Focus is on developing intervention approach and procedures for installing FC (Note: has cross-over relationship with SAFE-FC Team).  
6. **Safety Services Team.** Co-leads are Holder and Kleinedler. Focus is on assessing and developing strategies for any system barriers and gaps in the availability or delivery of PII-related safety services.  
7. **Pop 2 Case Review Team.** Co-leads are Kleinedler and Negron. Focus is on pre-implementation task of screening Pop 2 cases for available parent or other caregiver.  
8. **Communications Implementation Team.** Lead is Theresa Anderson. Focus is on installing a PII communication structure.  
9. **Leadership Team.** Co-leads are Durand and C. Holder. Focus is on assessing overall teaming structure, communications, and adherence to implementation plan. Facilitates any immediate decisions and realignments as necessary. Meets weekly. |

Note: The specific membership, meeting frequency, and scope of work developed by the various teams is further refined by team leads and monitored by the ILT.
and needed to create new teams to manage increasingly important functions. Additionally, the functions of some teams had evolved over time. The Intake Team had completed its work to install enhancements to the intake assessment structure and process.

As SAFE-FC is delivered, the ILT ensures that data is collected on the capacity of the practitioner to deliver SAFE-FC as intended. The Project Director and the Evaluation Liaison collect data through performance assessments, competency exams, and fidelity reviews. The ILT reviews the data and passes its analysis and interpretation of the data on to supervisors, who are on the ILT making it a mechanism for them to share their concerns with the decision makers.

**WCDSS EXAMPLE**
The ILT Team changed the protocol (see Appendix B) for its monthly meeting during installation to ensure that follow-up on assignments was occurring. It also identified that SAFE-FC, which was in an evaluation phase within the larger Washoe County Children's Services Division, was not well integrated into the larger agency. This left the practitioners feeling isolated from their peers within the agency. The county created the SAFE-FC Practitioners Team to collectively support their ability to deliver the intervention as intended and to use the data from fidelity reviews, supervision, and coaching to improve performance. This revised team structure is pictured below in **Figure 4**.

**FIGURE 4: REVISED WCDSS TEAMING STRUCTURE**

- Executive Management Team
- Project Management Team
- Implementation Leadership Team
- Monitoring & Evaluation Team
- Supervision & Coaching Team
- Intervention Practitioners Team SAFE-FC from CC and WCDSS led by Dena
4 PRACTITIONER RECRUITMENT AND SELECTION

An implementing agency may need to design its own practitioner recruitment and selection process. WCDSS used a randomized controlled design, the gold standard for program evaluation, to test the effectiveness of WCDSS to improve permanency outcomes among the target population. In randomized controlled design, study participants are randomly assigned to either a treatment or control group. This design minimizes the chances that any final differences between the treatment and comparison group stem from factors other than the intervention. In order for the rigor to be at the highest level for the intervention, Washoe County agreed to randomize its permanency caseworkers into either the intervention group or the control group. The CC staff were not randomly assigned. In addition, as turnover occurred, Washoe County project staff informed leadership of a randomized staff selection process for treatment units or control units that was previously developed in conjunction with PII-ET.

The following sections detail the values, competencies, and skills staff should have to implement SAFE-FC without the restriction of random assignment.

Roles and Qualifications of SAFE-FC Staff

SAFE-FC Leadership

The Project Director directs the PMT and co-facilitates the ILT. He or she is responsible for the day-to-day management of the project, including forming and managing the PMT, involving and communicating with initiative partners, coordinating and managing the implementation plan, and overseeing administrative and financial reporting and accountability. The Project Director is responsible for the supervision of the Fiscal Manager and assigned administrative support. WCDSS’s team also included an Evaluation Liaison as part of the rigorous evaluation. The Evaluation Liaison performs those data research and other activities as assigned by the Project Director, as well as those critical to the program evaluation.

A service provider must be identified whose primary responsibility is the delivery of safety services and change-focused and concrete services to those children and families who have been randomized into the SAFE-FC intervention. In Washoe County, The CC had a Family and Youth Intervention (FYI) Program Director. The FYI Program Director is the lead administrator responsible for planning, development, and oversight of the Coordinator, supervisors, and case managers involved in SAFE-FC and other programs under CC’s umbrella. He or she is responsible for the supervision of the Coordinator who, in turn, supervises a marriage and family therapist intern, a program assistant, and two supervisors. The supervisors oversee the day-to-day functions of four and six case managers respectively. WCDSS assessment supervisors and SAFE-FC supervisors send referrals directly to the CC Coordinator, who assigns cases to the case managers.

LESSON LEARNED

The provision of safety and concrete services does not need to be solely contracted out to a private agency. WCDSS is exploring the development of internal staff to provide safety services to improve their timely provision, which would allow more children to remain in their homes rather than entering out-of-home care or agency custody.
SAFE-FC Worker

The SAFE-FC worker is the implementing agency’s permanency worker who is responsible for conducting PCFA and PCPA with the family. The worker monitors the effectiveness and intrusiveness of the safety plan in collaboration with the case manager and is also responsible for all tasks related to ongoing cases with the public child welfare agency (e.g., case planning, court reviews, reasonable efforts, etc.).

Values

A SAFE-FC worker’s personal qualities and beliefs are influential aspects of his or her professional competency, which significantly affect how the PCFA is performed. The PCFA at its core is a highly interpersonal process that relies heavily on what a SAFE-FC worker brings “to the table,” including values, beliefs, motives, and perceptions about families who need SAFE-FC intervention. The PCFA is caregiver-centered, consistent with the person-centered approach advanced by humanistic psychologist, Carl Rogers. According to Roger, the three most important personal characteristics are (1) authenticity or genuineness, (2) acceptance, and (3) empathy. The PCFA incorporates four additional personal qualities or beliefs advanced by pioneering clinician, Albert Ellis: (4) motive, (5) self-awareness, (6) open-mindedness, and (7) optimism.

To be an effective helper, it is important that the SAFE-FC worker expresses a belief that maltreating caregivers, even those who have multiple problems, have the potential to change. Furthermore, he or she asserts the belief that when caregivers are approached in a nonjudgmental manner, they will be more inclined to become internally motivated to make changes in behaviors and conditions that jeopardize their protective capacity.

Qualifications

In Washoe County, SAFE-FC workers were hired as part of a civil service classification and merit system. The units comprise workers at various levels of experience, from Case Manager I to Social Worker III. The Social Worker series is divided by level of experience, from 1–3 years, with possession of a master’s degree serving as partial experience at each level. The entry-level Case Manager I requires a bachelor’s degree from an accredited college or university in criminal justice, psychology, social work, sociology, or a closely related field. The Case Manager must complete a master’s degree in social work and obtain a license to practice social work in order to be promoted to the Social Worker level. Social Worker I, II, or III also requires a license to practice social work in the State of Nevada at the time of appointment.

In addition to the requirements of the Case Manager and Social Worker classifications, the SAFE-FC worker needs the following qualifications:

- Personal qualities, knowledge, and skills to facilitate the PCFA process
- Working knowledge of the concepts that form the basis of child safety assessment in order to effectively serve caregivers and family members during the PCFA
- Knowledge of theories and models that contribute to and govern the PCFA
- Interpersonal skills that enable him or her to effectively engage and direct conversations with caregivers
- Demonstrated ability to apply safety-related concepts and criteria as part of safety intervention responsibilities and continuing safety management
- Ability to:
  - Prepare for Discovery meetings through determining how computer-assisted self-interview (CASI) clinical measures will be used to raise caregiver self-awareness
  - Identify both diminished caregiver protective capacities on which discussions with caregivers will focus (i.e., what must change and the caregiver’s readiness to change) and children’s unmet needs and how best to meet them
- Use a family system approach in facilitating Discovery and case plan meetings with caregivers and thoroughly document outcomes of those meetings
- Develop SMART goals and SMART case plans

**Responsibilities**

The SAFE-FC worker is responsible for:

- Activities that surround the development of the PCFA (e.g., reviewing the NIA, CASI, safety plan, and family assessments; engaging family; arranging for professional evaluations)
- Development of SMART case plans with caregivers and others that identify the core outcomes and SMART goals and are stated in caregiver language and related to enhancing diminished caregiver protective capacities
- Implementation and management of safety plans and safety services and confirmation of safe environments
- Case coordination, as outlined in the SAFE-FC protocol, that provides support and social connection and facilitates the change process
- Meeting caregiver and child needs and enhancing caregiver protective capacities through services provided and outlined in the SMART case plan
- Completion of the PCPA, which measures progress and change related to case plan outcomes and goals, effectiveness of interventions, and enhancement of caregiver protective capacities, and of safety plans
- Participation in weekly consultations with the SAFE-FC supervisor and providing him or her all updates and progress reports

**SAFE-FC Supervisor**

Consultation between the SAFE-FC worker and the SAFE-FC supervisor related to practice and decision making is the most important factor for changing practice and helping families. The discussions and problem solving sessions are aimed to coach and help the SAFE-FC worker engage families to guide and involve them through the CPS involvement and stages of service provision. The consultations are also a way for the SAFE-FC worker to increase their interviewing, engagement and assessment skills when working with families. Consultation and coaching are two of the “Competency Drivers” to further the Department’s goal toward maintaining fidelity to the SAFE-FC model.

**Qualifications**

A SAFE-FC supervisor must possess a license to practice social work or a master’s degree from an accredited college or university in marriage and family therapy (MFT) or a closely related field and licensure in the State of Nevada to practice as a marriage and family therapist and have 3 years of experience in children’s services. The SAFE-FC supervisor must possess the knowledge and skills to oversee the SAFE-FC workers performance of SAFE-FC practices and to provide the coaching and mentoring necessary to encourage skill building and effective performance.

**Responsibilities**

The SAFE-FC supervisor, in addition to the knowledge, skills, and abilities required for the position, is responsible for the following:

- Assigning the case to a SAFE-FC worker
- Scheduling the transfer staffing to include critical parties (e.g., SAFE-FC worker and supervisor and assessment worker and supervisor)
- Reviewing the case material, CASI clinical measures, safety assessment, and safety plans for consultation with the SAFE-FC worker in initiating the PCFA Preparation Stage and in managing child safety
- Supporting case movement and effective practice and decision making with the SAFE-FC worker at each stage of the case
4  Practitioner Recruitment and Selection

- Reviewing and approving SMART case goals and plans and documentation from the various processes
- Providing coaching, mentoring, practicum experiences, and training to enhance worker performance through weekly case consultations

SAFE-FC Coordinator

The SAFE-FC Coordinator is the senior program manager with direct oversight of the SAFE-FC supervisors and their units. The Coordinator provides direct oversight to the SAFE-FC supervisors during the day-to-day operation of the program. This individual also reports directly to the CPS Division Director and facilitates communication throughout the organization on matters affecting the SAFE-FC units. The Coordinator ensures that the necessary resources are identified and available to sustain the mission of the SAFE-FC units. The Coordinator will, in the absence of a supervisor, perform direct case consultation and supervision to SAFE-FC staff.

Qualifications

A SAFE-FC Coordinator must be (1) licensed to practice social work or eligible for licensure or (2) have a master’s degree from an accredited college or university in MFT or a closely related field and have a license or eligibility for licensure to practice as a marriage and family therapist: and have 3 years of supervisory experience. In addition to policy development, project planning, and budget development and monitoring, the SAFE-FC Coordinator must have the knowledge and skills to develop and maintain linkages to the community, evaluate program effectiveness, and analyze trends which affect program services and activities.

Responsibilities

The SAFE-FC Coordinator is viewed as an expert in the SAFE-FC intervention. In addition to program oversight and the duties required for the Coordinator position, the SAFE-FC Coordinator is also responsible for:

- Monitoring the results of competency exams and developing the skill level of the SAFE-FC supervisors in coaching and mentoring their workers in areas as identified as needing improvement
- Assisting in the development of quality assurance systems for tracking various measures (e.g., weekly face-to-face contacts with clients and service providers, child visitation) and of meeting outcomes
- Developing strategies to sustain SAFE-FC in conjunction with others working on the project

Roles and Qualifications of Children’s Cabinet Staff

As stated earlier, the CC was selected to collaborate with WCDSS in the SAFE-FC project because it possesses characteristics that are both aligned with the foundational values of SAFE-FC and conducive to the implementation of community-based safety management. These characteristics, which have allowed for success in the development and sustainment of community-based safety services include:

- A positive reputation in the community as a resource for families; more important than particular services, the CC is known for promoting family-centered practice.
- The flexibility to amend agency policies to allow for the required range of safety management practices. For example, the CC allows evening and weekend hours, work to occur despite typically acceptable reasons for office closure (e.g., holidays, extreme weather, etc.), and flex-time (e.g., employees can work more or less hours each day and week as safety plan activities fluctuate).
- An established, or are able to establish, an on-call system in order to be reached by families after hours
- Experience and success with writing for, being awarded, and effectively managing grants to develop matching funds to support sustainability
• An existing, effective working relationship with WCDSS
• A financial and leadership infrastructure that allow for the ability to enter into and execute contracts in a timely fashion
• The ability to hire and train staff as needed to manage fluctuating amounts of work as the program is developed, implemented, and maintained
• Possession of agency liability insurance for a variety of purposes, including work with children and families, providing transportation, and conducting home visits

The CC staff selection process initially involved opening the SAFE-FC-related positions to interested staff across multiple existing programs. The CC then chose staff from the pool of applicants that showed interest in the new challenge and who expressed values aligned with the SAFE-FC program philosophy during the interview process. This may not have been as rigorous a staff selection process as desired. These decisions were reviewed by CC management, who approved a change in the work-duty assignment. The chosen staff were successful working at the CC previously and aligned with their agency’s values and philosophy.

LESSON LEARNED
In hindsight, additional qualities of successful safety management staff were identified as community-based safety management in the context of SAFE-FC began to take shape. Because of the distinctive nature of safety management, and thus the requirement for specialized training, safety management is well suited to entry-level (and beyond), bachelor-level employees. With appropriate training and subsequent consultation support, safety case management (SCM) is successful with staff that possess the following character traits:

• Ability to express empathy toward caregivers
• Genuine engagement skills
• Ability to maintain unconditional positive regard
• Working knowledge of community resources (e.g., food banks, rental assistance, utility assistance, transportation, etc.)
• Experience working with families and, particularly, caregivers
• Comfort level and familiarity with home visits
• Ability to self-manage schedule and priorities on a daily basis

Children’s Cabinet Safety Case Management Program
The CC SCM Program is designed to provide safety management, planning, plan coordination, and services to WCDSS families with unsafe children who have been randomly assigned to the SAFE-FC intervention. The program is organized in alignment with WCDSS structure. SCM supervisors maintain weekly or more communication with Safety Case Managers in a coaching and consultative role to assure accurate application of safety management standards and protocols. The Safety Case Managers are managed by a Coordinator who assures consistent and effective program implementation.

Children’s Cabinet Case Manager
The case manager provides safety-related case management services in the program for families who are going to receive the SAFE-FC intervention with constant collaboration with the family’s social worker (a SAFE-FC worker).
Qualifications
The Case Manager should possess a bachelor’s degree in human services or a related field or a bachelor’s degree plus 2 years of experience in human services. He or she must have:

- Knowledge of family and youth issues
- Case management skills
- Knowledge of community resources
- Appropriate interactions with youth and families
- Organizational skills
- Demonstrated follow-through
- Ability to:
  - Learn new ideas and skills through reading or hands-on training
  - Express ideas clearly and concisely orally and in writing
  - Work with adults and youth of diverse backgrounds and beliefs
  - Problem solve in stressful situations
- Knowledge and skills to:
  - Assess child safety
  - Recognize behaviors of family members that pose present or impending danger to a child

Responsibilities
The Case Manager assigned to SAFE-FC is responsible for:

- Implementing the SAFE-FC program
- Providing:
  - Information and referrals for SAFE-FC families
  - Direct safety services and SCM to SAFE-FC families
  - Appropriate referrals to school and community resources regarding status offenses, as well as concrete and emergency basic needs
  - Case management services to families and youth that participate in the family strengthening programs
- Profiling and screening for needs of youth and families
- Participating in:
  - Supervision staffing of cases at least weekly
  - Safety plan determination meetings (SPDM) with SAFE-FC workers as described in PCFA and PCPA policies and procedures
  - The PCPA process in consultation with the SAFE-FC worker by assessing caregivers and children through assessments and providing reports to the SAFE-FC worker
- Entering all case level case notes the state’s Statewide Automated Child Welfare Information System (SACWIS)
- Delivering directly or arranging for other community formal safety services and assuring safety services are suitable and relevant to managing impending danger
- Providing targeted treatment services to support SMART case plans or will facilitate, consult, and contract with other treatment providers in conjunction with completed evaluations that occurred as part of PCFA
- Developing an array of services, which (1) match the enhancement of core caregiver protective capacities and child outcomes and (2) provide targeted treatment services to support SMART case plans or will facilitate, consult, and contract with other treatment providers in steps and services that respond to the needs of children or their families
- Actively contributing to the ongoing monitoring and support to families to achieve case outcomes and goals by (1) participating in the collaborative case coordination meetings with the SAFE-FC worker and the family and (2) maintaining routine contact with caregivers, children, and in and out of home providers
Children’s Cabinet Case Management Supervisor

The Children’s Cabinet Case Management Supervisor oversees and manages the CC safety case managers, assigns cases, reviews casework, ensure compliance to program policies and regulations, provides consultation and may provide direct casework services to families in the SAFE-FC program.

**Qualifications**

The CC Supervisor should have a bachelor’s degree and at least 2 years’ work experience, which includes program planning, case management, and crisis management experience. The position also requires:

- Knowledge of community agencies and resources
- Understanding of the problems facing children, youth, and families
- Leadership skills, including sound decision making, crisis management techniques, staff motivation
- Case management skills
- Self-motivation and ability to be a team player
- Organization skills
- Demonstrated follow through
- Ability to:
  - Express ideas clearly and concisely both orally and in writing
  - Work with adults and youth of diverse backgrounds and beliefs
  - Problem solve in stressful situations
  - Implement case management strategies with identified families

**Responsibilities**

The CC Supervisor is responsible for:

- Scheduling and organizing intakes on all families for SAFE-FC and monitoring case manager workload
- Monitoring referrals and scheduling appointments, as needed
- Assisting case managers and interns in contacting families and resolving identified concerns with families
- Monitoring and assisting case managers in provision of safety services and management to clients, as needed
- Creating and maintaining contacts with safety service provider agencies within the community
- Entering, updating, and monitoring computerized client databases(s) for SAFE-FC, as needed
- Staffing weekly with SAFE-FC case managers
- Completing monthly chart audits and conducting program evaluation to ensure service quality
- Disseminating information about SAFE-FC, including community presentations and program materials, and performing other outreach functions, as needed

Children’s Cabinet Case Management Coordinator

The Children’s Cabinet Case Management Coordinator manages the day-to-day programmatic operation of the safety case management program. This individual provides direct supervision and consultation to the CC Supervisors; collaborates and consults with the SAFE-FC Coordinator, and oversees the resources allocated to the program. The CC Coordinator communicates to both internal and external stakeholders about the program and develops resources to support the sustainability of services.

**Qualifications**

The Children’s Cabinet Case Management Coordinator position requires a bachelor’s degree and at least 2 years’ work experience, which includes program planning, case management, and crisis management.
experience. The position also requires:

- Knowledge of community agencies and resources
- Understanding of the problems facing children, youth, and families
- Leadership skills, including sound decision making, crisis management techniques, staff motivation
- Case management skills
- Self-motivation and ability to be a team player
- Organization skills
- Demonstrated follow through
- Ability to:
  - Express ideas clearly and concisely both orally and in writing
  - Work with adults and youth of diverse backgrounds and beliefs
  - Problem solve in stressful situations
  - Implement case management strategies with identified families

**Responsibilities**

The CC Case Management Coordinator is responsible for:

- Collaborating directly with the implementing agency to ensure program development and implementation
- Developing and implementing SAFE-FC
- Coordinating the referral and intake processes for SAFE-FC
- Maintaining and monitoring all families involved with SAFE-FC
- Assisting supervisors resolving identified concerns with personnel and families
- Ensuring all program-related policies and procedures are implemented and followed
- Participating in ILT activities, including meetings, updates, trainings, and revisions to policies and procedures, as needed
- Participating in research and data collection, as required
- Entering, updating, and monitoring computerized client databases(s) for the identified program
- Completing monthly program reports and conducting program evaluation to ensure service quality
- Disseminating information about the identified program, including community presentations and program materials, and performing other outreach functions, as needed
- Scheduling and organizing intakes on all families
- Maintaining and monitoring the program waiting list, including client and referral contacts and appointments
- Submitting monthly reports on program activities to the Program Director and funding sources, as needed
- Implementing and evaluating measurable outcomes for SAFE-FC
- Setting annual goals and objectives related to specific job functions
- Assisting case managers and interns in contacting families and resolving identified concerns with families
- Participating with the SAFE-FC worker and family in the SPDM
- Monitoring the need and use of safety services to further examine gaps and to drive the development of necessary services. In conjunction with the Service Array Workgroup and PII-ET, the coordinator will develop a consistent, standardized method of tracking what services are used, what service development may be needed beyond the original plan, and what services were unable to be developed, as well as a way to communicate this monitoring to the PMT and ILT
- Facilitating the assignment of a Safety Services Specialist to develop and implement additional safety services at the level of intensity needed to manage safety
5 CLIENT RECRUITMENT AND SELECTION

As discussed earlier, two populations of children and families are served by SAFE-FC.

**Population 1:** Population 1 consists of all new cases deemed unsafe based on impending danger after an initial assessment is completed. In this manual, the NIA is referenced as the assessment tool; other agencies may replace the NIA with their own investigation instrument and process. Existing cases receiving a new NIA are ineligible for Population 1 assignment. Children aged 17½ or younger deemed unsafe on a new incoming case are eligible for Population 1. When a new report is received, an assessment period of up to 30 days occurs during which safety is determined. At the end of this assessment period, a case is either deemed safe, and is ineligible for the intervention, or unsafe and therefore eligible. Those cases assigned to treatment are then assigned to a SAFE-FC worker.

In Washoe County, random assignment of families into intervention and control groups occurred after the initial determination of unsafe. At this point, randomization will occur within the UNITY system (Nevada’s SACWIS), and a caseworker will be assigned after random assignment.

**Population 2:** Population 2 includes current cases that meet the three inclusion criteria: (1) have been in care 12 or more months at the date of implementation, (2) have one or more case risk characteristics at time of placement (e.g., parental substance abuse, homelessness or inadequate housing, single-parent households, or parental incarceration), and (3) have an available caregiver. The first step in determining eligibility is a review of available information to assess whether a child meets the first two inclusion criteria and does not fit the exclusion criteria.

If a child meets the first two inclusion criteria, then a case review determined whether a child has an available caregiver (i.e., the person from whom the child was removed) who is willing to become a permanency option for the child in care. If a caregiver is available, then the case becomes eligible. Eligible Population 2 cases will remain with their assigned caseworker.

**WCDSS EXAMPLE**

Based upon the evaluation plan, 40 percent of incoming cases were randomly assigned to treatment, and 60 percent were randomly assigned to usual permanency services. This proportion was intended to adjust for the caseload capacity of the treatment workers as there were additional case activities required, such as weekly contacts with caregivers. While UNITY was programmed to determine if a case went to treatment or control, the Evaluation Liaison was actually responsible for making the case assignment to the worker to ensure that these percentages were accurate. This was because a system error prevented this from occurring in the first month of implementation.
6 OPERATIONALIZED INTERVENTION

As discussed in prior sections, there are two overall phases of SAFE-FC: (1) Safety Assessment and Management, which occurs during the public child welfare intake and assessment process, and (2) Change Focused Intervention and Ongoing Safety Management. The Safety Assessment and Management phase is designed to identify which families will be served by the implementing agency (pre-SAFE-FC activities). Phase 2, Change Focused Intervention and Ongoing Safety Management, reflects the SAFE-FC intervention, which addresses the changes required to restore caregivers to their protective role. Phase 2 only occurs once a decision is made that the case needs to be opened for ongoing services.

Safety Assessment and Management

Intake Assessment
Intake Assessment (IA) is the first assessment within the safety protocol. The IA is the decision-making method concerned with evaluating reports of threats to child safety to identify families that may be in need of SAFE-FC. The IA occurs as part of the intake process. Intake has two service objectives: (1) to provide the point of contact for the community to express its concerns about children who may be in need of protection and (2) to launch the safety intervention process whereby children in need of protection and families in need of SAFE-FC are identified and served. The purpose of the IA is to identify caregivers (after receiving a report of an unsafe condition) as being unable or unwilling to protect their children from impending danger. This includes consideration of the presence of threats to a child’s safety, of vulnerable children, and of caregivers with diminished caregiver protective capacities.

Nevada Initial Assessment
As discussed earlier, in safety intervention, the NIA is the first assessment occurring face to face with a family to determine the need for protective service. This process may have previously been called an investigation. The NIA employs safety concepts and decision-making methods concerned with reconciling information contained within CPS reports about alleged severe maltreatment and alleged threats to child safety. The purpose of the NIA is to determine who will be served by CPS in the process of assessing and reaching conclusions about caregivers who are unable or unwilling to protect their children from impending danger. This includes the assessment and management of present and impending danger, the identification of vulnerable children, and the assessment of caregivers with diminished caregiver protective capacities.

The NIA results in three decisions:
1. Has maltreatment occurred, or is maltreatment occurring?
2. Is a child in this family subject to impending danger?
3. Is this a family who should be served by ongoing CPS?

Change Focused Intervention and Ongoing Safety Management

Using Standardized Assessment Instruments
SAFE-FC is an outcome-driven practice model. Thus, standardized assessment instruments are used as part of the assessment process. Workers may evaluate change over time by examining the changes in scores on instruments, and these instruments may also enhance the workers’ awareness of the families’ strengths and needs, particularly as they relate to caregiver protective capacity. The use of standardized
assessment instruments may also increase workers’ understanding of progress that families make in strengthening their capacity in identified areas of functioning.

Selection of Standardized Assessment Instruments
Selection of each standardized assessment instrument occurred through a process that included its relevance and direct relation to the SAFE-FC theory of change and logic model, prior use by similar programs, and its psychometrics (i.e., reliability and validity).

Relevance to SAFE-FC Theory of Change
A theory of change includes underlying assumptions about why proposed strategies are intended to produce positive intervention outcomes. With the implementation of SAFE-FC, positive changes, or increases, were proposed for caregiver resilience, parenting attitudes, social support, and home stability. Simultaneously, decreases were proposed for parenting stress, caregiver mental health problems, and child behavior problems. Factors thought to mediate, or facilitate, the change process included the helping alliance and caregiver readiness to change. Figure 5 illustrates the SAFE-FC theory of change graphically.

FIGURE 5: SAFE-FC THEORY OF CHANGE
Nine standardized assessment instruments are included in SAFE-FC:

1. Resiliency Attitudes Scale (RAS)
2. Adult-Adolescent Parenting Inventory (AAPI)
3. Social Provisions Scale (SPS)
4. Adverse Childhood Experiences (ACE)
5. Parenting Stress Index (PSI)
6. Brief Symptom Inventory (BSI)
7. Child Behavior Checklist (CBCL)
8. Readiness for Change Index (REDI)
9. Helping Relationship Inventory (HRI)

Additionally, a set of housing questions adapted from work conducted by Susan Zuravin and Diane DePanfilis are also included.

**Lesson Learned**
It should be noted that the number of assessment instruments used in the research was larger than what may be necessary in future replication efforts.

**Protective Capacity Family Assessment**
The PCFA is a structured intervention component of SAFE-FC, a comprehensive safety intervention system. It is the assessment completed after a case is transferred from the assessment worker to the SAFE-FC worker and is the beginning of planned change. The process of implementing the PCFA is crucial for setting the tone regarding the working relationship between SAFE-FC workers and caregivers and for establishing the outcomes for targeting service delivery. The PCFA process is intended to engage caregivers in a partnership to clarify what must change to enhance caregiver protective capacities and, ultimately, to achieve safety, permanency, and child well-being. The PCFA is an interpersonal discovery process between the SAFE-FC worker and caregivers, which results in SMART case plans. The case plans identify how impending danger can be reduced or eliminated and which diminished caregiver protective capacities can be enhanced.

**Objectives**
The objectives of the PCFA are the following:

- Explore caregivers’ perceptions related to impending danger threats that were identified through the NIA and to fully understand how impending danger is occurring in a family
- Verify that the safety plan developed at the conclusion of the NIA is sufficient to manage impending danger
- Make adjustments to the safety plan as necessary
- Ensure that the caregivers are provided with explicit information regarding the justification for their case to be opened for SAFE-FC
- Use standardized self-assessment instruments to gather information from caregivers about factors that may enhance or diminish their behavioral, cognitive, and emotional protective capacities
- Provide caregivers with an opportunity to participate in conversations regarding identified family problems
- Explore solutions for addressing identified family problems
- Increase self-awareness of caregivers related to enhancing diminished caregiver protective capacities
- Support caregiver self-determination and promote ownership among caregivers in the determination of necessary changes to enhance their capacity to be protective
- Assess the individual needs of children and collaborate with caregivers in the determination of goals and solutions for meeting their children’s needs
- Determine the readiness, willingness, and ability of caregivers to work toward behavioral change related to caregiver protective capacities
• Develop criteria-based SMART goals with caregivers that target intervention related to the enhancement of diminished caregiver protective capacities
• Determine a strategy for supporting caregiver change and for identifying treatment services that will be incorporated into an individualized case plan

**PCFA Intervention Stages**

The PCFA includes three stages designed to achieve the practice objectives for engaging caregivers, raising self-awareness about problems, considering the need for change, and seeking agreement regarding what must change. At the conclusion of the PCFA, the SAFE-FC worker and caregivers agree on case outcomes that will later drive the identification of SMART goals in the case planning component of SAFE-FC.

The PCFA stages are Preparation, Introduction, and Discovery, which outline the level of effort required by the SAFE-FC worker for completing the assessment process. Each PCFA intervention stage has identified areas of assessment content to be considered. The requirements for effectively completing the PCFA include facilitative objectives that represent what needs to be accomplished during each PCFA stage. The three sequential stages of the PCFA give SAFE-FC workers a “road map” for guiding caregivers through the intervention process by helping them stay focused when facilitating conversations.

During the Preparation Stage, the SAFE-FC supervisor reviews the NIA case material and CASI Family Profile and makes judgments about the status of the case; the sufficiency of information provided; the NIA decisions; and the relationship of results of the CASI measures to other data and NIA results. The review also prepares the supervisor to provide guidance to SAFE-FC workers to prepare for the PCFA process and for immediate safety management.

The Introduction Stage is about creating a good first impression. To the extent that caregivers view the SAFE-FC worker as open, accepting, nonjudgmental, genuinely concerned, respectful and understanding, it will go a long way toward establishing a relationship with caregivers that is helpful for promoting change.

The intent of Discovery is for caregivers to become internally motivated to change. In this sense, the “discovery” that occurs as a result of PCFA intervention is primarily for the caregiver. Therefore, the SAFE-FC worker understands that it is important to be creative in approaching Discovery Stage conversations as well as appreciating that his or her use of self is key to meeting facilitative objectives.

During the Discovery Stage, the SAFE-FC worker continues to employ interpersonal skills and techniques that contribute to involving the caregiver in an exploration of what must change in order to restore the caregiver to his or her protective role and responsibilities. The intent of the Discovery Stage is to identify and discuss with caregivers what must change with respect to diminished caregiver protective capacities associated with safety threats and determine what parents/caregivers are willing to address and change.

As the SAFE-FC worker proceeds through the Introduction and Discovery Stages of the PCFA, caregivers are encouraged to participate in conversations that include:

- Discussing their perceptions regarding child welfare agency involvement
- Discussing the reason the case was opened
- Seeking caregiver viewpoint about problems that were identified as related to impending danger
- Considering their perspective about what they do well as caregivers
- Raising self-awareness about the need for change
- Seeking mutual agreement about the need for change
- Identifying what must change related to the enhancement of diminished caregiver protective capacities
Later, the results of the PCFA are used to develop SMART goals during the case planning component of SAFE-FC.

While the three PCFA stages provide SAFE-FC workers with a defined structured, the assessment process should be approached in a flexible manner. The PCFA stages delineate specific assessment content questions and facilitative objectives; the assessment approach, however, is flexible in terms of the interaction with families.

**Decisions**
The PCFA decisions are:

- Is the safety plan sufficient and the least intrusive way to manage impending danger?
- What is the caregiver’s level of readiness for changing the behaviors and conditions that threaten the safety of the children?
- What behaviors and conditions contribute to impending danger and diminished protective capacity and, alternatively, what factors serve to enhance caregiver protective capacities?
- What specific physical, emotional, cognitive, behavioral, and social needs of the children should be targeted for intervention?
- What are the specific family outcomes that will drive the development of SMART goals in the case plan (i.e., the next SAFE-FC component)?

**Facilitative Role of the SAFE-FC Worker**
The SAFE-FC worker’s primary role is to facilitate a caregiver-centered interpersonal assessment process that is based on a set of basic principles for facilitation. The SAFE-FC worker’s professional “use of self” with respect to actively facilitating the PCFA process is essential to intervention effectiveness. The PCFA is not a passive activity. SAFE-FC workers must be prepared to take the lead in involving caregivers’ participation in completing the process.

In terms of promoting practice efficiency, it is necessary that the SAFE-FC workers intentionally guide caregivers through the process by facilitating conversations with caregivers. The conversations that occur with caregivers during the PCFA intervention stages are formed around the achievement of specific desired results. In other words, it is the facilitative objectives of the PCFA that dictates what needs to be discussed with caregivers and how SAFE-FC workers should behave when conducting the intervention. From this perspective, it is crucial that SAFE-FC workers are fully informed regarding the rationale for the PCFA with respect to the purpose and practice objectives and that they are thoroughly prepared for what they want to accomplish during each meeting that occurs during each of the PCFA intervention stages.

There are five general responsibilities that a SAFE-FC worker has for facilitating the PCFA process:

1. Interact with caregivers in such a way that they are actively engaged to participate in the process
2. Guide conversation during the PCFA intervention stages based on the achievement of designated facilitative objectives
3. Empower caregivers during the process by assuring that they are provided with timely information that keeps them informed regarding the overall status of their case and the status of their children
4. Assure that safety is sufficiently managed by effectively overseeing the provision of safety plans
5. Assist caregivers and children in accessing treatment services that are best suited to help them reach identified goals for change

**Figure 6** summarizes the basic principles for facilitating the PCFA.
Level of Effort and Diligence for Completing the PCFA

The protocol typically occurs over 30–40 days and represents approximately 6–11 hours of time getting to know the caregiver and the family. When caregivers are more easily engaged and have fewer issues and children, the level of effort may be less than if the caregiver is highly resistant to engaging with the SAFE-FC worker and/or when children in the family have specific needs that need to be understood.

To meet SAFE-FC fidelity criteria, a minimum of 1 hour per week is spent getting to know the family in the PCFA process. However, workers will typically meet with the family more than once per week during the PCFA. Necessary contact is determined by what can be considered reasonable effort to arrive at a consensus about essentially defining the outcomes that will drive the change process.

All dates and length of contacts made with and on behalf of family members should be documented, noting the relevant PCFA stage. During weekly consultation with the supervisor, the SAFE-FC worker will discuss the level of “reasonable and acceptable contact” appropriate for each family. It is important that the SAFE-FC worker and supervisor set parameters for how much time is available for PCFA meetings with caregivers and other family members to facilitate efficient completion of the PCFA. The diligent SAFE-FC worker understands the importance of timely face-to-face contacts with caregivers (e.g., individually, jointly, group meetings) in achieving the objectives of the PCFA (i.e., respect, engagement, partnership, mutuality, etc.).

Case Planning

The purpose of SMART case planning is to further engage caregivers and other family members in a process to operationalize the goals and intervention strategies that logically follow the conclusions of the PCFA. The PCFA Discovery Stage ended with clarifying what must change as a result of the SAFE-FC intervention. This involved identifying core SAFE-FC outcomes that will drive the intervention components.
that follow the PCFA. The first case plan is developed to specifically focus SAFE-FC intervention for the next 90 days. Subsequent case plans are developed following review of progress in the Protective Capacity Progress Assessment (PCPA).

Following the completion of the PCFA and the implementation of the SMART case plan, SAFE-FC workers meet with caregivers to provide an intervention service on a weekly basis. The practice of having contact for a minimum of 1 hour each week with caregivers is a key feature of SAFE-FC intervention because it is essential for helping to promote change by supporting families to make incremental changes each week toward the achievement of SMART goals and family outcomes.

**Objectives**

Objectives of case planning are to:

- Prioritize the outcomes that will drive the development of the case plan for the next 90 day service period;
- Develop SMART goals that the caregiver, child, and other family members agree to achieve or make progress toward over the next 90 days; and
- Identify specific change strategies, which include the caregiver and will be used by the worker and other service providers to support the change process and will be incorporated into an individualized, change-focused SMART case plan.

**Decisions**

Based on the conclusions of the Discovery Stage of the PCFA:

- What caregiver protective capacity and child-focused outcomes should be selected to drive the development of the case plan?
- What SMART goals do caregivers and other family members want to achieve that will ultimately move them closer to enhancing caregiver protective capacities and meeting child needs?
- What change strategies will help the caregiver and other family members achieve SMART goals?
- Who will facilitate each change strategy selected (i.e., SAFE-FC worker or other service provider)?
- What is the caregiver’s stage of change with respect to achieving each SMART goal?

**Change Focused Intervention**

Change Focused Intervention is an interpersonal process facilitated by the SAFE-FC worker that begins with the implementation of the PCFA and continues during SMART case planning. Change Focused Intervention is concerned with enhancing caregiver protective capacities to achieve child safety and permanency. Case coordination and safety management are responsibilities of the SAFE-FC worker, while other formal and informal systems may deliver some safety and treatment interventions, as directed by the SMART case plan. The foundations for competency emphasized in the PCFA stage are relevant for implementing Change Focused Intervention.

Change Focused Intervention refers to what the SAFE-FC worker does from week to week to facilitate successful achievement of SMART goals and case outcomes. This is the primary intervention method between implementation of the SMART case plan and the PCPA and for each subsequent 90-day period until case closure. Change Focused Intervention consists of interpersonal interaction, activities, facilitation, communication, and management of others who are involved in the SAFE-FC case process.

**Objectives**

Change Focused Intervention is used to involve caregivers, promote caregiver participation, resolve barriers to service provision, encourage caregiver progress and change, and build and maintain a working alliance between SAFE-FC workers and caregivers. It requires effective interpersonal and core skills and consists of facilitation, relationship building, case coordination, and safety management. The purpose is to facilitate
a caregiver’s progress through the stages of change resulting in his or her taking action to enhance diminished protective capacities by achieving SMART case goals and case outcomes. **Figure 7** lists the objectives of Change Focused Intervention.

**Decisions**
The following are the decisions made during the Change Focused Intervention.

- How well is the safety plan working to control impending danger, and do adjustments in the plan or safety services need to be made before the routinely scheduled PCPA 90 days from the development of the case plan?
- How well is the SMART case plan working as the roadmap to support caregivers to strengthen protective capacities and to meet the children’s needs more effectively? Does the plan need to be adjusted prior to the next PCPA?
- What SMART case goals should be the focus of caregiver change talk each week?
- Are safety and treatment services provided by others being delivered as specified in the safety and SMART case plans?
- What changes in caregiver behavior, circumstances, and family conditions are observed week to week with respect to the specific reasons for agency involvement?

**FIGURE 7: OBJECTIVES OF CHANGE FOCUSED INTERVENTION**

- Implement interpersonal interaction with caregivers for a minimum of 1 hour per week to routinely and consistently foster successful changes in caregiver protective capacities.
- Implement change-focused services to support improvement in identified unmet child needs.
- Employ skills that build and maintain the helping relationship with family members as the vehicle for change.
- Assess motivation and readiness to change on an ongoing basis and use motivational interviewing skills, when appropriate, to enhance and sustain the change process.
- Elicit “change talk” with caregivers by raising self-awareness about the need for change, enhancing problem recognition and acceptance of the need for change, and assisting caregivers to prepare and take action to make needed changes.
- Provide coaching and resources and implement specific change-focused strategies to support caregivers and children to achieve SMART case goals.
- Make and coordinate referrals to treatment and other service providers when SMART goals would be more readily achieved with these additional services.
- Manage the SMART case plan by continuously assessing the progress toward goal achievement and the effectiveness of services provided by others to support goal achievement.
- Manage the safety plan by assessing the sufficiency of the safety plan and safety services to control impending danger and evaluate the caregiver’s responsiveness to assure that safety services are delivered as intended.
- Implement routine and consistent service contacts with children as dictated by the safety and SMART case plans; initiate contact with treatment providers on at least a monthly basis to evaluate responsiveness and progress, making adjustments to plans and services based on progress and new events that may affect these plans and services.
- Maintain oversight with safety service providers directly or through the case manager on at least a weekly basis to evaluate the sufficiency of the safety plan and to determine whether adjustments to more or less intrusiveness is warranted.
- Facilitate visits between caregivers and children as an integrated component of Change Focused Intervention when safety is temporarily being managed with an out-of-home safety plan.
- Incrementally review progress that is linked to the PCPA every 90 days.
Operationalized Intervention

- What is the caregiver’s status regarding stages of change, readiness, and motivation to participate and work toward change?
- What is the quality of the helping relationship as demonstrated by the caregiver’s degree of openness and engagement with the Change Focused Intervention?

Developing a helping relationship with caregivers is perhaps the single most critical influence to change the conditions or patterns of behavior that contribute to the reasons for SAFE-FC intervention. Change Focused Intervention success depends heavily on the quality of the SAFE-FC worker’s relationship with caregivers. The strength of the helping relationship, as measured by the HRI, predicted which families successfully completed Change Focused Intervention by achieving case plan goals and case outcomes. The helping relationship is a product of the worker’s commitment to helping the children and family, his or her ability to relate effectively on an interpersonal level, and the caregiver’s willingness to be open and risk “relating” to the SAFE-FC worker. Worker behavior can significantly increase the chances that a positive relationship will develop.

**Protective Capacity Progress Assessment**

The PCPA is a core component of SAFE-FC. It is a calculated method for supporting and perpetuating change. Metaphorically, one can compare SAFE-FC to taking a train trip to a desired destination. The desired destination is caregiver outcomes. The decision to take the trip occurs during the PCFA. The plan for how to get to the desired destination is the SMART case plan. The Change Focused Intervention is what occurs to assure continued travel to the desired destination. And the PCPA, which occurs at least every 90 days, is each train station where one stops to confirm, adjust, and continue travel plans for the next leg along the way to the desired destination. The purposes of the PCPA are to:

- Regulate the Change Focused Intervention process
- Assure sufficient safety management
- Assure SMART case plans are working effectively
- Involve caregivers and provide feedback concerning SAFE-FC
- Determine the appropriateness of the permanency goal
- Determine the achievement of family and child outcomes

**Relationship Between the PCFA and PCPA**

The PCFA and PCPA are integrated processes. SAFE-FC provides an assessment continuum as presented in Figure 8, the SAFE-FC Intervention System diagram. The IA informs the NIA; the NIA informs the PCFA; and the PCFA informs the PCPA. The PCPA essentially picks up the assessment process where the PCFA ends (with the establishment of the SMART case plan). The PCFA process results in SMART goals related to what must change associated with diminished caregiver protective capacities. The SMART goals represent what successful caregiver change looks like.

The establishment of SMART goals (i.e., enhancement of caregiver protective capacities and improvement in child well-being) at the conclusion of the PCFA is the beginning point or starting line toward helping caregivers move toward change and intervention success. The PCPA is intended to track progress toward this success at scheduled intervals. In other words, the PCPA measures progress in SMART goal achievement. The PCPA is also a time to check in on the quality of the helping relationship and the degree to which specific behaviors and conditions are changing in the intended direction as measured by assessment instruments in the CASI every other PCPA (i.e., at 6-month intervals).

**Objectives**

The objectives of the PCPA are to:

- Measure progress toward SMART goals achievement
• Consider and calculate in CASI measures and form judgments and justification for progress
• Track caregiver progress toward the enhancement of diminished caregiver protective capacities
• Assess the effectiveness of SMART case plans
• Determine that SMART goals are relevant and contributing to what must change and that change-focused treatment services are relevant and contributing to achievement of SMART goals
• Ascertain the suitability of change-focused treatment providers
• Evaluate the nature and quality of the SAFE-FC worker-caregiver relationship
• Assess the sufficiency of the safety plan
• Confirm the suitability of safety service providers
• Conduct a safety plan determination and assure that it is the least intrusive safety plan
• Confirm safe environments when safety plans involve child placement
• Evaluate caregiver motivation and readiness to participate in the Change Focused Intervention
• Plan the process for reunification when children are returned home in in-home safety plans

Caregiver service compliance is not the foremost issue of concern when completing the PCPA. Determining a caregiver’s compliance in participating and completing change-focused treatment is a secondary objective of the PCPA. Caregiver compliance with services is mainly important information to consider in relationship to the greater assessment issue of whether caregivers are motivated and investing effort to change behavior (e.g., receiving services which address SMART goals).

Definition
The PCPA is an intervention component which begins after a SMART case plan is in effect and continues every 90 days until the case is closed or the permanency goals change. It consists of information collection, analysis, and measurement of progress toward achievement of SMART goals and changes in behaviors and conditions. The PCPA process involving information collection occurs during any meaningful contact with caregivers, family members, change-focused treatment providers, and safety service providers. At a minimum, the PCPA event occurs every 90 days following the implementation of the SMART case plan and can occur at any time based on the judgment that progress measurement, SMART case plan revisions, or safety plan revisions are needed. The PCPA event occurs over a 3-week period of SAFE-FC worker and caregiver weekly Changed Focused Intervention contacts. At any time (i.e., every 90 days or sooner) when it is determined that a PCPA event is needed, there are incremental tasks and activities the SAFE-FC worker must complete during the 3-week period of the PCPA:

• Week 1—Assures that the HRI is completed prior to the PCPA event
• Week 1—Advises the caregiver in advance that the next meeting or time together will be devoted to considering progress, case planning, and safety planning (the PCPA event)
• Week 2—Facilitates the PCPA event addressing discussion and decisions as outlined in this manual
• Week 3—Reviews decisions, follows through with actions agreed to during PCPA event, and confirms changes that might have occurred as a result of the PCPA event

The PCPA is a formal intervention. This means that it is structured and must be conducted in a rigorous manner. While traditionally child welfare staff are expected to conduct periodic case evaluations, the PCPA is designed to perpetuate the intervention that enhances diminished caregiver protective capacity and is formed as a process and event that involves focused information collection and standardized judgments and conclusions.

Measuring progress toward achievement of SMART goals as required in the PCPA is not a hard science.
Measuring progress is subject to and based upon what is believable; can be considered factual; is supportable from what can be observed; and can be corroborated based on what caregivers, family members, others who know the family, and safety service providers say and what change-focused treatment services providers report. If the SMART goals agreed on in the case plan are clear and specific, it is easier to measure the degree that they have been accomplished.

It is important to be mindful that the PCPA is a safety intervention and, as such, it is serious business. Given that SAFE-FC workers are assessing progress related to changes in caregiver performance associated with impending danger and child safety, it is necessary to be cautious in judgments drawn, decisions made, and conclusions reached.

**Assessment Issues**

There are three main assessment issues that are covered in the PCPA:

- **Progress**—The extent to which caregivers are making progress related to SMART goal achievement is assessed (i.e., the enhancement of diminished caregiver protective capacities).
- **Safety**—Safety management is paramount in the PCPA. During the PCPA, SAFE-FC workers and supervisors must reconfirm the sufficiency of safety plans. This involves determining the status of impending danger and completing a safety plan determination to assure that the safety plan is the least intrusive and most appropriate. In cases where the safety plan is out-of-home placement (foster care or kinship), this means determining the status of conditions for return (CFR) and whether it is possible to decrease the level of intrusiveness and reunify children with the implementation of an in-home safety plan.
- **Readiness for change**—During the PCPA, SAFE-FC workers assess and determine the current status of the motivational readiness of caregivers to change and participate in change-oriented services. The primary role of SAFE-FC workers during intervention is to be facilitators of change. To be effective at facilitating change with caregivers, it is important that workers recognize the stages of change that caregivers are in at the point that a PCPA is being completed.

**Decisions**

The PCPA decisions are:

- Have all relevant information sources been included?
- Is there a difference in impending danger?
- Is the child safe?
- Is the safety plan sufficient?
- Can a less intrusive safety plan be implemented?
- Is progress being made toward achievement of SMART goals?
- Is the SMART case plan appropriate and effective?
- Are caregivers involved and informed?
- What is the quality and nature of the relationship between the SAFE-FC worker and caregivers?
- Is the SAFE-FC worker being effective?
- Should the permanency goal be revised?
- Can the case be closed?

**Figure 8** diagrams the SAFE-FC intervention and its incorporation of PCFA and PCPA.
FIGURE 8: THE SAFE-FC INTERVENTION SYSTEM

SAFE-FC Intervention System: A Behavioral Change Focused Model

SAFE - FC Mission: Safe home that provides an environment and living circumstance that once established can be judged to assure a child’s safety and provide a permanent living arrangement

SAFE-FC Intervention Components: How the PCFA and the PCPA contribute to the achievement of the mission

Safety Case Management Program

The purpose of the Safety Case Management program (SCM) is to contribute to the effective planning, management, and implementation of in-home safety plans. In-home safety plans are established and revised by public child welfare agencies for children who are assessed as unsafe. The program performs collaboratively with the implementing agency in the process of establishing or revising safety plans and, in many cases, provides primary proactive management of in-home safety plans as the case manager and as a safety service provider.

In accordance with the in-home safety plan, the SCM program is concerned with the activities required to direct the in-home safety plan and to manage impending danger. This means that the case manager collaborates with the assessment worker when in-home safety plans are being developed and with the SAFE-FC worker when in-home plans are being implemented and out-of-home safety plans are being revised to in-home safety plans.
**Objectives**

The objectives of the SCM program are to:

- Participate effectively in the safety planning process occurring at different junctures during the intervention
- Manage impending danger in accordance with the specifications of each in-home safety plan
- Effectively manage, perform, and coordinate safety categories and safety services as set forth in in-home safety plans and as assigned for case management
- Ensure timely communication about and coordination of the management and implementation of in-home safety plans with the public child welfare agency

**Decisions**

The SCM program decisions are as follows:

- Is the impending danger well understood in relation to its origin and to the method and the means to control it?
- Is the in-home safety plan clearly delineated and specific regarding the means to control the impending danger?
- Is the case manager role and responsibility clearly spelled out and understood?
- Are the responsibilities of others in the in-home safety plan clearly defined?
- Are communication and personnel meeting or conference times established and understood between the SAFE-FC worker and the case manager?

**Documentation for Change Focused Interventions and Safety Management**

SAFE-FC workers document the primary purposes and service activities for all change-focused and safety management direct and indirect contacts with family members in the case notes section of the management information system. The purpose of documenting case notes is to provide a specific understanding of:

- The level of effort that SAFE-FC workers and case managers invest in providing services to families
- The specific direct or indirect services that were provided by selecting up to three direct or indirect services after first selecting the usual note type and TCM activity (if applicable)
- The responsiveness of the caregiver, the children, and others associated with the family to the change focused intervention process
- The progress made by family members to achieve SMART case goals
- Any changes in the family that may represent a change in the need for a safety plan
7 TRAINING FOR DELIVERY

ACTION and the RYC adapted and developed the training curricula, training materials, protocols, and manuals for pre- and in-service training for SAFE-FC workers, supervisors and service providers. The curriculum emphasizes collaborative case planning and case management, in-home safety management, change-focused service provision, and enhancement of caregiver protective capacities. The training also places emphasis on a coaching and consultation model for supervisors. ACTION developed a coaching protocol for new supervisors and SAFE-FC workers and provided ongoing coaching and consultation to ensure fidelity to the intervention model.

The ILT, SAFE-FC supervisors, continuous quality improvement staff, and the training unit are responsible for training new staff and for ongoing training of the model and practices. New workers are trained as they join the project, and the training follows the same process as the originally trained SAFE-FC staff, using the same materials, timeline, and process. Attendance sheets for SAFE-FC staff ensure that all foundational training and practicums are completed. Data on the workers’ competency exams should also be collected and tracked. Once the workers have cases, they then also receive fidelity reviews. Data should be used to ensure that new staff receive the same training with fidelity to the training provided to the original team. The data may also be used to improve the quality of the training.

Training Protocols

The SAFE-FC intervention training curriculum consists of training modules related to each phase of the intervention and includes varied practice exercises related to consultative supervision, intake, in-home safety services, change-management services, motivational interviewing, PCFA, PCPA, safety management, SMART case plans, use of clinical assessment measures (e.g., CASI), concurrent planning, reunification, CFR, and therapeutic visiting. Learning objectives are tied to fidelity criteria and practice standards.

Training sessions should be scheduled prior to the implementation of the intervention stages to permit practicum experiences in between training modules. SAFE-FC supervisors receive training first to then become active participants and experts in the training of staff. The curriculum is designed to build on the SAFE-FC supervisors and SAFE-FC workers’ existing knowledge, and the overall objective of the practicum experiences is to increase their knowledge and skills for use in casework practice and supervisory consultation. The SAFE-FC learning approach document provides a list of competencies targeted by the curriculum (see Appendix D).

WASHOE EXAMPLE

The Nevada Partnership for Training and the Division of Child and Family Services have been included in the training to build and support long-term state capacity. During PII, one of the SAFE-FC supervisors worked with ACTION to train new SAFE-FC workers as they joined the project. This was intentional to prevent contamination as the training unit was providing training to new staff who were part of the control group. New workers were randomized into SAFE-FC or the control group, usual permanency services, within 2 weeks of starting with the child welfare agency. The protocols for filling vacancies in SAFE-FC were pre-determined through the evaluation plan. This required extensive monitoring by the Evaluation Liaison.
Competency Exams
Competency exams are available in module form and are administered through an online course management system (the “Blackboard”) following each designated training session. This is in order to serve as a baseline for the focus of coaching sessions for small groups and individual sessions between supervisors and SAFE-FC workers. Competency exams and proficiency demonstrations are conducted, first with the Implementation Purveyor Team members and then with staff and service providers. Competency exams are initiated periodically and as appropriate to measure increased competency through consultative supervision and coaching.

Proficiency Demonstrations
Skills are also assessed through proficiency demonstrations that require actual demonstration of skills in practice simulations. Practicum experiences target specific competencies to practice the skills needed to implement the PCFA, PCPA, and SMART case plan development and to review stages of SAFE-FC intervention. The supervisory practicum session is designed to build supervisory consultation and coaching skills. The SAFE-FC worker practicum experiences mirrors the supervisory practicum schedule, with the exception of the focus on building supervisory consultative skills.

8 COACHING

Coaching Model
The coaching model is designed to build the capacity of the supervisors and the Implementation Team to gradually assume the primary responsibility for coaching staff to implement SAFE-FC interventions with fidelity. Coaching should be conducted monthly with SAFE-FC supervisors primarily and with SAFE-FC workers secondarily. Training materials and peer and roundtable discussions and meetings are good coaching tools. The coaching model also assists the supervisors with performance evaluation and training identification. (See Appendix E for the coaching and consultation plan.)

Consultative Supervisory Training
In SAFE-FC, supervisors are expected to meet with workers weekly to provide case consultation. Consultation related to practice and decision making is one of the most important activities that a supervisor performs. All supervisors and program coordinators are to participate in the training. Further emphasis of the supervisory role to support SAFE-FC practice is addressed through training provided to the ILT. There is a supervisory consultation guide to guide the coaching the supervisor provides. The supervisors are selected through an internal interview process by the agency’s leadership. The implementing agency will work with the purveyors and the ILT to identify the philosophical and leadership values that aligned with the model. An interview protocol is available based upon that. The process was very intentional for interviewing and selecting supervisors with the goal of creating internal purveyors of the SAFE-FC model. Their role is designed with the long-range goal of building champions of SAFE-FC.
Use of Supervision

This consultation between the SAFE-FC worker and supervisor related to practice and decision making is the most important factor for changing practice and helping families. The discussions and problem-solving sessions are aimed to coach and help the SAFE-FC worker engage families to guide and involve them through CPS involvement and the stages of service provision. The consultations are also a way for the SAFE-FC worker to increase his or her interviewing, engagement, and assessment skills when working with families. Consultation and coaching are two of the competency drivers to further the WCDSS goal of maintaining fidelity to the SAFE-FC model.

The SAFE-FC worker is expected to meet weekly with his or her supervisor for consultation and coaching. The type of consultation and the level of coaching or strategizing that is used by the SAFE-FC supervisor depend on the experience level of the SAFE-FC worker. Consultation and coaching can take the form of a discussion, questions and answers, role playing, as well as defining or clarifying roles, processes and mandates. Case notes for each consultation should be documented by both the SAFE-FC worker and the supervisor.

The following information helps the SAFE-FC worker to prepare for case consultation at each stage and to know what to expect during the case consultation. (See Appendix F, which provides an example of a coaching session.)

Initial Assignment

Cases are assigned to the SAFE-FC worker following the completion of the NIA by the assessment worker and the Safety Plan Determination Meeting (SPDM). A case transfer meeting should be scheduled within 5 business days after the SPDM. The initial focus of consultation will be preparation for the case transfer meeting. The SAFE-FC worker should be familiar with the case, the NIA, safety assessments, safety plan(s), and the CFR and should bring these case records to the consultation. The SAFE-FC worker should also bring the PCFA model overview and instruction guidelines to the session to help guide initial discussions concerning the PCFA process for assessing a family’s needs and for determining the goals to achieve the changes in behaviors required to reunite and/or preserve the family. The SAFE-FC worker and SAFE-FC supervisor consultation at this stage may include:

- Review of the NIA and safety assessments and plans
- Review of the CASI and any additional assessments completed on behalf of family members
- Discussion about the SAFE-FC worker’s understanding of the safety interventions and the reasons for the actions taken, whether there are urgent responses needed, and the sufficiency of the safety planning
- Discussion about the SAFE-FC worker’s understanding of the established CFR and whether the SAFE-FC worker is in agreement with the decisions made
- Writing down any questions or concerns that result from the discussion for review in the case transfer meeting
- Review and discussion about the next steps and the PCFA Process

Introductions With the Family

The assessment worker is to introduce the SAFE-FC worker to the family and transfer the case within 5 business days following the case transfer meeting. The focus of consultations with the SAFE-FC supervisor at this stage may include:

- The outcome of the case transfer meeting, safety factors, safety planning, and any immediate responses required
- Further discussion about the PCFA process and the SAFE-FC worker’s role
When, where, with whom, and in what order the SAFE-FC worker will make contact with family members

Any challenges identified to approaching the family (e.g., resistance, safety issues for the child or family members, considerations around worker safety) and how best to address those challenges

Any missing information that needs to be collected and how and when the information can be gathered

How the SAFE-FC worker:
- Plans to discuss the safety information and the PCFA with the family
- Plans to discuss the CFR with the family
- Can seek feedback from the caregivers and ways to gain a commitment from them to participate with the PCFA

Protective Capacity Family Assessment—Discovery Stage
As discussed in earlier sections, the PCFA is a means for collecting information to identify the family’s specific needs for what must change and to inform the delivery of treatment services. This stage ends with the completion of the family’s SMART case plan. The decision to provide services on nonlegal cases occurs at the point of approval of the NIA. The PCFA is a process involving interviews and discussions to engage the caregivers and families with the identification of behaviors that need to change to allow their child to be safe in the home. The SAFE-FC worker needs to bring any new information, assessments, or reports for review at the consultation. Figure 9 lists topics the worker should be prepared to discuss.

Case Planning Stage
Gaining the caregiver’s commitment in the case planning process is the key to the caregiver’s success with the acceptance of services and behavioral change. The case planning stage considers the caregiver’s needs as well as the needs of the children being served. It also must consider the changes that must be made for the return of the children to the home. All of the efforts to engage the caregivers and

**FIGURE 9: SAFE-FC SUPERVISOR AND SAFE-FC WORKER PCFA CONSULTATION**

- Any questions about the PCFA process at this stage
- The SAFE-FC worker’s observations, perceptions, and questions related to the family’s commitment to the PCFA process
- Any issues the SAFE-FC worker may be having concerning engagement or commitment of the caregivers (e.g., what went well or what did not, any strategizing needed to work better with the family)
- The review of the CASI and any assessments completed on behalf of family members or of reports received
- The caregiver’s enhanced or diminished protective capacities and the SAFE-FC worker’s thoughts about how these affect safety and protective capacities
- Discussion of how to assist the caregivers and the family identify behaviors or conditions that need to be changed
- Identification or addressing of areas of (dis)agreement about what needs to change
- Discussion of whether there are discrepancies between the caregiver’s perceptions of how he or she is doing and the observed behaviors and of how to address these with him or her
- Explanation of how to review the PCFA purpose and objectives with the family clearly
- Determination of whether any additional or less intrusive safety interventions are needed during the completion of the PCFA
- Discussion of whether conditions and circumstances in the family’s functioning have changed that require changes to the CFR
- Accomplishments of the family to this point
- Any updates regarding activities or tasks agreed upon at a prior consultation
the information gained during the Introduction and Discovery Stages of the PCFA are used to finalize the goals for change, the services to be used, and the priority of the services and to confirm that the safety interventions and plans continue to be sufficient.

Consultations at this stage will conclude when the initial SMART case plan is developed and provided to the court, if the case is court involved. The SAFE-FC worker should bring any new information, assessments, or reports for review at the consultation. Figure 10 lists the focus of discussions during consultations between the SAFE-FC worker and the SAFE-FC supervisor at this stage.

**Change Focused Intervention**
As referenced earlier, Change Focused Intervention refers to what the SAFE-FC worker does from week to week to facilitate successful achievement of SMART goals and case outcomes. This is the primary intervention method between implementation of the SMART case plan and the PCPA and for each subsequent 90-day period until case closure. Change Focused Intervention consists of interpersonal interaction, activities, facilitation, communication, and management of others who are involved in the SAFE-FC case process.

This intervention is used to involve caregivers, promote caregiver participation, resolve barriers to service provision, encourage caregiver progress and change,

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**FIGURE 10: SAFE-FC SUPERVISOR AND SAFE-FC WORKER CASE PLANNING CONSULTATION**

- Case planning objectives and the SAFE-FC worker’s perspective about his or her work with the family
- Discussions about what has occurred to this point with the family toward the development of the goals for the SMART case plan
- Additional discussion around the SAFE-FC worker’s understanding of the relationship between diminished protective capacity and impending danger in the family
- Review of the CASI and any assessments or reports completed on behalf of the family members and how they enhance the SAFE-FC worker’s awareness of the family’s strengths and needs, particularly as they relate to caregiver protective capacity
- Discussions of the medical, mental health, and educational needs of the children identified by the family during the case planning stage and what steps to take to address them
- Visitation, family interactions during visitation, frequency, and any safety concerns related to visitation
- Placement of the children, safety of the placement, and any needs that the alternative caregivers may have to support the needs of the children
- Any concerns about the adequacy of safety plans or interventions
- Specific areas of (dis)agreement about what must be addressed in the SMART case plan
- Caregiver’s involvement and commitment to the SMART case plan and strategies to gain or maintain a working relationship
- Order and focus for what must be addressed in the SMART case plan
- Assistance with goal writing to finalize outcomes and clearly describe what must change
- Identification of the activities and services for promoting change and achieving the outcomes (i.e., enhancing diminished protective capacities)
- Review of the CFR and whether there are different or less intrusive options required due to changes made or to progress of the family pertaining to child safety
- SMART case plan meeting, including scheduling, attendees, safety considerations for family members and staff, any concerns, and facilitation
- Discussion of how to achieve the timely completion of PCFA documentation and the SMART case plan
and build and maintain a working alliance between the SAFE-FC worker and the caregivers. It requires effective interpersonal and core skills and consists of facilitation, relationship building, case coordination, and safety management. Its purpose is to facilitate a caregiver’s progress through the stages of change resulting in his or her taking action to enhance diminished protective capacities by achieving SMART case goals and case outcomes.

**Protective Capacity Progress Assessment**

Consultations at this stage will focus on the progress made by the caregivers in achieving SMART case plan goals to change the behaviors that led to intervention. This stage begins following the initiation of the SMART case plan and ends with case closure. The PCPA is a process that involves weekly contact with the caregivers and safety service providers, regular contact with the children, and monthly contacts with care providers and change-focused treatment providers. The process also involves analyzing and assessing the sufficiency of safety interventions and SMART goals through information received by the treatment and safety service providers, discussions with the family members and care providers, and analysis of CASI measures. The process includes PCPA events or team meetings, the completion of the HRI prior to the events, and the completion of the SAFE-FC PCPA assessment every 90 days until the case is closed. The events and assessments will help the SAFE-FC worker and supervisor with ongoing safety assessments and planning and with determining the most appropriate permanency plan for each child. **Figure 11** lists topics on which consultations between the SAFE-FC worker and the SAFE-FC supervisor at this stage may focus.

**Reunification**

Supervisory consultation is required prior to the reunification of a child with a caregiver, and supervisory approval is necessary prior to the reunification of a child to the caregiver’s home. Additionally, there are court requirements regarding the reunification of children. The decision to reunify can be made at any point in the case when it has been determined that the CFR have been met. It is a serious decision requiring a thorough analysis of the family’s current status and a plan that requires the ongoing support through supervisory consultation. The process requires conversations with the children, caregivers, care providers, and treatment providers and a PCPA event to outline the reunification plan, treatment needs, safety planning, safety planning oversight, and the completion of the PCPA form. The process also requires immediate and ongoing assessment and oversight following the reunification of the child with a caregiver. **Figure 12** details critical areas of discussion when considering reunification.

**Case Closure**

Case closure is the final step in the intervention process. When a case is closed, WCDSS involvement with the family ends. Case closure, like all casework decisions, is a result of a carefully planned process. Case closure decisions should be planned and made by the SAFE-FC worker and SAFE-FC supervisor and the caregivers, family members, children, and other members of the Child and Family Team in a PCPA Event and in the completion of the PCPA form. Case closure must also be coordinated with the family court when legal jurisdiction has been established. **Figure 13** lists topics that consultations when considering case closure may include.
FIGURE 11: SAFE-FC SUPERVISOR AND SAFE-FC WORKER PCPA CONSULTATION

- Continued discussions around the SAFE-FC worker’s understanding of the relationship between diminished protective capacity and impending danger in the family
- PCPA objectives and the SAFE-FC worker’s perspective about his or her work with the family
- Discussions regarding updates to medical, mental health, and educational needs of the children and the steps to take to address them
- Caregiver’s involvement and commitment to the SMART case plan and strategies to gain or maintain a working relationship
- Discussions and analysis of:
  - Reports from safety service and treatment providers
  - Information received from the children, caregivers, and community resources
  - Observed behaviors of the caregivers and children during contacts with the SAFE-FC worker
  - CASI measures and how they relate to caregiver protective capacities
- Child and caregiver visitations (e.g., frequency, place where held, observations of behaviors and quality of interaction, level of supervision)
- Determination of whether the SMART case plan goals are appropriate and effective and of whether any changes may be warranted
- Discussion of whether safety threats for the children continue or have been eradicated, new threats have been identified, or protective capacities allow for in-home safety planning
- Results of the HRI completed by the SAFE-FC worker and how to use the results when working with the family
- PCPA events, including planning, attendees, and agenda items for the event
- Determination of whether case circumstances require an additional PCPA event
- Achievement of a timely completion of the SAFE-FC PCPA assessment
- Placement of the children, safety of the placement, and any needs that the alternative caregivers may have to support the needs of the children
- Discussion of whether the established CFR remain appropriate and have or have not been met
- Planning for reunification, including the need for court approval prior to returning a child under the age of 5 years to the caregivers
- Discussion concerning the implementation or expedition of concurrent planning when the caregivers are unable or unwilling to make the changes in behaviors or conditions that led to the intervention
- Determination of whether the permanency plan for each child is appropriate or needs to be changed and specific tasks required if a change in planning is required
FIGURE 12: SAFE-FC SUPERVISOR AND SAFE-FC WORKER REUNIFICATION CONSULTATION

- Discussion of whether impending danger threats for the children continue or have been eradicated, new threats have been identified, or protective capacities allow for in-home safety planning
- In-home safety planning, specific tasks, and the supervision of the plan
- Child and caregiver visitations (e.g., frequency, place where held, observations of behaviors and quality of interaction, level of supervision)
- Status of the family regarding the CFR
- Willingness, ability, and commitment of the caregiver(s) to participate with an in-home safety plan
- Observations and perceptions of the family, care providers, and treatment providers and their opinions regarding reunification
- Establishment of the reunification plan
- Preparation of the children, family, caregiver(s), and care providers for reunification
- SAFE-FC worker follow-up after reunification occurs
- SAFE-FC worker’s understanding of safety alerts and what to look for during home visits
- Discussions and analysis of observed behaviors of the caregivers and children during contacts with the SAFE-FC worker
- Ongoing consultation around the safety plan oversight and information received from safety service and treatment providers, extended family, and community resources
- Adjustment and progress of each family member following reunification;
- Discussions and analysis of CASI measures and how they relate to caregiver protective capacities
- Any additional safety, treatment, or intervention needs identified post reunification
- Updates concerning caregiver’s protective capacities and progress with SMART case plan goals
- Discussions concerning the ability of the caregiver’s to meet any special needs of the children
- Planning for case closure

FIGURE 13: SAFE-FC SUPERVISOR AND SAFE-FC WORKER CASE CLOSURE CONSULTATION

- Conditions and behaviors in the home that have led to the eradication of any safety threats
- Observations and perceptions of safety treatment providers
- Planning for the PCPA event to bring the Child and Family Team together for discussions pertaining to closure
- Observations and perceptions of the family, care providers, safety service providers, and treatment providers and their positions regarding case closure
- Discussions and analysis of observed behaviors of the caregivers and children during contacts with the SAFE-FC worker
- Determination of whether permanency requirements have been met to finalize adoption, guardianship, or a plan other than reunification
- Safety of any alternative placement
- Ongoing ability of the alternative placement to meet the needs of the child
- Ability of the family to access needed resources independently
- Preparation of the team and family members for case closure
- Discussion of whether or not continued voluntary services are necessary for the well-being of the family or child
9 FIDELITY ASSESSMENT

For SAFE-FC cases, fidelity is the extent to which the intervention is faithful to the SAFE-FC intervention model. Fidelity assessment is a process used to measure how faithfully staff adhere to the intervention processes through a review of their documentation, service provision, and decisions. Fidelity assessment occurs through the documentation procedures, supervisory consultation, and collaboration in each phase of the case: intake assessment, NIA, PCFA, SMART case plans, PCPA, and case closure. Supervisory approvals of decisions, documents, and case closures are reviews of worker performance. These initial assessment reviews, consultations, and approvals by supervisors with the SAFE-FC worker move the case forward and guide service delivery. Fidelity criteria have been developed for each core component of the intervention. The criteria are used to guide the coaching process to ensure adherence to the model and to assist with performance evaluation and skill development. (See Appendix G for fidelity criteria.)

Administrative reviews of performance using fidelity performance assessment tools and the management information system, which may be a state’s SACWIS, and its outcome reports help the agency measure progress with changes in processes and the implementation of practice models. They also help identify any needed training, resources, and supports required to improve practice. Results of fidelity assessments (e.g., case reviews measuring the SAFE-FC’s adherence to the intervention model) will be shared with the ILT and individual SAFE-FC supervisors to individualize and tailor coaching sessions with staff. The results of the fidelity assessments are primary to ongoing skill development and performance enhancement.

Case Management and Fidelity Assessment

The SAFE-FC Worker’s Role
The SAFE-FC worker’s performance is assessed on an ongoing basis. The core competencies (i.e., attitudes, values, qualities, knowledge, and skills) learned by the SAFE-FC worker through training, coaching, and experience are observed and measured through competency exams, case consultation, collaboration, and review. It is the SAFE-FC worker’s role to use the learned concepts and methods during his or her interactions with families and community partners to engage, motivate, collaborate, and problem solve during case management. Competence coupled with thorough and timely documentation practices are crucial for service need identification, initiation of services, and the achievement of successful outcomes for children and families. The SAFE-FC worker’s documentation is also fundamental for performance evaluation and fidelity assessment.

The SAFE-FC Supervisor’s Role
The SAFE-FC supervisor’s performance is also assessed on an ongoing basis. The core competencies listed for workers, as well as coaching and consultation skills learned by the supervisor through training, consultation, coaching, and experience, are measured through competency exams, collaboration, and review of oversight and consultation documentation. Additional skill building for supervisors occurs through the intervention training curriculum, which includes consultative supervisory training sessions, monthly roundtable discussions, and the sharing of reviews and SACWIS reports.

The supervisor’s role as a coach is to encourage day-to-day applications of skills, provide timely case and situation-specific feedback, encourage SAFE-FC workers to apply themselves personally in the coaching process, and focus on listening to workers as they express their needs and experiences.
This is accomplished through consultations, collaboration, case progress meetings, and documentation reviews with the SAFE-FC worker to help him or her adhere to the model and skill development. SAFE-FC supervisors should use the specific oversight and approval information found in each assessment and service provision section of the intervention manual. Supervisors, once trained, will also participate in the formal fidelity assessment review process using the developed Fidelity Performance Assessment Tool (see Appendix H) to assess individual, unit, and agency fidelity and performance. These assessments will be used to individualize and tailor further training and coaching.

**Administrative Role**

The ILT fulfilled the administrative role for case management. Model fidelity lies in the development, assessment, and revisions of the intervention training curriculum for staff training, competency exams, and coaching and updating of staff and supervisors about changes and about providing progress reports. Additionally, administration is responsible for the recruitment and selection of both safety service providers and change-focused service providers to deliver direct services to SAFE-FC families. Administrative coaching and consultation occurs through Coordinator participation in individual case meetings and reviews with the SAFE-FC worker and supervisor, as well as through monthly roundtable discussions with SAFE-FC supervisors. Administration is also responsible for consulting in the development and implementation of the quality assurance framework, which includes data collection and reports, fidelity assessment, training for staff to complete the assessments, and a feedback process for staff and community partners.

**Case Reviews**

The primary method for assessing fidelity is to conduct structured case reviews using a fidelity assessment instrument (see Appendix H). The review process is comprehensive in scope and corresponds to the core elements of the SAFE-FC intervention model. These reviews, as well as the SACWIS and data reports for measuring outcomes, are a part of the fidelity performance assessment that is shared with supervisors and staff to guide supervision and the coaching and mentoring process. The reviews also assess the agency’s overall fidelity to the model, measure progress and success of the program related to the outcomes of the services provided to children and families, ensure the institutionalization of the model, and determine future resources required for its long-term sustainability.

For each review, an agency should select a random sample of cases drawn from all cases assigned to SAFE-FC workers during a specified period. Up to two cases per SAFE-FC worker should be selected. After the first 6 months of implementation of SAFE-FC, cases are reviewed on a quarterly basis for the life of the project’s data gathering. The reviews can be conducted by the purveyor (ACTION and the RYC) or personnel trained in the process and evaluated in their reliability using fidelity performance criteria and assessment instruments. Reviewers use sections of the case record and entered values using Qualtrics during the onsite fidelity review. Data are then downloaded and analyzed in a statistical software package (e.g., SPSS PASW, version 21). Descriptive statistics are generated for the fidelity criteria identified for the reviewed components. The assessments are focused on the degree to which SAFE-FC workers demonstrate proficiency in delivering the intervention related to PCFA, PCPA, safety management, SMART case planning, and Change Focused Intervention.

**Fidelity Assessment Development**

Fidelity criteria that can be assessed by objective reviews of information in case records are translated into coding items and guided by questions that focused on assessing the quality of information collection, decision making, documentation, and use of supervision. The RYC created the PCFA and
SMART case planning fidelity assessment tool using an iterative process in which members of the ILT articulated fidelity criteria based on PCFA and SMART case planning standards.

**LESSON LEARNED**

WCDSS learned while developing the fidelity assessment process that the scope, resource demands, complexity, manpower, and skills required to apply the fidelity assessment process were beyond the agency’s experience. One lesson learned for any future project is to be aware of the data collection and analysis technology requirements and reporting process and the skills needed to participate in the process and to translate fidelity reports to staff.

10 USING DATA FOR DECISION MAKING AND IMPROVEMENT

**Data Indicators for Implementation and Evaluation**

Several indicators and data elements can be used to track evaluation and implementation improvement, including data elements related to the program outputs and core components of SAFE-FC and elements related to the organizational and implementation supports.

Data should be captured and reports created specific to the intervention core components that involve the completion of the PCFA and the PCPA (e.g., number of assessment protocols, number of 90-day evaluations). Other examples include the number of:

- Cases assigned to SAFE-FC workers and to usual permanency services workers
- Worker-family contacts and frequency
- Safety plans
- Case plans and their timeliness
- Hours spent on direct and indirect services
- Families who complete services or that return to the agency after case closing
- Children who achieve permanency within 12 months of entry into care (and the percentage)
- Cases with the following characteristics:
  - Neglect
  - Substance abuse
  - Child or parent mental or behavioral health problems
- Single-parent household
- Housing instability
- Safety threats
- African American
- Parental incarceration
- Caregiver history of abuse or trauma

Other valuable data to capture include:

- Parent’s stress, attitudes, competence, social support, and readiness for change
- Home safety and home stability
- Resource utilization
- Length of time the family receives the intervention
- Reasons families drop out of the intervention
- Determination of whether a child was successfully prevented from entering care because of the use of an in-home safety plan

Lastly, data on the types and costs of safety services provided and staff vacancy rates for SAFE-FC are useful to capture. WCDSS captured all sorts of administrative and case file information from SACWIS and case reviews. Some of that was for Westat’s research, fidelity reviews, installation/implementation, or coaching/consultation feedback and training plan development.

In addition to capturing information about program outputs and core components of the intervention, it is equally important to capture information about the organizational and implementation supports to improve the implementation of the intervention. This key information can be tracked through the administration of several different instruments, as well as the collection of data. These elements include:

- Number of staff trained
- Level of participant satisfaction with training
- Percentage of cases that meet fidelity criteria
- Number of hours of supervision and coaching provided to each SAFE-FC worker
- Organizational context
- Knowledge of intervention
- Organizational readiness to change
- Management support
- Change efficacy
- Work attitudes, workload, competence, and responsiveness
- Supervision
- Role overload

Data Collection Procedures and Schedule

Several data elements should be captured on an ongoing basis as part of case practice and implementation of SAFE-FC components, including through the CASI administered to SAFE-FC caregivers. Incentives were given to encourage caregivers to complete the CASI; however, one lesson learned is that the CASI was too long and not completed in a timely enough manner to make the information useful for SAFE-FC workers to use for assessment purposes.

Data elements related to implementation supports and organizational readiness should be captured on specific schedules through the use of structured instruments. For example, the organizational readiness surveys can be administered to SAFE-FC staff every 12–18 months following the baseline survey.

Data Entry System

A data entry system is essential to the implementation and evaluation of SAFE-FC. It is recommended that the implementing agency have an experienced data programmer who is a specialty member of the SAFE-FC team in order to support system modifications that will be necessary at the beginning and throughout implementation as the system adapts and changes its child welfare practice approach. Modifications of a state’s SACWIS may be necessary. In Washoe County, for example, modifications were made to UNITY to support the new interventions and
to ensure that outputs (e.g., hours of service by type) for SAFE-FC and usual permanency services were effectively tracked.

In addition, the logic models for SAFE-FC identify data elements already available through SACWIS to track differences in distal outcomes. Design changes to support documentation of such SAFE-FC components as PCFA, PCPA, and SMART case plans must take into account supervisory regulation and approval processes.

**Process for Using Data to Improve Implementation**

As noted earlier in the manual, the ILT is the primary team guiding the implementation of SAFE-FC. Therefore, the ILT is responsible for reviewing and sharing the multiple reports that provide information about applying the intervention as intended and for identifying areas that need improvement. The ILT should create action plans for improvement based on the ongoing review of data, including working with the purveyor to enhance training and coaching. In addition, on a weekly basis, the Project Director should meet with the manager and supervisors of the SAFE-FC units to review not only programmatic-level data, but also worker-level data. This provides information to supervisors to inform their supervision and coaching and to SAFE-FC workers to enhance their performance (See Appendix I for an example of an action plan.).

It can be challenging for the ILT to condense the data, provide clear messages to staff, and provide timely feedback and information about decisions for systemic improvement. The fidelity assessment process is a good example of using data to improve implementation because it occurs frequently (quarterly), provides real-time feedback to SAFE-FC workers, and is used directly in coaching with workers and supervisors. The creation of a continuous quality improvement unit to continue data collection, analysis, and reporting throughout the life of the project may also be valuable to the implementing agency.
NOTES

1. The Grantees include Arizona Department of Economic Security; California Department of Social Services; Illinois Department of Children and Family Services; Los Angeles LGBT Center; University of Kansas; and Washoe County, Nevada Department of Social Services. For more information about Grantees’ target populations and interventions, please visit http://www.acf.hhs.gov/programs/cb/resource/pii-project-resources.

2. At the time of this printing, PII Grantees are in the 5th year of their projects.

3. Evidence-supported interventions are specific, well-defined policies, programs, and services that have shown the potential, through rigorous evaluation, to improve outcomes for children and families (Framework Workgroup, 2014).


5. For more information about the evaluation, see: http://www.acf.hhs.gov/programs/opre/research/project/permanency-innovations-initiative-pii-evaluation.


7. Contact Diane DePanfilis, Professor, Silberman School of Social Work at Hunter College, diane.depanfilis@hunter.cuny.edu and/or ACTION for Child Protection, Inc., at http://action4cp.org.


9. The Family Connections intervention is developed by the Ruth H. Young Center for Families and Children (the RYC) at the University of Maryland, School of Social Work.

10. Conditions for return (CFR) are statements which identify specific behaviors and circumstances that must exist within a child’s home for the child who is placed to return home. The statement is related to the impending danger that warrants placement. CFR statements are concerned with what must occur within a child’s home. This is an environmental statement more than a statement about people and what they must do. It is a statement about the status or state of circumstances within a child’s home and a description of what the home must be like and who must be involved in order to be a safe environment. CFR statements are the benchmarks for reunification.

11. Specific, Measureable, Achievable, Relevant, and Time-limited.


23. The CFSA data from Nevada was specific to Washoe County rather than to Clark County or the Rural counties.


30. The Permanency Innovations Initiative Cross-Site Implementation Study administered the Driver Assessment Survey, The Permanency Innovations Initiative Training and Technical Assistance Project team for Washoe facilitated the onsite Drivers Assessment.

31. WCDSS chose to structure its teams to include a Community Advisory Committee, facilitated by the Project Director, intended to consult directly with the County Director and PMT to advise on all aspects of planning and integration with internal and external stakeholders.


35. Discovery is a stage in the PCFA process where the SAFE-FC worker conducts conversations, inquiries, and discussions with caregivers focused on exploring and discovering what must change with respect to diminished caregiver protective capacities. The SAFE-FC worker and caregiver reach mutual understanding and agreement about what caregivers are willing to work on during planned services.

36. Core fidelity criteria for SAFE-FC include using standardized assessment instruments to (1) inform the assessment and case plan and (2) measure change over time. Findings from standardized assessment instruments inform the PCFA, particularly as points of discovery, and also are used when assessing change over time through the PCPA at 6-month intervals. These assessments are completed via CASI.
37. If a case is currently open, the occurrence of a new NIA does not make the case eligible for Population 1. The case remains assigned with its current caseworker. It is not randomly assigned based on the new incoming NIA.


39. These curricula, protocols, and manuals are proprietary.

40. The Implementation Purveyor Team was the SAFE-FC Coordinator, Evaluation Liaison, and SAFE-FC supervisors, i.e., the people who would be supervising the staff.

41. Competency drivers are activities to develop, improve, and sustain practitioners’ and administrators’ ability to put programs and innovations into practice to benefit the families. The four competency drivers include selection, training, coaching, and fidelity assessment. Collectively, they can effectively provide professional development that makes a difference for both practitioners and families.

42. http://www.qualtrics.com

43. Westat was the lead on PII-ET, the evaluation team for PII.
APPENDIX
Appendix A: The Washoe County Implementation Leadership Team’s Terms of Reference

February 21, 2012

Creation

The Project Implementation Team (PIT) was identified in the Permanency Innovations Initiative (PII) Grant Proposal submitted on August 5, 2010, to the Administration for Children and Families (ACF), Department of Health and Human Services (HHS), as the entity responsible for carrying out the tasks and activities of the implementation plan. However, in January 2012, the Project Management Team (PMT) replaced the existing PIT with an Implementation Leadership Team (ILT), which further refined the roles and responsibilities of not only the leadership team but of sub-groups that were responsible for carrying out specific activities identified by the ILT.

Purpose

The purpose or mission of the ILT is to plan for implementation strategies outlined by the PMT and to direct the various implementation teams or specialty designated workgroups.

Membership

The ILT includes representatives who have primary project implementation influence and responsibilities and includes staff from Washoe County Department of Social Services (WCDSS), the Children’s Cabinet (CC), ACTION for Child Protection (ACTION), and the Ruth H. Young Center for Family and Children (the RYC). These include Jim Durand, Project Director; Clint Holder, Implementation Director; Todd Holder, Director of Casework Services at ACTION and Senior Staff Associate with the National Resource Center for Child Protective Services; Otto Lynn, WCDSS Children Services Coordinator Supervisor; Diane DePanfilis, PhD., Professor, Associate Dean for Research at the University of Maryland School of Social Work, and Director of the RYC; Mike Capello, Senior Staff Associate at ACTION; Dena Negron, WCDSS Case Compliance Reviewer; Jacqueline Kleinedler, CC Coordinator; and Sherri Cline, WCDSS Children Services Coordinator Supervisor. Members may be added or changed at the direction and approval of the PMT according to the needs of the initiative as it moves from the planning phase to full implementation.

Terms

There are no term limits for members of the ILT. The term under the auspices of the grant will dissolve at the end of the grant period effective September 29, 2015.

Responsibilities

The ILT will collaborate with the Community Advisory Committee (CAC) in developing a community awareness package for PII, assist CAC in a delivery of presentations to community partners, and plan for how PII will implement its advice.
The ILT will assist the PMT in identifying purveyors or individuals representing a program or practice participating in the broader child welfare system and help them develop awareness of their role in the project and their understanding of Safety Assessment Family Evaluation (SAFE) and Family Connections (FC) relevant to their area of responsibility in support of implementation.

The ILT will implement roundtables with WCDSS and CC Supervisors focusing on their coaching role with staff implementing SAFE-FC and SAFE-FC. The effectiveness of the coaching program will be evaluated and suggestions for adaptation will be considered by the ILT and PMT.

The ILT and the CC will collaborate in a process of developing in home safety services, including a detailed description of each safety service, its purpose and function, and appropriate providers. The ILT will support the CC in developing a recruitment process to establish a referral base of professional and paraprofessional safety service providers.

The ILT will identify key components of the assessment for the WCDSS and the community and will assign specific actions to a designated workgroup to carry out the assessment plan. This workgroup will provide a status report to the ILT on the implementation of the assessment plan and its cumulative findings. Based on those findings, the PII implementation plan may need further refinement.

The ILT, in conjunction with ACTION and the PII Evaluation Team (PII-ET) will participate in pilot testing the final selection of the computer-assisted self-interview instrument (CASI) and defining the family profile that will be provided to SAFE-FC practitioners. The ILT will provide input into the development of fidelity criteria, operational definitions, and fidelity measures, including the plan for routinely implementing fidelity assessments to guide the coaching program.

Under the guidance of the ILT, and with feedback from the PII Training and Technical Assistance Project (PII-TTAP), the RYC and ACTION will collaborate to develop a series of training curricula and related materials to guide the training and practicum experiences that will occur during implementation.

The ILT, along with the CC, ACTION, the RYC and WCDSS will evaluate the effects of PII implementation on management, administration, quality assurance systems, workload management, and resource allocation of partner agencies and on the supervision and staff development of implementation agencies.

The ILT will identify and analyze agency policies and procedures affected by the implementation of PII and draft required revisions to state regulations in obtaining approval for policy and procedural changes at the county and state level.

The ILT, with UNITY support, will identify information systems that inform assessment. They will evaluate characteristics of the target population and provide an overview of assessment and its initial impact on implementation.

The ILT will collaborate with state and community agencies to plan the investment of federal, state, local, and private funding streams in the initiative. The PMT will submit a refined, detailed implementation plan, including the plan for sustainability to the Children’s Bureau.
Values and Ways of Work

The value system that supports the team structure consists of:

- Creative project management, problem solving, product development, consultation and technical assistance (TA) delivery, and use of people and resources
- Collaboration with respect to involvement, informing, trusting, relying upon, effectively making use, being egalitarian, empowering, and cooperating with the community workers and supervisors, management; PII contract partners; and others who become a part of the project;
- Flexibility with respect to introspection, ownership, adjustment of schedules, participant inclusion, and relationships
- Quality with respect to thinking, planning, decision making, consultation, TA, service delivery, products, communication, and performance
- Timeliness with respect to meeting milestones, responding, initiating, maintaining and meeting schedules, delivery of products, and involvement of others
- Diligence with respect to level and rigor of work, maintaining initiative, commitment and motivation, inclusion, problem solving, and maintaining the implementation plan

The ILT will employ a ways-of-working process that applies to individual performance, interactive performance, installation and initial implementation activities and products, and PII relationships. The process begins by soliciting input from any person associated with the project who is relevant to a task and willing to contribute, followed by controlled efforts to develop, design, and draft plans, methods, products, and activities. To ensure that development does not occur within a vacuum confined to only a few people, a review by relevant contributors provides feedback in conjunction with the testing of ideas and methods, which occurs as part of refinement of the activity or product. Once refined, the activity, task, service, or product is put into practice. Once implemented, evaluating effectiveness occurs, which leads to refinement by looping back to the beginning of the process (involving input ideas).

Co-Chairpersons

The Project Director, Jim Durand, will be responsible for chairing the ILT meetings with the ACTION Implementation Director, Clint Holder, acting as Co-Chairperson.

Meetings

The ILT will meet on a biweekly basis or as necessary, based on need. Phone or Web-based meetings may be used at regular meetings or between in-person meetings.

Attendance

All ILT members shall make a good-faith effort to attend each ILT meeting. If the member is unable to attend a meeting in person, he or she may participate by telephone conference and will be considered present for meeting attendance purposes. Committee members are strongly urged to participate in person for a fully effective committee.
Quorum

There shall be a quorum present when a majority of members is present for the meeting, including those who participate by phone.

Decision Making, Consensus Building, and Reporting

Formal recommendations of the CAC shall be decided by consensus with exception to those areas having a financial or program impact on Washoe County and the CC, wherein they have the final decision.

There will be target dates set by which time recommendations and reporting must be made in order for the project or activity to move forward.

The Project Director and ACTION Implementation Director will serve as liaisons to the PMT, facilitate bi-directional communication, and work with the Communications Implementation Team (CIT) member linked to the CAC to identify the type of information to be shared and timeframes and format for information dissemination and feedback.

The ILT will provide feedback to the PMT on the CAC’s recommendations and projects or activities; however, the PMT has final decision-making authority on the CAC’s recommendations.

Minutes

Decision-making minutes shall be kept at every meeting of the ILT by the Office Support Specialist and distributed to members by email prior to the next scheduled meeting.

Task Teams

The ILT has established a CIT to be responsible for development and implementation of the communication plan with both internal and external partners, which will include information dissemination and obtaining, reviewing, and sharing feedback obtained from the PII internal and external communication processes. The team’s co leads are Theresa Anderson, WCDSS Program Specialist, and Sarah Fries, WCDSS Facilitator; their focus will be on installing a PII communication structure.

The CAC was initiated in April 2011 to provide guidance to the PIT and PMT and to develop the community awareness campaign for PII project, to be carried out with the assistance of the ILT. Jim Durand, Project Director, is the lead.

The SAFE-FC Implementation Team’s fundamental role will be to influence change in the professional behavior of casework staff in order to achieve implementation fidelity. The team will provide consultation, coaching, and TA to build caseworker competency related to the SAFE-FC assessments, Protective Capacity Family Assessment (PCFA) and Protective Capacity Progress Assessment (PCPA). It will identify competency development needs, serve as staff development advisors to external expert implementation partners, and communicate with the field about implementation efforts and how implementation activities correspond with the broader plan for SAFE-FC implementation. Finally, the team will identify barriers to SAFE-FC implementation, assist in forming strategies to respond to those
barriers, and communicate with the ILT about the status of implementation efforts. The SAFE-FC Purveyor Team, with co-leads Sherri Cline and Todd Holder, will focus on installing SAFE-FC interventions (SAFE-FC and FC).

The SAFE Purveyor Team, led by Otto Lynn and Clint Holder, will focus on the installation of ACTION SAFE model enhancements.

The Intake Team, with co-leads Otto Lynn and Michael Capello, will focus on installing enhancements to the Intake Assessment (IA) and Nevada Initial Assessment (NIA) structure and process.

The Population 2 (Pop 2) Case Review Team will focus on the pre-implementation task of screening Pop 2 cases for inclusion into the research. The co-leads are Jacqueline Kleinedler and Dena Negron.

The FC Intervention Team, with co-leads Jacqueline Kleinedler and Diane DePanfilis, PhD, will focus on the development of the intervention approach and procedures for installing FC, which also interconnects with the SAFE-FC Team.

The Evaluation Team, with co-leads Dena Negron and Diane DePanfilis, will focus on PII research and evaluation tasks and on the development of the evaluation plan in collaboration with Westat.

The Safety Services Team with co-leads Clint Holder and Jacqueline Kleinedler, will focus on assessing and developing strategies for any system barriers and gaps in the availability or delivery of PII-related safety services.

The PII Leadership Team, led by Jim Durand and Clint Holder, will focus on assessing overall the teaming structure, communications, and adherence to the implementation plan. They will facilitate any immediate decisions and realignments as necessary and, in doing so, will meet weekly.

**Work Products and Publications**

The WCDSS will provide to the Children’s Bureau for review and approval drafts of all updated or new materials that are developed or printed with resources made available under the cooperative agreement with the Children’s Bureau. Any dissemination of products or information related to PII (e.g., information regarding local-, state-, or foundation-level work funded through PII) will be submitted to either its PII-ET site liaison or directly to Matthew McGuire, Children’s Bureau.

The WCDSS will include the phrase “A service of the Children’s Bureau” and proper disclaimer language and HHS logo (to be provided) on all formal products or materials produced, developed, and disseminated with resources made available under the agreement with the Children’s Bureau. Following review and approval by the Children’s Bureau, the WCDSS will finalize, print, and disseminate these materials.

**Staff Support**

The ILT is assisted by an Office Support Specialist in carrying out those general, clerical support functions as required by the Project Director and PMT. A WCDSS fiscal lead will develop cost templates for tracking all implementation and service costs and for reporting these data to the external evaluator. The Case Compliance Reviewer will participate in quality assurance and fidelity activities, as
well as policy development. The Project Director and Implementation Director will be responsible for the
day-to-day management of the project; participate in the design and implementation of the PII
intervention; provide management oversight of information systems design modifications; contribute to
semiannual Children’s Bureau reports; attend required Grantee meetings; and the agenda, preparation,
and chairing of the ILT meetings.

Budget

The ILT does not have a discretionary budget. All costs associated with this team are covered out of
the Washoe County budget or the initiative’s budget, which includes contracts with ACTION and the CC.

Dissolution

The ILT will be dissolved at the end of the grant period ending on September 29, 2015, or whenever the
PMT deems it is no longer required under the auspices of the cooperative agreement.

Effective Date

These guidelines are effective upon approval of the PMT.
Appendix B: Implementation Leadership Team—Meeting Protocol

This worksheet is designed to help the WCDSS Implementation Leadership Team (ILT) implement a sustainable program improvement cycle for the SAFE-FC intervention approach. The protocol below provides a series of questions for implementing an improvement plan each month. Many initiatives fail for lack of study and reflection on what is actually being done and what the results are from having done it. Observing, describing, and documenting are key aspects to a program improvement cycle and are particularly critical during the pilot phase when key functions of interventions are emerging.

1. Are there any outstanding issues from last month that we need to address?
   - Technical
   - Adaptive
2. What formal and informal data have we reviewed this month?
   - WCDSS SAFE-FC Coordinator
   - CC Coordinator
   - Other
3. What are the data telling us?
4. Are we implementing the SAFE-FC intervention as intended?
5. What barriers have we encountered in implementing SAFE-FC intervention?
6. Are there systems issues we need to address? What is our plan for addressing these barriers and ensuring that strategies are implemented?
7. Do SAFE-FC staff need support with any particular skills to improve their practice? What is our plan for addressing this need and ensuring that strategies are implemented?
8. Would improving the usefulness of one or more of the implementation drivers help address this barrier?
   - Selection
   - Training
   - Coaching
   - Performance assessment
   - Decision support data system
   - Facilitative administration
   - Systems intervention
9. What systems issues seem to be working well? How can we ensure these systems interventions continue working well?
10. What practice issues seem to be working well? How can we ensure these practices continue working well?
11. What items need to be linked out from the ILT and to what team/group?
12. What items were linked in to the ILT and by what team/group?
Appendix C: SAFE-FC Communications Plan

Revised November 2012

Project Background and Grantee Profile

Overview

The Permanency Innovations Initiative is (PII) is a 5-year, $100 million, multi-site demonstration project designed to improve permanency outcomes among children in foster care who have the most serious barriers to permanency. PII includes 6 grantees, each with a unique innovation to help a specific subgroup of children leave foster care in less than 3 years.

Grantee Overview

The Washoe County Department of Social Services (WCDSS), Children’s Services Division is collaborating with ACTION For Child Protection, Inc., (ACTION), the Ruth H. Young Center at the University of Maryland (the RHC), and The Children’s Cabinet (CC) to develop a new approach to permanency. Washoe County provides child welfare services to approximately 680 children and youth annually. The Nevada Initiative to Reduce Long-Term Foster Care is focused on:

- Preventing children from entering long-term foster care
- Improving permanency for children in foster care
- Decreasing the amount of time it takes for foster care youth to achieve permanency

Target Population

There are two populations PII targets:

1. Population 1: Children who are assessed as unsafe due to impending danger following a new report of child abuse or neglect
2. Population 2: Families with children who are in care for 12 months or longer and who, at the time of placement, presented with one or more of four risk characteristics:
   - Single-parent household
   - Parent substance abuse
   - Homelessness or inadequate housing
   - Parent incarceration with an available parent or caregiver to participate in the intervention.
WCDSS will employ the SAFE-FC model (described below) to increase parent readiness for change, parent resilience, and percentage of children who achieve permanence within 12 months. It will also decrease the time to case closure, reunification, and permanence.

**Barriers to Permanency**

Permanency for children in foster care means a legally permanent, nurturing family occurring through reunification with a child’s family, adoption, or guardianship. In Washoe County, barriers to permanency include caregivers with inadequate protective capacities, complex problems, lack of resources, and deficits in meaningful visitation when children are in care.

**Interventions:**

Washoe County is implementing SAFE-FC, which is a model based on two established interventions:

1. Safety Assessment Family Evaluation (SAFE)—A comprehensive assessment and intervention approach connected by four assessments which result in decisions that move the family through the child protective services process
2. Family Connections (FC)—A multifaceted, community-based services program that works with families in their homes and neighborhoods to help them meet the basic needs of their children and to reduce the risk of child neglect

**Purpose and Scope of This Document**

This plan outlines the overall approach for communicating with internal and external stakeholders of SAFE-FC. It outlines key messages, identifies key stakeholders, and describes communications activities. It covers the implementation phase of the project and includes communications at three levels:

- Communication with internal stakeholders about the project mission, goals, services, structure, referral and assignment process, and benefits to the children
- Communication among identified internal stakeholders about program improvement for implementation and installation of specific services and innovations
- Communication with identified external stakeholders about the program mission, goals, services, structure, referral and assignment process, and benefits to division staff and children

**Communications Objectives**

The main objectives of this Communication Plan are to:
Appendix

- Provide accurate, timely, and meaningful information to staff and stakeholders
- Mitigate and overcome barriers to communication and understanding among staff and to identify facilitators for this process
- Establish clear lines of communications and expectations of project partners, staff, and stakeholders.

Assumptions

A number of assumptions underlie the development of this plan. Internally:

- Staff are concerned about how this project will affect their jobs (e.g., increased caseloads and expectations).
- Some families are unwilling to participate in research.
- Staff will participate on the Communication Implementation Team.
- Communication processes need to be tracked.
- This plan is a reference tool and living document that must be updated regularly.

Externally, partner stakeholders need more in-depth updates as they are involved in the day-to-day decision making of the project. There is need to understand what information gets shared with whom (e.g., staff, stakeholders). There needs to be a clarification of roles and lines of communication.

Branding and Logo Use

A primary goal is to have staff and partners consistently refer to this project as the SAFE-FC Intervention under the Permanency Innovations Initiative rather than “PII” or “SIPS” as it was formerly called. The purpose of branding is to give acknowledgement to the integrative models we will be using. The Program does not have a logo, and we will be using the Washoe County logo, the ACTION for Child Protection logo, the Ruth H. Young Center for Children and Families logo, The Children’s Cabinet logo, and the PII logo on documents and reference materials.
Communication Agents:

The Implementation Leadership Team (ILT) established the Communication Implementation Team (CIT) to develop and implement a communication plan, which is to include information dissemination, as well as reviewing and sharing feedback obtained from internal and external communication processes. The CIT will be led by the designated team leader and comprises strategically selected staff. It is tasked with managing the internal and external communications and with creating, updating, and implementing this communications plan. The CIT meets the 1st and 3rd Wednesday of each month to discuss any communication-related issues and to brainstorm solutions.

Implementation of the Plan:

The CIT is responsible for developing a communication plan for each target audience listed below. Each member of the CIT will have a communication protocol (chart) identifying the stakeholder group, type of information to be shared, and timeframes and format for the information dissemination and feedback. The Project Implementation Team (PIT) and Project Management Team (PMT) will approve CIT communication protocols. The protocols included the following audiences:

**Target Audiences**

- WCDSS SAFE-FC workers and supervisors—It will be critical to obtain feedback from the SAFE-FC workers and supervisors about policy and program guidelines that are working and about resource issues or systemic barriers affecting the intervention. A subset of this protocol will include a venue for WCDSS staff to converse with CC staff about working together.
- Usual Permanency Services Team—The type of information to be shared with staff on this team will be important to manage staff expectations and morale and to answer any questions about the process and role of assessment workers on intervention cases and about the steps to take once a case is chosen for the intervention.
- Service Providers—PII will use a cadre of safety and change services providers who may serve families involved with both SAFE-FC and usual permanency services staff. Some are existing providers who will need to be informed about the initiative and a change in expectations (level of accountability) of providers who agree to serve families participating in SAFE-FC (e.g., contracted mental health experts, etc.).
- Community Advisory Committee—Key community partners, such as the school district, public health, service providers, and others, participate on this committee. These individuals, in turn, link, the information shared about PII to their respective fields.
- Model Court—It is imperative that the court and related parties be kept informed of practice changes. Business rules for how the court operates occur through this venue as do as agreements that need to be developed between WCDSS and the various legal counsel, including public defenders and children’s attorneys. This is also the appropriate venue to discuss updates with PII and how they will affect the court process (e.g., the information gathering instruments, assessments, court reports).
• University of Nevada, Reno, Title IV-E Training Partnership—The partnership identifies and approves the pre-service and advanced training curricula of WCDSS and the Rural DCFS. Needed changes identified through the PII will need to be communicated to the partnership to adjust or enhance training curricula. The partnership is responsible for providing the foundation curriculum to all new hires and provides CEUs for current staff. It will need to be informed of the service model used for the PII.

• Children’s Cabinet—The Project Coordinator will be the lead communicator between the two agencies, along with the Project Director. The CC Project Coordinator and Program Director are members of the PMT and PIT and will use those venues to discuss communications issues and then relay the information to their agencies.

Communication Protocol

<table>
<thead>
<tr>
<th>Communication Vehicles</th>
<th>Audience/Location</th>
<th>How It Will Be Used</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division Meeting Updates</td>
<td>All WCDSS staff</td>
<td>Any updates about staffing, budget, project changes, etc., will be announced during these meetings.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Memos/Newsletters</td>
<td>WCDSS staff, clients, foster parents, providers, stakeholders</td>
<td>The information in the newsletters will need to be modified depending on the target audience.</td>
<td>Bimonthly</td>
</tr>
<tr>
<td>Presentations</td>
<td>WCDSS staff, clients, foster parents, providers, stakeholders, model court, legislature, other agencies,</td>
<td>Presentations will be used to discuss the project and to promote awareness.</td>
<td>As needed</td>
</tr>
<tr>
<td>Meetings</td>
<td>WCDSS supervisors and coordinators, PMT, ILT, etc.</td>
<td>Issues that may come up will be addressed, as will project changes, updates, and implementation.</td>
<td>Weekly</td>
</tr>
<tr>
<td>SharePoint (Agency Intranet)</td>
<td>All WCDSS staff</td>
<td>All presentations, meeting agendas and minutes, press releases, newsletters, and other program-related documents will be stored in SharePoint for staff to access. An Excel spreadsheet of questions to be addressed at the next meeting will also be kept, on which workers can submit questions to be added to the agenda.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Communication Vehicles</td>
<td>Audience/Location</td>
<td>How It Will Be Used</td>
<td>Frequency</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Communication Plan</td>
<td>All WCDSS staff</td>
<td>CIT members will track ongoing PII-related information that was disseminated in an Excel spreadsheet. This information must be reported to the Children’s Bureau during biweekly dissemination calls.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Emails</td>
<td>All</td>
<td>Project Coordinators will use this vehicle or the day-to-day communications related to the project.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Press Releases</td>
<td>All</td>
<td>Press releases will be disseminated as needed by the Project Director to relay important information to the community.</td>
<td>As needed and approved</td>
</tr>
<tr>
<td>Trainings</td>
<td>SAFE-FC staff</td>
<td>SAFE-FC staff and new hires will require additional training in order to meet the project requirements. Trainings will be facilitated to communicate the program model.</td>
<td>As needed</td>
</tr>
<tr>
<td>Project Dissemination</td>
<td>CAC</td>
<td>Any communication of the project must be reviewed and approved by the cross-site CIT.</td>
<td>As needed</td>
</tr>
</tbody>
</table>
### Stakeholder Objective Key Messages Communication Vehicles Date Completed Feedback Mechanisms

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Objective</th>
<th>Key Messages</th>
<th>Communication Vehicles</th>
<th>Date Completed</th>
<th>Feedback Mechanisms</th>
</tr>
</thead>
</table>
| **All Child Welfare Staff**  | To inform staff of the overall scope of PII, including:                   | 5-year grant to improve permanency outcomes. Focus is to:  
- Prevent children from entering long term foster care  
- Improve permanency for children in foster care  
- Decrease the amount of time it takes for foster care youth to achieve permanency  
Two target populations  
Intervention model established on two interventions: SAFE and FC  
Reason for randomization of workers | Division meeting(s)  
Supervisor meeting (s)                                                                 | October 2011  
November 2011  
December 2011 | Q&A time with staff |
| **All Child Welfare Staff**  | Supervisor & Coordinator selection                                        | The SAFE-FC Leadership Team was selected using the core concepts of implementation Research  
Reason for randomization of workers | Announcement of staff via email by the Project Director                                                                 | October 2011 | |
| **All Child Welfare Staff**  | Staff selection                                                           | Staff will be randomized into SAFE-FC.                                                                 | Division meeting(s)  
Supervisor meeting (s)  
Supervisor-to-individual staff communication                                                                 | February 2012 | |
| **All Child Welfare Staff**  | Randomization of families into the intervention                           | Inform supervisors that a popup screen will alert them when a case is randomized into intervention. Supervisor will be emailed by onsite evaluation liaison. Supervisor guides assessment worker on difference in process.  
Randomization will begin on August 6, 2012 | Division meeting(s)  
Supervisor meeting (s)                                                                 | July 2012 | |
<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Objective</th>
<th>Key Messages</th>
<th>Communication Vehicles</th>
<th>Date Completed</th>
<th>Feedback Mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Child Welfare Staff</td>
<td>To help staff understand why facilitators cannot be used to conduct Safety Plan Determination Meetings (SPDM) and how the SPDM replace facilitated Family Solution Team meetings.</td>
<td>The SAFE model is based on a helping alliance between the worker and the family. SAFE uses motivational interviewing to increase readiness for change.</td>
<td>Supervisor meeting (s)</td>
<td>October 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unit meeting (s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Child Welfare Staff</td>
<td>To inform assessment and SAFE-FC staff of the FAQs process.</td>
<td>Help assessment workers understand the role of the FAQs and the evaluation process and how to present the FAQ's to a family.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Child Welfare Staff PII-TTAP site Visit</td>
<td>To present key components of evaluation activities</td>
<td></td>
<td>Cathy Welsh (CSF) and Allison Metz (NIRN)</td>
<td>March 2012</td>
<td>Evaluation Liaison reviews use of HSSS and HSSS referral data to determine appropriateness of service.</td>
</tr>
<tr>
<td>All Child Welfare Staff</td>
<td>To inform all staff on the use of Human Services Support Specialist (HSSS) for SAFE-FC cases.</td>
<td>Health Services Support Specialist (HSSS) are able to help on SAFE-FC cases as part of the safety services plan developed by the CC</td>
<td>Supervisor meeting (s)</td>
<td>November 2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unit meeting(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanency Worker (usual permanency services)</td>
<td>To inform the usual permanency services workers that they may be invited to the SPDM</td>
<td>Permanency workers may attend the SPDM and must read the NIA prior to the SPDM.</td>
<td>Communicated via supervisors and at SPDM training</td>
<td>October 2012</td>
<td>Survey assessment workers: Ask if it is it helpful to have permanency workers attending SPDM.</td>
</tr>
<tr>
<td>Permanency Worker (usual permanency services)</td>
<td>Identify practices on control side that are working</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Permanency Worker (SAFE-FC)</td>
<td>Pilot the use of CC safety services consultation for out-of-home cases</td>
<td>Assessment workers informed that supervisor and worker to have initial consultation with CC for safety services out-of-home cases as well</td>
<td>Workers informed at unit meetings</td>
<td>October 15, 2012</td>
<td>Will get verbal feedback from CC supervisors to WCDSS supervisors then to Coordinator and Project Director on case-by-case basis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Division Supervisors were informed at supervisors meeting.</td>
<td>October 17, 2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Workers informed at CIT and unit meetings.</td>
<td>October 18, 2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For each case that is randomized, Dena will email supervisor and worker to remind them.</td>
<td></td>
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<tr>
<td>Stakeholder</td>
<td>Objective</td>
<td>Key Messages</td>
<td>Communication Vehicles</td>
<td>Date Completed</td>
<td>Feedback Mechanisms</td>
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<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Permanency Worker (SAFE-FC)</td>
<td>Identify methodology to assign trainees to a permanency position</td>
<td>How were randomized workers trained? When trainee is assigned to SAFE-FC, he or she will be removed from training unit to receive additional training from SAFE-FC Supervisor.</td>
<td>Westat developed formula for assigning new permanency workers to control and treatment positions. When a vacancy occurs in whichever condition, then that vacancy will be filled prior to jumping back in to the sequence that was developed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanency Worker (SAFE-FC)</td>
<td>Identify how those assigned to SAFE-FC will get trained</td>
<td>Trainees that get assigned to SAFE-FC will require additional training.</td>
<td>ACTION and the RYC will draft the training curriculum and coaching manuals; PIT and PII-TTAP will revise and edit. PIT, with feedback from PII-TTAP, the RYC, and ACTION will collaborate to develop a series of training and practicum experiences that will occur during implementation. Evaluation Liaison, CC Coordinator, supervisors and SAFE-FC Coordinator in charge of implementing training plan to any new SAFE-FC worker hired after November 2012 (Implementation plan, pg 69)</td>
<td>November 2012</td>
<td></td>
</tr>
<tr>
<td>Permanency Worker (SAFE-FC)</td>
<td>To inform staff about training</td>
<td>Training for SPDM, safety planning, and safety management on how to include CC on the process</td>
<td>Email by Evaluation Liaison ACTION provided individual trainings.</td>
<td>October 2012</td>
<td></td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Objective</td>
<td>Key Messages</td>
<td>Communication Vehicles</td>
<td>Date Completed</td>
<td>Feedback Mechanisms</td>
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</tr>
<tr>
<td>Implementation Team</td>
<td>Discover if HSSSs are allowed to help SAFE-FC cases</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Clarify role of CC vs. HSS in in-home and out-of-home placements</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Communication Team</td>
<td>Changes to communication plan should be made from division and supervisor meetings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Parents &amp; Kids Kottage</td>
<td>To inform foster parents how having children assigned to SAFE-FC may affect the foster parent</td>
<td>Worker may visit youth more often. Foster parent may be invited to meetings with the CC worker.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s Cabinet</td>
<td>Pilot the use of the CC safety services consultation for out-of-home cases</td>
<td>WCDSS supervisor to contact CC supervisors for consultation on both in-home and out-of-home cases</td>
<td>By CC Project Lead</td>
<td>October 2012</td>
<td></td>
</tr>
<tr>
<td>Public Defender (PD)</td>
<td>Involve PD in SAFE-FC stages (introduction, discovery, and case planning)</td>
<td>Are PDs told if client is in SAFE-FC group?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Court &amp; Family Drug Court (FDC)</td>
<td>How FDC cases would be managed during the project.</td>
<td>WCDSS Project Director conducted a presentation to the FDC policy team on January 10, 2012, for discussion on how FDC cases would be managed.</td>
<td>Project Director presentation</td>
<td>January 2012</td>
<td></td>
</tr>
<tr>
<td>University of Nevada Reno-Training Partnership</td>
<td>Monitor the coaching and training process for future curriculum development post project</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Community (judges, prosecutors, defense attorneys, CASA, child attorneys, and other judicial staff)</td>
<td>Overview of the SAFE-FC intervention approach with focus on system changes relevant to the group</td>
<td>Overview of the SAFE-FC intervention approach with focus on system changes relevant to the group</td>
<td>Clint Holder from ACTION Judges National Resource Center for Child Protection</td>
<td>November 2012</td>
<td></td>
</tr>
<tr>
<td>Community Advisory Committee</td>
<td>Report on PII implementation activities to key stakeholders</td>
<td>Report on PII implementation activities to key stakeholders</td>
<td>Project Director presentation</td>
<td>October 2011</td>
<td></td>
</tr>
<tr>
<td>Service Providers</td>
<td>To inform WCDSS contract service providers about the initiative and a possible change of expectations</td>
<td></td>
<td></td>
<td>January 2012</td>
<td></td>
</tr>
</tbody>
</table>
We are required to add the Grantee statement to all documents and materials pertaining to PII:

The Nevada Initiative to Reduce Long-Term Foster Care is operated by the Washoe County Department of Social Services and is funded by the Children’s Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services, under grant number 90-CT-0157.
Appendix D: SAFE-FC Learning Approach

May 29, 2012

Under the guidance of the project purveyors, the RYC and ACTION, the ILT will collaborate to develop a series of training curricula and related materials to guide the training and practicum experiences that will occur during implementation. The Intervention Training Curriculum will consist of training modules related to each core component of the intervention manual, including varied practice exercises related to:

- Consultative supervision
- In-home safety services
- Change-management services
- Motivational interviewing
- PCFA
- PCPA
- Safety management
- SMART case plans
- Use of clinical assessment measures (via CASI)
- Concurrent planning
- Reunification and conditions for return
- Therapeutic visiting.

Learning objectives will be tied to fidelity criteria and practice standards. Sessions will be staged based on the timing of when intervention stages will be implemented (in order to permit practicum experiences in between training modules). Supervisors will receive training first, and will then become active participants in the training of workers. This transfer of learning design will be based on testing results and case problem-solving scenarios and will allow for the application of problem-solving skills from one situation to another. Additionally the transfer of learning design will include demonstration (a purveyor or expert modeling behavior) and tandem methods (combining supervisors and workers in the learning experience).

The training curriculum will be designed to build on supervisors and workers’ existing knowledge and will be integrated with other learning experiences (e.g., consultation, classroom training, use of intervention manuals, etc.) to achieve what Perkins and Salomon (1992) call “high road transfer,” which is cognitive integration, understanding from context, and a deliberate search for connections from one situation to another. The overall objective of the practicum experiences is to increase knowledge and skill for supervisors and workers to use them more effectively in casework practice and supervisory consultation. The experiences will draw connections to real cases being dealt with routinely.

The practicum experiences will be separated for supervisors and workers and will be designed to ensure that staff and supervisors receive just-in-time skills practice specifically tailored to the

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implementation of SAFE-FC. The chart below outlines the primary core competencies related to the intervention and are imbedded in the learning approach curricula and performance-based experiences.

**PRIMARY SAFE-FC COMPETENCIES**

<table>
<thead>
<tr>
<th>VALUES/PHILOSOPHY COMPETENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Values and expresses caregiver acceptance</td>
</tr>
<tr>
<td>Expresses a nonjudgmental attitude</td>
</tr>
<tr>
<td>Maintains confidentiality</td>
</tr>
<tr>
<td>Respects and supports individualization</td>
</tr>
<tr>
<td>Maintains emotional control</td>
</tr>
<tr>
<td>Values and demonstrates cultural sensitivity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASSESSMENT COMPETENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engages caregivers in identifying children’s unmet need</td>
</tr>
<tr>
<td>Engages caregivers to participate in PCFA</td>
</tr>
<tr>
<td>Conducts guided conversations</td>
</tr>
<tr>
<td>Introduces and clarifies purpose of SAFE-FC</td>
</tr>
<tr>
<td>Explains role of SAFE-FC</td>
</tr>
<tr>
<td>Explains what to expect in SAFE-FC intervention process</td>
</tr>
<tr>
<td>Explains and discusses reasons for SAFE FC intervention</td>
</tr>
<tr>
<td>Confirms safety assessment for Pop 2 Level 1 during PCFA</td>
</tr>
<tr>
<td>Discusses impending danger and rationale for safety conclusions</td>
</tr>
<tr>
<td>Reviews SPDM decisions</td>
</tr>
<tr>
<td>Discusses safety plan</td>
</tr>
<tr>
<td>Explains and discusses enhanced and diminished caregiver protective capacities</td>
</tr>
<tr>
<td>Discusses clinical measure results</td>
</tr>
<tr>
<td>Conducts stages of PCFA</td>
</tr>
<tr>
<td>Addresses discrepancies</td>
</tr>
<tr>
<td>Addresses resistance</td>
</tr>
<tr>
<td>Promotes self-awareness about diminished capacities and impending danger</td>
</tr>
<tr>
<td>Assesses stages of change</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CASE PLAN COMPETENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discovers what must change to enhance caregiver protective capacities</td>
</tr>
<tr>
<td>Examines caregivers understanding of needs of own children</td>
</tr>
<tr>
<td>Reaches mutual understanding about caregiver protective capacities and impending danger</td>
</tr>
<tr>
<td>Determines needs for professional evaluations</td>
</tr>
<tr>
<td>Discusses professional evaluation findings with caregivers</td>
</tr>
<tr>
<td>Seeks mutuality for content for case plan</td>
</tr>
<tr>
<td>Develops SMART goals based on caregiver protective capacities</td>
</tr>
<tr>
<td>Identifies and arranges for services to enhance caregiver protective capacities</td>
</tr>
<tr>
<td>Identifies and arranges for services to meet needs related to permanency</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERPERSONAL COMPETENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides support and encouragement</td>
</tr>
<tr>
<td>Expresses empathy</td>
</tr>
<tr>
<td>Encourages client self-expression (e.g., thoughts, opinions, feelings)</td>
</tr>
<tr>
<td>CASE MANAGEMENT COMPETENCIES</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>Oversees safety plans</td>
</tr>
<tr>
<td>Revises safety plans</td>
</tr>
<tr>
<td>Conducts weekly face-to-face client contacts</td>
</tr>
<tr>
<td>Encourages openness and participation</td>
</tr>
<tr>
<td>Advocates for client</td>
</tr>
<tr>
<td>Provides direction for client during case-planned services</td>
</tr>
<tr>
<td>Solves problems and removes barriers during case-planned services</td>
</tr>
<tr>
<td>Affirms, accentuates, and mobilizes client strengths and resources</td>
</tr>
<tr>
<td>Acquires necessary resources to support case-planned services and participation</td>
</tr>
<tr>
<td>Intervenes in crises</td>
</tr>
<tr>
<td>Communicates with caregiver, family members, and service providers</td>
</tr>
<tr>
<td>Manages legal responsibilities in case</td>
</tr>
<tr>
<td>Participates in weekly consultative supervision</td>
</tr>
</tbody>
</table>
Appendix E: Coaching and Consultation Plan

Washoe County Department of Social Services

SAFE-FC
Implementation Competency Driver:
Coaching and Consultation Plan

2nd Draft

Prepared by:
ACTION for Child Protection, Inc.

January 31, 2013
Appendix

Introduction

The development of SAFE-FC supervisor and worker competency (e.g., knowledge, skill, professional qualities) to provide consultation and perform SAFE-FC assessment processes as intended is fundamental to implementation success and intervention fidelity. Expert coaching, mentoring, consultation, and technical assistance from intervention model purveyors is essential for supplementing preliminary foundational learning that supervisors and staff receive from traditional stand-up training.

Data from literature pertaining to implementation science reveal that while traditional knowledge-based training is a necessary method or driver for competency development, the extent to which supervisors and staff are able to fully retain and apply content from training experiences is limited. Timely, objective-oriented, and planned coaching, mentoring, and consultation strategies assure that training knowledge becomes well rooted and continues to grow. Coaching is ideal for targeting the development of professional skills necessary for meeting the practice objectives of SAFE-FC.

This document is intended to provide a plan for coaching and consultation in the context for how this competency driver fits with the broader SAFE-FC implementation efforts to develop supervisors and workers’ knowledge and skill. The plan will include the objectives for coaching, key competency development goals, the rationale for the general approach, specific targets of coaching and consultation, and strategies and timeframes for its delivery.

Status of SAFE-FC Implementation

A considerable amount of effort related to the development of SAFE-FC supervisor competency began in January 2012 and continued through June 2012. During this time, SAFE-FC supervisors participated in numerous competency-development activities, including training, skill-building practicum sessions, and coaching and consultation. As part of the larger strategy for SAFE-FC implementation, the work on the competency drivers purposely focused initially on SAFE-FC supervisors to prepare them to be better able to support the competency development of their staff. In June 2012, work began on delivering foundation training to SAFE-FC workers. Protective Capacity Family Assessment (PCFA) and SMART case plan training was completed in July 2012, followed by a PCFA skills practicum, which occurred in August.

Following the completion of PCFA-SMART case plan training, follow-up individual supervisor-worker and unit-level coaching and consultation opportunities were provided nearly weekly through September and then approximately every other week into the middle of December. Multiple methods were used to support initial learning. Most often used were joint coaching experiences that included SAFE-FC expert purveyor and SAFE-FC supervisors working in tandem to build SAFE-FC worker competency.

The two remaining SAFE-FC intervention components, the Change Focused Intervention and Protective Capacity Progress Assessment (PCPA) were formally put into place after SAFE-FC supervisors and workers received training at the end of 2012. To date, there has been very limited opportunity for coaching and mentoring related to either the weekly Change Focused Intervention or the PCPA. These intervention components and renewed efforts to further develop competency related to the PCFA and SMART case plan will become the focus of coaching for the remainder of the third year of SAFE-FC implementation. With all of the SAFE-FC foundational
training having been completed to date, attention to continue building supervisor expertise and worker competency will shift to the coaching driver. The primary attention of coaching activities will be on applying knowledge and on mastery skills necessary for intervention fidelity.

Overview of Progress Related to Competency Driver and Implications for Coaching and Consultation

SAFE-FC Supervisor Consultation

- All SAFE-FC supervisors are demonstrating a remarkable level of effort and commitment for providing structured, criteria-based consultation to their staff. Supervisors are continuing to increase their expertise in the PCFA and SMART case plan and have only just recently began providing consultation related to the PCPA.
- Supervisors remain somewhat challenged in working with staff on preparing for the Discovery Stage. Specifically, supervisors acknowledge difficulties in consulting with staff to help them think of ways of raising caregiver self-awareness about what must change and of connecting diminished caregiver protective capacities to the development of SMART goals.
- Other areas of need related to consultation include helping to refine SMART goals and assisting workers in determining objectives and creative approaches for the weekly Change Focused Intervention.

SAFE-FC Worker Performance Related to Intervention Components

- One factor that is influencing staff competency is that some SAFE-FC workers have not had frequent opportunity for applying knowledge and developing skills. That said, SAFE-FC workers have done an exceptional job of trying to adhere to the intervention standards.
- They complete the PCFA intervention stages as designated even if they continue to struggle with certain aspects of the approach, namely the Discovery Stage. For the most part, SAFE-FC supervisors and workers report feeling more confident conducting the PCFA Introduction Stage versus the Discovery Stage.
- Most SAFE-FC workers report having continued difficulty working with caregivers on developing SMART goals. Subsequently, the writing of SMART goals remains a significant area of need.
- The majority of SAFE-FC workers report being unclear and frustrated about what they are to be discussing with caregivers during the weekly Change Focused Intervention contacts. SAFE-FC workers are consistently making their weekly contacts, but they are having difficulty connecting the objectives for the contacts with ongoing efforts to promote progress toward the achievement of SMART goals.
- A related issue to conducting weekly contacts is the documentation of weekly Change Focused Intervention contacts in the case notes. While there have been some efforts to provide guidance related to professional documentation, this is likely an area of continued need among SAFE-FC workers.

Ongoing Safety Management and Provisional Protection

- SAFE-FC supervisors and workers have worked steadily on increasing their knowledge base related to safety management. They have participated in in-service training sessions, and they have also been involved in individual case consultations. Some of these consultations have resulted in the decision to decrease the level of intrusiveness of the safety plan. While the initial
trainings and consultation have been helpful for developing knowledge related to the application of safety concepts for safety management decision making, there remains a continued need for focus on ongoing safety management.

- Specific practice and decision-making issues related to safety management requiring coaching and mentoring include:
  - Evaluating the relevance of conditions for return and making revisions as indicated
  - Effectively applying criteria for determining sufficient safety plans
  - Analyzing how progress related to SMART goals relates to conditions for return and has implications for reunification and the use of less intrusive safety plans

SAFE-FC Implementation Coaching Approach

The coaching approach will be an interaction and dynamic way of building upon existing foundational learning. The coaching approach will be used to help supervisors become expert in the model and to assist workers in becoming proficient in completing SAFE-FC assessment processes. The approach for coaching and mentoring discussed in this plan is consistent with the following quotations:

“Coaching in the truest sense is giving the responsibility to the learner to help them come up with the answers on their own.”—Vincent Lombardi

“Coaching is unlocking a person’s potential to maximize their own performance. It is helping them to learn rather than teaching them”—John Whitmore

These quotations are illustrative of where SAFE-FC supervisors and workers are at in the learning process and what they need from model purveyors to continue their professional development. The remainder of Year 3 implementation activities associated with competency development are currently at the point of transitioning to more individualized learning. With the completion of formal pre-service SAFE-FC training, competency development will shift to a more targeted coaching and mentoring approach based on status of intervention fidelity and on individual supervisor and worker needs based on performance related to model intervention standards.

The coaching approach will be “consultee centered”, whereby conversations with supervisors and workers are facilitative and intended to draw upon existing foundational learning and to maximize individual professional capacity. SAFE-FC supervisors and workers, on the whole, possess sufficient foundational knowledge and exposure to the model at this point in implementation to become even more actively engaged in their own learning and problem solving.

Coaching Objectives

- To continue to build capacity among supervisors to support the use of concepts and criteria when provided structured coaching and consultation
- To continue to build independence and critical thinking skills among supervisors for guiding practice, identifying intervention fidelity issues, and determining solutions
To model an approach to coaching that can be used by supervisors to engage workers in discussions that consider alternative perspectives and problem solving and stimulates creative ideas for intervention

To collaborate with supervisors in developing worker competency that builds staff independence and critical thinking skills

To improve communication and to establish feedback loops for evaluating competency needs and establishing learning plans

To change professional behavior among SAFE-FC workers by building upon personal qualities and characteristics, knowledge, and skills conducive for SAFE-FC implementation

Coaching Sessions

Coaching sessions will occur primarily in a collegial fashion. In capturing the interactive spirit of mutual learning, the coaching approach will avoid an expert-a-leader style that is often characteristic of case consultation exchanges. The model purveyors will serve as competency development resources to mentor SAFE-FC supervisors and to assist with the facilitation of coaching sessions.

Model purveyors will work primarily in tandem with supervisors to assist them in transfer of learning to SAFE-FC workers. The partnership between the model purveyors and SAFE-FC supervisors will be a continuation of the mentor and mentoree relationship that has already been established. Model purveyors will focus on supporting supervisors in their role for implementing SAFE-FC and continue efforts to build their internal capacity for sustaining coaching sessions with workers as individual cases are proceeding through the intervention process.

Coaching sessions will be dynamic in the sense of being both prearranged based on prevalent competency needs among supervisors and staff (e.g., drafting SMART goals, CFR, etc.) and spontaneous based on emerging issues and questions related to specific case circumstances.

Coaching Sessions and Feedback Loops

Communication and defined feedback loops are essential to assuring the coaching sessions are making a difference. Coaching is fundamental driver for developing professional competency and, as such, it is merely a means to an end. What is most important is that individual competency needs are being correctly identified, and coaching sessions are having an impact on addressing those needs.

This coaching plan will rely on a number of sources of information for determining status of intervention fidelity, competency needs, and effectiveness of coaching sessions. Information sources that will be used to inform the coaching plan include, but are not necessarily limited to, the ILT, SAFE-FC supervisors, SAFE-FC workers, and periodic SAFE-FC fidelity assessments.

Feedback loops discussed in the coaching plan serve as the vehicle for assessing progress toward change related to competency. Approaching competency development from a change-based mentality means that the coaching plan is flexible and open to revision. Predetermined coaching sessions will target specific goals that are associated with specific SAFE-FC intervention standards and fidelity criteria. As coaching sessions are being completed, feedback will be elicited from different sources over time as implementation is proceeding to
determine the extent to which there is change in professional behavior. The coaching plan will be revised as necessary based on feedback, analysis, and ideas for solutions.

**Coaching Session**  
**Goal:** PCFA Intervention Standard: SAFE-FC Workers Can Achieve Discovery Stage Objectives  

**Scheduled Coaching Sessions:**  
Developing Knowledge and Skill for PCFA Discovery Stage  

**Evaluate Progress**  
Re: Ability of SAFE-FC Workers to Complete PCFA Discovery Stage (Seek Feedback)  

**Adjust Coaching Plan (as indicated):**  
Collaborate With SAFE-FC Supervisors and Seek Guidance from ILT  

---

**SAFE-FC Competency Development Goals and Coaching Sessions**

<table>
<thead>
<tr>
<th>Competency Goal</th>
<th>Coaching Session(s)</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFE-FC supervisors provide structured, criteria-based consultation and coaching that is consistent with SAFE-FC supervisor consultation standards.</td>
<td>Model purveyor will meet with SAFE-FC supervisors at designated times to discuss approaches, styles, issues, and challenges specifically related to providing SAFE-FC consultative supervision. Model purveyor will offer coaching ideas for supervisors to use during individual and/or weekly unit meetings.</td>
<td>Ongoing—Occurring during every site visit for a scheduled period of time</td>
</tr>
<tr>
<td>Competency Goal</td>
<td>Coaching Session(s)</td>
<td>Timeframe</td>
</tr>
<tr>
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</tr>
<tr>
<td>SAFE-FC workers are knowledgeable about and able to perform all SAFE-FC</td>
<td>Model purveyor and SAFE-FC supervisors will facilitate individual case consultations with SAFE-FC workers as needed.</td>
<td>Ongoing—Time will be designated during every site visit for individual SAFE-FC worker case consultation.</td>
</tr>
<tr>
<td>intervention components consistent with practice and decision-making standards.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SAFE-FC supervisors and worker recognize that safety management is provisional and are able to determine effectively the sufficiency of safety plans that are least intrusive and most appropriate.</strong></td>
<td>The model purveyor will develop a structured method for reviewing SAFE-FC cases where children are in care and the case is at the point of the PCPA (or just recently completed PCPA), discuss progress on the case, consider safety plan sufficiency, review CFR, and revise as indicated.</td>
<td>See coaching schedule (next section).</td>
</tr>
<tr>
<td>SAFE-FC supervisors and workers use CFR to judge reunifying children who are placed per the safety plan and assure safety with an in-home safety plan upon reunifying a child with his family.</td>
<td></td>
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</tr>
<tr>
<td>SAFE-FC worker uses Change Focused Intervention (weekly) to involve caregivers, promote caregiver participation, resolve barriers to service provision, encourage caregiver progress and change, and build and maintain a working alliance between the SAFE-FC worker and caregivers.</td>
<td>Model purveyor and SAFE-FC supervisors will facilitate a coaching session on approaches SAFE-FC can take when meeting with caregivers on a weekly basis. The coaching session will have SAFE-FC workers refer to their own cases when considering objectives for meetings and strategizing ideas</td>
<td>See coaching schedule (next section).</td>
</tr>
<tr>
<td>Competency Goal</td>
<td>Coaching Session(s</td>
<td>Timeframe</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>SAFE-FC worker documents weekly Change Focused Intervention contacts to describe facilitative objectives with caregivers, case management activities related to the coordination of services, and safety management activities and to justify PCPA decision making.</td>
<td>Concurrent with the coaching session related to weekly contact, the model purveyor and SAFE-FC supervisors will have conversations with the SAFE-FC worker about the documentation of weekly Change Focused Intervention contacts.</td>
<td>See coaching schedule (next section).</td>
</tr>
<tr>
<td>SAFE-FC worker creates SMART goals, that are verified by the SAFE-FC supervisor, to be associated with diminished caregiver protective capacity and to meet SMART goal criteria.</td>
<td>Model purveyor will facilitate conversations with SAFE-FC Supervisors and workers about criteria for SMART goals. The coaching session will refer to the session on PCFA Discovery Stage (i.e., how conversations with caregivers inform the development of SMART goals). Current SMART goals in SAFE-FC cases will be discussed.</td>
<td>See coaching schedule (next section).</td>
</tr>
<tr>
<td>SAFE-FC worker has knowledge of techniques and has specific interpersonal skills that enable him or her to engage effectively in direct conversations with caregivers during the PCFA and weekly Change Focused Intervention meetings. SAFE-FC worker is able to engage effectively caregivers who are resistant and in pre-contemplation about the need for change.</td>
<td>Model purveyor will facilitate activities to develop SAFE-FC worker interpersonal skills necessary for engaging difficult or resist caregivers. Coaching will focus primarily on the use of motivational interviewing techniques.</td>
<td>See coaching schedule (next section).</td>
</tr>
<tr>
<td>Competency Goal</td>
<td>Coaching Session(s)</td>
<td>Timeframe</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>SAFE-FC supervisors provide consultation and coaching that is effective for advancing SAFE-FC intervention fidelity. SAFE-FC workers are knowledgeable about and able to perform all SAFE-FC intervention components consistent with practice and decision-making standards.</td>
<td>Model purveyor and SAFE-FC supervisors will collaborate to develop a coaching plan “tool box”. The “tool box” will include numerous resources (e.g., videos, articles, handouts, self-assessment tools, etc.) and guidance on how to use the resources for coaching.</td>
<td>See coaching schedule (next section).</td>
</tr>
</tbody>
</table>

### SAFE-FC Coaching and Consultation Schedule

Week: February 11th

<table>
<thead>
<tr>
<th>Monday 2/11</th>
<th>Tuesday 2/12</th>
<th>Wednesday 2/13</th>
<th>Thursday 2/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Individual Case Consultation and Coaching</td>
<td>Coaching Session 101: Using Motivation Interviewing to Engage Resistant Caregivers</td>
<td>CFR Case Review and Coaching</td>
<td>CFR Case Review and Coaching</td>
</tr>
<tr>
<td>2:00-3:00</td>
<td>9:00-10:30</td>
<td>9:00-2:00</td>
<td>9:00-4:30</td>
</tr>
<tr>
<td>Action Office</td>
<td>FST room 3, 6th floor</td>
<td>Fishbowl office next to Sherri’s office, 2nd floor by the front desk</td>
<td>Fishbowl office next to Sherri’s office, 2nd floor by the front desk</td>
</tr>
<tr>
<td>Model Purveyor and SAFE-FC Supervisor Consultation Meeting: 3:00-4:30 2nd floor conference room</td>
<td>Coaching Session 101: Using Motivation Interviewing to Engage Resistant Caregivers</td>
<td>Coaching Session 101: Using Motivation Interviewing to Engage Resistant Caregivers</td>
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</tr>
<tr>
<td></td>
<td>11:00-12:30</td>
<td>2:00-3:30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FST room 3, 6th floor</td>
<td>FST room 3, 6th floor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CFR Case Review and Coaching 2:00-5:00</td>
<td>Open Individual Case Consultation and Coaching 3:30-4:30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fishbowl office next to Sherri’s office, 2nd floor by the front desk</td>
<td>Action Office</td>
<td></td>
</tr>
</tbody>
</table>
Week: March 4th

<table>
<thead>
<tr>
<th>Monday 3/4</th>
<th>Tuesday 3/5</th>
<th>Wednesday 3/6</th>
<th>Thursday 3/7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Individual Case Consultation and Coaching</td>
<td>Coaching Session 102: Developing Skills for Completing PCFA Discovery Stage 9:00-10:30 Action Office FST room 3, 6th floor</td>
<td>Open Individual Case Consultation and Coaching 9:00-12:00 Action Office</td>
<td>Coaching Session 103: Delivery and Documenting Weekly Change Focused Intervention 9:00-10:30 2nd floor conference room</td>
</tr>
<tr>
<td>2:00-3:00 Action Office</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model Purveyor and SAFE-FC Supervisor Consultation Meeting: 3:00-4:30 2nd floor conference room</td>
<td>CFR Case Review and Coaching 11:00-5:00 Fishbowl office next to Sherri’s office, 2nd floor by the front desk</td>
<td>Coaching Session 102: Developing Skills for Completing PCFA Discovery Stage 2:00-3:30 FST room 3, 6th floor</td>
<td>Open Individual Case Consultation and Coaching 11:00-12:00 2nd floor conference room</td>
</tr>
<tr>
<td>Model Purveyor and SAFE-FC Supervisor Consultation Meeting: 3:00-4:30 2nd floor conference room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open Individual Case Consultation and Coaching</td>
<td></td>
<td>Open Individual Case Consultation and Coaching 3:30-4:30 Action Office</td>
<td>Coaching Session 103: Delivery and Documenting Weekly Change Focused Intervention 1:30-3:00 2nd floor conference room</td>
</tr>
<tr>
<td>3:30-4:30 Action Office</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Week: April 1st

<table>
<thead>
<tr>
<th>Monday 4/1</th>
<th>Tuesday 4/2</th>
<th>Wednesday 4/3</th>
<th>Thursday 4/4</th>
</tr>
</thead>
</table>
| Open Individual Case Consultation and Coaching  
2:00-3:00  
Action Office | Coaching Session 102:  
Developing Skill for completing PCFA Discovery Stage  
9:00-10:30  
FST room 3, 6th floor | Open Individual Case Consultation and Coaching  
9:00-12:00  
Action Office | Coaching Session 104:  
Skill building for Developing SMART Goals  
9:00- 1:00  
2nd floor conference room |
| Model Purveyor and SAFE-FC Supervisor Consultation Meeting:  
3:00-4:30  
2nd floor conference room | Open Individual Case Consultation and Coaching  
11:00-4:30  
Action Office | Coaching Session 103:  
Delivery and Documenting Weekly Change Focused Intervention  
2:00-3:30  
FST room 3, 6th floor | Coaching Session 104:  
Skill Building for Developing SMART Goals  
1:30- 3:30  
2nd floor conference room |
| | | Open Individual Case Consultation and Coaching  
3:30-4:30  
Action Office | |
## Week: April 22nd

<table>
<thead>
<tr>
<th>Monday 4/22</th>
<th>Tuesday 4/23</th>
<th>Wednesday 4/24</th>
<th>Thursday 4/25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Fidelity Assessment and Consider Implications for Coaching 2:00-4:00 2nd floor conference room</td>
<td>Coaching Session 104: Skill Building for Developing SMART Goals 9:00-11:00 FST room 3, 6th floor</td>
<td>Open Agenda, Planning, and Development: Reviewing UNITY-Based Reports Revise Coaching Plan; Conceive of Qualitative Assessment Approach 10:00-4:00 3rd floor directors conference room</td>
<td>Open Individual Case Consultation and Coaching 9:00-3:30 Action Office</td>
</tr>
<tr>
<td>SAFE-FC Supervisor Implementation Progress Assessment meeting 1:30-4:30 3rd floor directors conference room</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix F: Example of a Coaching Session

SAFE-FC Implementation:

Coaching Session 101: Addressing Caregiver Resistance
When Conducting the PCFA

Coaching Session 101 Goal:

Develop SAFE-FC worker skill for effectively addressing caregiver resistance at the onset of involvement during the PCFA and throughout the SAFE-FC intervention.

Objectives:

- Understand the meaning of resistance
- Recognize what influences resistance
- Alter perspective regarding caregiver resistance and consider changes to interpersonal approach
- Practice alternative approach for rolling with resistance

Resistance as a Result of Social Interaction:

_In order to subvert [your] influence, the involuntary clients [caregivers] must expend energy as they focus on not coming under another's control (i.e., resistance)._—Clifton Mitchell, PhD
In reaction to caregiver reluctance/resistance, most practitioners try even harder to influence. As practitioners’ attempts to influence increase, so do the caregivers’ rationale and inner need to circumvent this influence. —Clifton Mitchell, PhD

Influence of Caregiver Resistance on Us

There is a reason that clients are often called “patients”: One needs to cultivate one’s “patience” in order to work effectively with them! Like struggling in quicksand, pushing impatiently will only serve to further mire the process.

—J. Moursund and M. C. Kenny

Discussion:

• Identify a caregiver that has been “difficult” during the SAFE-FC process.
• Describe how they interact with you.
• What are your predominate thoughts and feelings about the caregiver?

Influence of Us on Caregiver Resistance

Perhaps resistance and defensiveness are often encouraged unwittingly by practitioners who never think of alternative views that might allow [caregivers] to save face and preserve what little self-esteem they have.

—C. D. Hammond, D. H. Hepworth, and V. G. Smith

Discussion:

What are your expectations for caregivers who are involved with you in the SAFE-FC process?

Reflection: How often have you thought or felt this…?

• I don’t understand why caregivers don’t do what’s right and change for the sake of their children.
• I feel like I am working harder than they are.
• I just don’t get why they don’t follow through on what they need to do.
• They are acting just like I expected OR They are not acting like I expected…

2 See http://www.cliftonmitchell.com/Articles.html
Why does it always take so long for them [caregivers] to accept that they need to change?  
I don’t understand their [caregivers] position; it doesn’t make sense.

Discussion:

Do you believe your established expectation for caregivers and your thoughts or feelings about their resistive behavior has an impact on how you interact with them?

Do the Unexpected: Resist Not the Resistance

Judo—“The Gentle Way”

能柔制剛

Superior Technique
Overcomes Power

—Jigoro Kano, Japan, 1882

Discussion: Techniques for Dealing With Resistance5

- Express empathy through the use of reflective listening.
- Develop discrepancies between current behavior and ideal or desired behavior.
- Use naive puzzlement or “Columbo questions”.
- Avoid trying to convince caregivers that they have a problem.
- Roll with resistance by seeking to understand caregivers’ perspective and responding using reflective listening.
- Support hope and belief for change among caregivers.

Discussion: Early Conversations With Caregivers Should Primarily Involve the Use of the OARS

- Open-ended questions
- Affirming
- Reflective listening
- Summarizing

---

Discussion and Application: Three Types of Reflective Listening Statements

- **Simple Reflection (neutral statement)**
  - Demonstration
  - Practice: 2 x simple reflections
- **Amplified Reflection (exaggerated statement)**
  - Demonstration
  - Practice: 1 x simple reflections and 1 x amplified reflection
- **Double-Sided Reflection (connecting past comment with current statement)**
  - Demonstration
  - Practice: 1 x simple reflection, 1 x amplified reflection, and 1 x double-sided reflection

**Individual Case Application: Practice With Principles and Techniques**

**Instructions**

1. Refer to the assigned caregiver that you discussed earlier in the session.
2. Each of you will have the responsibility for playing the role of “your assigned” caregiver, followed by your facilitating a discussion with the same caregiver.
3. The SAFE-FC coach will begin the rotation by facilitating a conversation with you (in the caregiver role). The topic of the conversation will focus on the facilitative objective related to discussing why the case was opened based on impending danger. (5 minutes)
4. Following this simulation, the roles will be reversed, and you will facilitate the same conversation with the SAFE-FC coach, who is now playing the role of the caregiver. (5 minutes)
## Appendix G: Fidelity Criteria

### Table 1. PCFA Fidelity Categories and Criteria

<table>
<thead>
<tr>
<th>Fidelity Criteria Category</th>
<th>Fidelity Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREPARATION</strong></td>
<td></td>
</tr>
<tr>
<td>Preparation-Review-Worker</td>
<td>Documentation - Worker Reviews NIA, SPD, &amp; Safety Plan prior to transfer meeting</td>
</tr>
<tr>
<td>Supervision 1</td>
<td>Worker - supervisor consult prior to transfer meeting</td>
</tr>
<tr>
<td>Case Transfer Meeting</td>
<td>SAFE-FC facilitates case transfer meeting with NIA worker and supervisors.</td>
</tr>
<tr>
<td>Supervision 2</td>
<td>Worker - supervisor consult to prepare for Introduction Stage</td>
</tr>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td></td>
</tr>
<tr>
<td>Introduction - Meet With Caregiver</td>
<td>SAFE-FC worker meets with caregiver.</td>
</tr>
<tr>
<td>Introduction - PCFA Purpose</td>
<td>SAFE-FC introduces and clarifies PCFA purpose.</td>
</tr>
<tr>
<td>Introduction - Reason for SAFE-FC Involvement</td>
<td>SAFE-FC worker explains the reason for SAFE-FC involvement, relates to impending danger.</td>
</tr>
<tr>
<td><strong>DISCOVERY</strong></td>
<td></td>
</tr>
<tr>
<td>Supervision 4a</td>
<td>Documents worker-supervisor consult to prepare for discovery stage</td>
</tr>
<tr>
<td>Supervision 4b</td>
<td>Documents worker-supervisor consult on how CASI findings will be used in Discovery Stage</td>
</tr>
<tr>
<td>Identifies Enhanced Caregiver Protective Capacities</td>
<td>Identifies enhanced caregiver protective capacities</td>
</tr>
<tr>
<td>Identifies Diminished Caregiver Protective Capacities</td>
<td>Identifies diminished caregiver protective capacities</td>
</tr>
<tr>
<td>Documents Attempts to Raise Caregiver Self-Awareness About What Must Change</td>
<td>Documents attempts to raise caregiver self-awareness about what must change regarding diminished caregiver protective capacities and impending danger</td>
</tr>
<tr>
<td><strong>Documents Use of CASI Measures in Discovery</strong></td>
<td>Documents using CASI measures during discovery to raise self-awareness</td>
</tr>
<tr>
<td><strong>Agreement About What Must Change</strong></td>
<td>Documents areas of agreement about what must change by specifically identifying diminished protective capacities</td>
</tr>
<tr>
<td><strong>Areas of Disagreement About What Must Change</strong></td>
<td>Documents areas of disagreement about what must change by identifying specific differences related to diminished protective capacities</td>
</tr>
<tr>
<td><strong>Identifies Child’s Unmet Needs</strong></td>
<td>Identifies and documents unmet needs.</td>
</tr>
<tr>
<td><strong>PCFA PROCESS</strong></td>
<td><strong>Fidelity Criteria</strong></td>
</tr>
<tr>
<td><strong>Case Transfer Meeting - 5 days From Assignment</strong></td>
<td>Facilitates case transfer meeting within 5 days of case assignment</td>
</tr>
<tr>
<td><strong>Introduction Meeting - 5 Days From Case Transfer Meeting</strong></td>
<td>Conducts Introduction Stage meeting within 5 days of the case transfer meeting</td>
</tr>
<tr>
<td><strong>Minimum of Weekly Contact to Conduct the PCFA</strong></td>
<td>Maintains at least weekly face-to-face contact with caregivers while completing the PCFA</td>
</tr>
<tr>
<td><strong>PCFA Completion - 45 Days</strong></td>
<td>Completes the PCFA within 45 days of case assignment</td>
</tr>
<tr>
<td><strong>SAFETY MANAGEMENT DURING PCFA</strong></td>
<td><strong>Fidelity Criteria</strong></td>
</tr>
<tr>
<td><strong>Minimum of Weekly Contact With Safety Service Providers</strong></td>
<td>Makes personal contact with CC case manager or other safety service provider each week during the PCFA.</td>
</tr>
<tr>
<td><strong>PCFA DECISION-MAKING</strong></td>
<td><strong>Fidelity Criteria</strong></td>
</tr>
<tr>
<td><strong>Decision - Outcome Selection</strong></td>
<td>Identifies categories of protective capacities as outcomes for change</td>
</tr>
<tr>
<td><strong>Quality of Outcome Selection Decision</strong></td>
<td>Determines degree to which Section IIIIB diminished protective capacities match each outcome for change</td>
</tr>
<tr>
<td><strong>Specifies Impending Danger Status</strong></td>
<td>Determines status of impending danger</td>
</tr>
<tr>
<td><strong>Confirms Safety Plan Sufficiency</strong></td>
<td>Confirms safety plan sufficiency</td>
</tr>
<tr>
<td><strong>Supervision 6</strong></td>
<td>Supervisor reviews and authorizes PCFA process and documentation, including safety management.</td>
</tr>
<tr>
<td>SMART CASE PLAN Process</td>
<td>Fidelity Criteria</td>
</tr>
<tr>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>** Supervision 1**</td>
<td>Worker and supervisor consult to prepare for case planning meeting.</td>
</tr>
<tr>
<td><strong>Case Plan Meeting</strong></td>
<td>Conducts a SMART case plan meeting, reaches agreement on SMART goals with caregiver, and discusses change strategies.</td>
</tr>
<tr>
<td><strong>Case Plan Meeting - 5 days from PCFA Completion</strong></td>
<td>Conducts SMART case planning meeting within 5 days of completion of the PCFA</td>
</tr>
<tr>
<td>** Supervision 2**</td>
<td>Worker-supervisory consult to debrief case plan meeting</td>
</tr>
<tr>
<td>** Supervision 3**</td>
<td>SMART case plan is finalized with supervisory approval and client signature within 5 days of the case plan meeting.</td>
</tr>
<tr>
<td>Makes referrals</td>
<td>Arranges change services to be provided by others as specified in the case plan</td>
</tr>
<tr>
<td><strong>SMART CASE PLAN DECISION MAKING</strong></td>
<td></td>
</tr>
<tr>
<td><strong>SMART Goals - Caregiver</strong></td>
<td>Develops goals for caregivers that meet SMART criteria</td>
</tr>
<tr>
<td><strong>SMART Goals - Child</strong></td>
<td>Develops goals for child's unmet need that meet SMART criteria</td>
</tr>
<tr>
<td><strong>Selection of Change Strategies</strong></td>
<td>Determines appropriate change strategies that will support achievement of SMART goals</td>
</tr>
<tr>
<td><strong>Selection of Providers</strong></td>
<td>Selects a specific provider to match SMART goals</td>
</tr>
<tr>
<td>** Determination of Stage of Change - Each Goal**</td>
<td>Determines caregiver's stage of change with respect to achieving each SMART goal</td>
</tr>
<tr>
<td>Change Focused Intervention - Facilitation</td>
<td>Fidelity Criteria</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Change Focused Intervention</td>
<td>Implements interpersonal process and interaction with caregiver for a minimum of 1 hour per week to routinely and consistently foster successful changes in caregiver protective capacities and to manage impending danger</td>
</tr>
<tr>
<td>Change Focused Intervention</td>
<td>Determines which SMART goals should be the focus of caregiver change talk each week</td>
</tr>
<tr>
<td>SMART Goals</td>
<td>Seeks caregiver involvement and maintains caregiver investment to discuss issues related to SMART goals and what must change, including what caregivers think about change and feel about the need for change and their perceptions about the ability to make changes</td>
</tr>
<tr>
<td>Stages of Readiness</td>
<td>Considers caregiver’s stage of readiness in Change Focused Interventions strategy selection and implementation.</td>
</tr>
<tr>
<td>Caseworker Facilitation</td>
<td>Communicates the connection between impending danger, SMART goals, and CFR for out-of-home cases</td>
</tr>
<tr>
<td>Caseworker Facilitation</td>
<td>Communicates the connections between impending danger, SMART goals, and in-home safety plans for in-home cases</td>
</tr>
<tr>
<td>Change-Based Services</td>
<td>Implements change-based services during parent-child visits for out-of-home cases</td>
</tr>
<tr>
<td>Change-Based Services</td>
<td>Includes children in family meetings when case plan identifies improving parent-child interaction in order to deliver change-based services.</td>
</tr>
<tr>
<td>Caseworker Facilitation</td>
<td>Discusses caregiver's visitation experience with children in foster care</td>
</tr>
<tr>
<td></td>
<td>Gathers caregiver’s perception of treatment services</td>
</tr>
<tr>
<td>Change Focused Intervention - Case Management and Coordination</td>
<td>Fidelity Criteria</td>
</tr>
<tr>
<td>Case Coordination</td>
<td>Makes and coordinates referrals to treatment and other service providers</td>
</tr>
<tr>
<td>Communication With Providers</td>
<td>Assures that treatment services provided by others are coordinated effectively by communicating with treatment providers on at least a monthly basis regarding progress achieved during service provision</td>
</tr>
<tr>
<td>Safety Management</td>
<td>Fidelity Criteria</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Safety Plan Assessment and Sufficiency</strong></td>
<td>Assesses the sufficiency of the safety plan and safety services to control impending danger</td>
</tr>
<tr>
<td></td>
<td>Assessing the sufficiency of the safety plan and safety services by gathering information from caregiver weekly</td>
</tr>
<tr>
<td><strong>Safety Plan Assessment</strong></td>
<td>Makes appropriate changes to safety-plan as needed</td>
</tr>
<tr>
<td><strong>CFR Sufficiency</strong></td>
<td>Assesses and revises CFR to consider a less intrusive safety plan</td>
</tr>
<tr>
<td><strong>Safety Service Providers</strong></td>
<td>Assesses sufficiency of safety service providers</td>
</tr>
<tr>
<td><strong>Supervisor Consultation</strong></td>
<td>Consults with supervisor about a developed or revised CFR</td>
</tr>
<tr>
<td><strong>PCPA Information Collection</strong></td>
<td>Fidelity Criteria</td>
</tr>
<tr>
<td></td>
<td><strong>Caregiver Inclusion</strong></td>
</tr>
<tr>
<td></td>
<td>Involves caregiver as the primary source of information for the PCPA event</td>
</tr>
<tr>
<td></td>
<td><strong>Information Collection</strong></td>
</tr>
<tr>
<td></td>
<td>Seeks information from other key informants and case participants, including CC case managers, safety service providers, treatment service providers, family members, or others involved in the case</td>
</tr>
<tr>
<td></td>
<td><strong>Preparing for and Conducting the PCPA Process</strong></td>
</tr>
<tr>
<td></td>
<td><strong>PCPA Timing</strong></td>
</tr>
<tr>
<td></td>
<td>Convenes a PCPA event at least every 90 days following the implementation of the SMART case plan</td>
</tr>
<tr>
<td></td>
<td><strong>HRI Completion and Timing</strong></td>
</tr>
<tr>
<td></td>
<td>Assures the HRI is completed 1 week prior to the PCPA event</td>
</tr>
<tr>
<td></td>
<td><strong>PCPA Preparation</strong></td>
</tr>
<tr>
<td></td>
<td>Advises caregivers 1 week in advance of the PCPA meeting</td>
</tr>
<tr>
<td></td>
<td><strong>PCPA Preparation</strong></td>
</tr>
<tr>
<td></td>
<td>Determination of the individuals who will participate in the PCPA event</td>
</tr>
<tr>
<td></td>
<td><strong>PCPA Preparation</strong></td>
</tr>
<tr>
<td></td>
<td>Prepares the caregiver and others participating for the PCPA event</td>
</tr>
<tr>
<td><strong>PCPA Decision Making</strong></td>
<td><strong>PCPA Assessment</strong></td>
</tr>
<tr>
<td></td>
<td>Concludes degree of progress toward SMART goals achievement</td>
</tr>
<tr>
<td></td>
<td><strong>PCPA Assessment</strong></td>
</tr>
<tr>
<td></td>
<td>Concludes that SMART goals are or are not relevant and contributing to what must change</td>
</tr>
<tr>
<td>Task</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>PCPA Assessment</strong></td>
<td>Concludes the nature and quality of the SAFE-FC worker–caregiver relationship is satisfactory or not</td>
</tr>
<tr>
<td><strong>Safety Assessment</strong></td>
<td>Determines the safety of the child, including determining the status of impending danger, and concludes the safety plan is sufficient or not</td>
</tr>
<tr>
<td><strong>Safety Assessment</strong></td>
<td>Confirms safe environments when safety plans involve child placement</td>
</tr>
<tr>
<td><strong>PCPA Assessment</strong></td>
<td>Determines the achievement of family and child outcomes</td>
</tr>
<tr>
<td><strong>Taking PCPA Actions</strong></td>
<td><strong>Fidelity Criteria</strong></td>
</tr>
<tr>
<td><strong>SMART Goal Revision</strong></td>
<td>Revises SMART goals as necessary</td>
</tr>
<tr>
<td><strong>PCPA Results</strong></td>
<td>Debriefs results of PCPA with caregiver</td>
</tr>
<tr>
<td><strong>PCPA Action - Reunification</strong></td>
<td>Creates reunification plan and follow-up, if appropriate</td>
</tr>
<tr>
<td><strong>PCPA Action - In-Home Safety Plan</strong></td>
<td>Creates of in-home safety plan if reunification is planned</td>
</tr>
<tr>
<td><strong>PCPA Action - Follow-Up</strong></td>
<td>Follows up in 1 week when reunifying and implementing in-home safety plan</td>
</tr>
<tr>
<td><strong>PCPA Result - Supervisor Approval</strong></td>
<td>Garners supervisor’s approval of change in safety plan</td>
</tr>
<tr>
<td><strong>PCPA Result - Supervisor Approval</strong></td>
<td>Garners supervisor approval of PCPA</td>
</tr>
</tbody>
</table>
Appendix H: Fidelity Assessment Tool

PCFA/Case Planning and PCPA/Change Focused Intervention

Rev 11.22.2012 - FOR DEC USE

Reviewer:

Case #:

Date case randomized to SAFE-FC:

Date case FIRST assigned to a SAFE-FC worker:

SAFE-FC worker FIRST assigned to case:

Has a new SAFE-FC worker been assigned since the case first opened in SAFE-FC?

☐ Yes
☐ No
Date new SAFE-FC worker assigned:

Select current SAFE-FC worker:

Supervisor name:

At the conclusion of the PCFA, was this an in-home or out-of-home safety plan?

- In-Home
- Out-of-Home
- Both in-home & out-of-home

Check (all) stages completed for this case:
- PCFA
- Case Plan
- Change Focused Intervention & Safety Management
- PCPA
- Case Closure

PCFA Preparation Stage

1. The SAFE-FC worker PREPARED for the PCFA, including reviewed the NIA, SPDM, and safety plan prior to the transfer meeting.

Quality of PREPARATION Stage:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reviewed NIA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Reviewed SPDM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Reviewed safety plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Consulted with supervisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prior to transfer meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Consulted with supervisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prior to Introduction Stage</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. The SAFE-FC worker participated in a case transfer meeting with the NIA worker (ideally with NIA and SAFE-FC supervisors).
   ✗ Yes
   ✗ No

3. Case transfer meeting held within 5 days of the SPDM
   ✗ Yes
   ✗ No

4. PCFA Introduction Stage 4. The SAFE-FC worker met with the primary caregiver for the Introduction Stage.
   ✗ Yes
   ✗ No

5. Please explain why the worker was unable to meet with primary caregiver (Select the best match below):
   ✗ Worker attempted but the caregiver was unavailable.
   ✗ No documentation of attempts to contact for introduction

6. The SAFE-FC worker held the Introduction Stage meeting with caregiver within 5 days of the case transfer meeting.
   ✗ Yes
   ✗ No

7. The SAFE-FC worker fulfilled the primary purposes of the Introduction Stage: (1) introduced self and clarified the purpose of PCFA to the caregiver; (2) explained the reasons for SAFE-FC involvement, including documenting the caregiver’s response and understanding and acceptance; (3) arrived at a conclusion about the caregiver’s willingness to participate in the PCFA process. Quality of Introduction Stage:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduced self &amp; clarified the purpose of the PCFA</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>2. Explained the reasons for SAFE-FC involvement</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>3. Arrived at a conclusion about the caregiver’s willingness to participate</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>
8. The SAFE-FC worker consulted with the supervisor to prepare for the discovery stage.

- Yes
- No

8a. Is there documentation on which part of the supervisory consultation focused on how the CASI findings would be used in the Discovery Stage?

- Yes
- No
- N/A

Discovery Stage Indicators:

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. The SAFE-FC worker identified enhanced caregiver protective capacities (including justification about the basis for those conclusions).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. The SAFE-FC worker identified diminished caregiver protective capacities (including justification of the basis for those conclusions).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Discovery Stage Indicators:

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
<th>NA - Despite worker efforts, parents did not participate in any discovery sessions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. The SAFE-FC worker documents attempts to raise self-awareness about what must change.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. The SAFE-FC worker documents areas of agreement and agreement with the caregiver related to what must change, including the need to enhance specific diminished caregiver protective capacities and the stage(s) of change.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
13. The SAFE-FC worker documents that CASI measures were used during Discovery to raise caregiver self-awareness

☐ Yes
☐ No
☐ N/A

14. The SAFE-FC worker identified a child’s unmet need on the PCFA.

☐ Yes
☐ No

15. If Yes, the unmet need conclusion on the PCFA form, Section IIIE is justified based on the severity of the health, mental health, behavior, or education need that is documented.

☐ Yes
☐ Partially (some, but not all, are justified)
☐ No

16. If No, the unmet need conclusion is justified because the record (including NIA) does not indicate that any child has an unmet need at a level that would require an intervention response.

☐ Yes
☐ Partially (some, but not all, are justified)
☐ No

17. The SAFE-FC worker met at least weekly with caregivers while completing the PCFA.

☐ Yes
☐ No

18. Why didn't the SAFE-FC worker meet at least weekly with caregivers while completing the PCFA?

☐ Worker made appropriate attempts to engage the caregiver but the caregiver was unavailable.
☐ Worker attempted, but due to advice of the lawyer, the caregiver refused.
☐ No indication that there was an attempt at meeting weekly to complete the PCFA.

19. The PCFA was completed within 45 days of case assignment

☐ Yes
☐ No
☐ Cannot Determine—No date on PCFA document

20. Enter information that might explain reasons for the delay to complete the PCFA within 45 days
Safety Management During PCFA:

21: The record (e.g., case notes) indicates that the SAFE-FC worker communicated with the CC case manager and/or other safety service provider (e.g., foster parent) each week during the PCFA process.

- Yes
- Partially (communicated with safety service providers at least twice during the PCFA process)
- No

22. The record (e.g., case notes, PCFA document) indicates that the SAFE-FC worker documented conversations with the parent related to the safety plan and safety management.

- Yes
- No

PCFA Decision Making:

23 The SAFE-FC worker identified categories of protective capacities as outcomes for change.

- Yes
- No

24. There is an alignment between diminished caregiver protective capacities (Section IIIB) and selected outcomes for change.

- Yes
- Partially (some, but not all, match)
- No

25. If the worker identified a child's unmet need in the PCFA, and the conclusion was justified, did the worker appropriately identify a child outcome?

- Yes
- No

26. Was the status of impending danger sufficiently identified?

- Yes
- No

27. Did the safety plan narrative sufficiently align with the analysis questions?

- Yes
- Partially
- No
28. The supervisor reviewed and authorized the PCFA process and documentation, including safety management.

- Yes
- No

29. Identify any specific areas that would indicate the need for TA based on review of the PCFA in this case:

30. Is there a case plan?

- Yes
- No

31. The SAFE-FC worker consulted with the supervisor to prepare for the case planning meeting with the parent.

- Yes
- No

32. The SAFE-FC worker conducted a SMART case planning meeting with the family within 5 days of completion of the PCFA.

- Yes
- No
- NA—Caregiver unavailable in timeframe.

32a. If No, please explain:

33. If No, was the case plan meeting with the family eventually held?

- Yes
- No
- NA—Family refused or unavailable for meeting

34. The SAFE-FC worker fulfilled the purposes of the case plan meeting:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reached agreement or attempted to reach agreement on SMART goals with the primary caregiver</td>
<td>✔</td>
</tr>
<tr>
<td>2. Discussed or attempted to discuss change strategies with caregivers</td>
<td>☐</td>
</tr>
</tbody>
</table>

2016 Washoe SAFE-FC Program Manual
35. The SAFE-FC worker submitted the SMART case plan for approval in UNITY within 5 days of the written case plan.

☐ Yes
☐ No

36. The SAFE-FC worker developed or modified the case plan AFTER completion of the PCFA, including identifying case outcomes.

☐ Yes
☐ No

37. The SAFE-FC worker arranged change services to be provided by others as specified in the case plan (including timeliness of a referral).

☐ Yes
☐ No
☐ N/A
SMART Case Plan Decision Making—Goals in Case Plan Meet SMART Criteria:

| 38. Are goals SPECIFIC statements of what must change such that participants (i.e., caregivers and/or children) are completely clear about what they will do differently? | AL | MOST | SOME | NONE |
| 39. Are goals MEASURABLE? For example, will all participants (i.e., caregiver, children, SAFE-FC worker, and others supporting the achievement of goals) know exactly whether this goal is achieved? Do goals specifically define what must change related to caregiver thinking, feeling, and behaving or to a child’s unmet need? Are goals described in positive terms about what it would look like, or how caregiver would specifically need to behave differently, in order for them to be protective? | | | | |
| 40. Are goals ACHIEVABLE? For example, are goals tailored to specific protective capacities or child needs so that it is reasonable and realistic that progress toward goal achievement can occur within 90 days? Do goal statements include caregiver’s own perceptions and language? Are goals prioritized in the order of greatest likelihood of being achieved? | | | | |
| 41. Are all SMART goals RELEVANT? For example, are SMART goals individualized based on the unique dynamics of the family associated with the reasons for SAFE-FC? Do the goals match specific SAFE-FC outcomes (caregiver or child) based on a thorough PCFA Discovery Phase? | | | | |
| 42. Are all SMART goals TIME-LIMITED? For example, are SMART goals linked to a time period of 90 days or less? Are SMART goals crafted narrowly so that they can be realistically achieved in 90 days or less? | | | | |
| 43. Appropriate change strategies and treatment intervention services are selected to support the achievement of SMART goals. | | | | |
| 44. Appropriate providers are selected to match SMART goals. | | | | |

45. Identify any specific areas for TA based on your overall review of this case plan.

(This section is the start of the PCPA fidelity assessment questions, if applicable)

1. Date the case plan was developed or modified:
2. The SAFE-FC worker developed or modified the case plan AFTER completion of the PCFA, including identifying case outcomes.

- Yes
- No

3. Identify the participants who received face-to-face direct services since the case plan was developed or modified:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Caregiver</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other (insert role and name below)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

3a. Name and role of other participants:

4. Identify the participants who received indirect services since the case plan was developed or modified:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Caregiver</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Child</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other (insert role and name below)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

4a. Name and role of other participants:

5. Using the UNITY SAFE-FC contact report for the 90 days following the case plan, identify the number of face-to-face direct service contacts provided to the caregiver.

- 0-3
- 4-5
- 6-7
- 8-9
- 10-12
- 13+
- N/A—Unable to consistently make weekly contact due to refusal or lack of availability of caregivers
6. Using the UNITY SAFE-FC contact report for the 90 days following the case plan, identify the number of minutes of direct services provided to the caregiver.

- 0-180 minutes
- 181-359 minutes
- 360-479 minutes
- 480-599 minutes
- 600-799 minutes
- 780 or more minutes
- N/A—Unable to meet standard because caregiver unavailable despite worker efforts

7. Considering only occasions in which the caregiver was available for change-focused meetings with the worker, the worker employed change-focused strategies that matched SMART goals.

- Most of the time (at least 85% of the time)
- Some of the time (at least 50% up to 84% of the time)
- Less than 50% of the time
- None of the time
- N/A—Caregiver never available for contacts during the full report period

8. A primary area of focus of direct service contacts by the SAFE-FC worker with the caregiver included discussion of progress toward achieving SMART goals.

- Most of the time (at least 85% of the time)
- Some of the time (at least 50% up to 84% of the time)
- Less than 50% of the time
- None of the time
- N/A—Caregiver never available during full report period

9. There is an indication in the record that the SAFE-FC worker considered the stage of caregiver readiness in planning and implementing change-focused strategies. (Note: If the caregiver was unavailable, but the worker considered stage of readiness, answer Yes.)

- Yes
- No
10. The SAFE-FC worker discussed the relationship between impending danger, SMART goals and conditions for return with the caregiver as appropriate (i.e. out-of-home case) (Note: this does not mean all aspects discussed at every meeting, but relevant aspects were discussed as appropriate)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A-Caregiver Unavailable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impending Danger Threats</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMART Goals</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conditions for Return</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. The SAFE-FC Worker discussed the relationship between impending danger, SMART goals, and status of in-home safety plan when appropriate (i.e. in-home case) (note: this does not mean all aspects discussed at every meeting, but relevant aspects were discussed as appropriate)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A-Caregiver Unavailable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impending Danger Threats</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMART Goals</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status of In-home Safety Plan</td>
<td>☑</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. The SAFE-FC worker met with the child at least monthly and explored the child's safety through personal conversations with the child or the child's caregiver if the child was too young for verbal conversation.

☑ Yes
☑ No

13. The SAFE-FC worker met with the child at least monthly and explored the child's well-being and permanency goals through personal conversations with the child or the child's caregiver if the child was too young for verbal conversation.

☑ Yes
☑ No

14. The SAFE-FC worker used parent-child visits as an opportunity to deliver change-based services

☑ Yes
☑ No
☑ N/A—No visits
15. When the case plan identifies improving parent-child interaction, the SAFE-FC worker included children in family meetings as an opportunity to deliver changed-based Services.

- Yes
- No
- N/A—Not applicable if case plan does not identify need to improve parent-child interaction

16. The SAFE-FC worker discussed the caregiver's visitation experience with children in foster care

- Yes
- No
- N/A—Not applicable if there are no caregiver-child visits

17. When treatment services by another agency were provided, the SAFE-FC worker sought input from the caregiver about his or her perception of treatment services.

- Yes
- No
- N/A—Not applicable because there were no outside treatments services provided

Comments—TA needs related to this section:

18. The SAFE-FC worker had contact with the safety service providers (in home) at least weekly.

- 912 weekly contacts
- 58 weekly contacts
- 14 weekly contacts
- No contact
- N/A

19. When treatment services were provided, the SAFE-FC worker had contact with treatment service providers at least monthly to discuss progress toward SMART goals.

- Contact at least monthly with service providers
- Contact less than monthly
- No contact
- N/A—No treatment services provided
20. During Change Focused Intervention, the case record indicates that the SAFE-FC worker assessed progress toward SMART goals and periodically discussed progress with the caregiver.

- Yes
- No
- N/A

Comments – TA needs related to this section:

Rate the following:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A-Caregiver Unavailable</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. SAFE-FC worker continually assessed changes within the family that affected the safety plan, including the status of impending danger and caregiver protective capacities.</td>
<td></td>
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<tr>
<td>22. The SAFE-FC worker discussed the safety plan with caregiver during Change Focused Intervention meetings as appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Based on discussions with caregiver and worker assessment, the SAFE-FC worker made changes in the safety plan as appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

24. Reviewer Judgment: Rate the sufficiency of safety management based on the evaluation of safety management above.

- Sufficient
- Partially Sufficient
- Insufficient
25. The SAFE-FC worker established and/or revised CFR that matched impending danger threats and diminished caregiver protective capacities in order to consider a less intrusive safety plan.

☐ Yes
☐ No

26. The SAFE-FC worker evaluated the suitability of safety service providers using specified safety service provider criteria.

☐ Yes
☐ No

27. The SAFE-FC worker consulted with the supervisor regarding the development or revision of CFR.

☐ Yes
☐ No

Comments—TA needs related to this section:

28. The SAFE-FC worker explored the caregiver's view of change and/or progress as a primary source of information for PCPA process.

☐ Yes
☐ No
☐ N/A—Caregiver not available

29. The SAFE-FC worker obtained information from other relevant key informants and case participants (e.g., CC case manager, safety service providers, treatment service providers, family member, or others involved in the case).

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC Case Manager</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Safety Service Providers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Treatment Service Providers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Family Members</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments—TA needs related to this section:
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A Caregiver Unavailable</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. SAFE-FC worker completed the PCPA meeting/event within 90 days of the SMART case plan.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>31. SAFE-FC worker completed the HRI prior to the PCPA meeting/event. (Date of HRI should be entered as case note.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>32. SAFE-FC worker scheduled and notified caregiver about the PCPA at least 1 week in advance.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>33. SAFE-FC worker engaged all key stakeholders (e.g., safety and treatment service providers) to participate in the PCPA meeting/event.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>34. SAFE-FC worker prepared caregiver and other participants for the PCPA meeting/event.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>35. SAFE-FC worker consulted with the supervisor to prepare for the PCPA process.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments—TA needs related to this section:
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Partially</th>
<th>No</th>
<th>N/A- Select for items if standard could not be met because caregiver was unavailable.</th>
</tr>
</thead>
<tbody>
<tr>
<td>36. SAFE-FC worker's decision related to caregiver progress assessment was reported on PCPA and justified by conclusion in relevant case and/or supervisory consultation notes.</td>
<td></td>
<td></td>
<td>No</td>
<td>N/A- Select for items if standard could not be met because caregiver was unavailable.</td>
</tr>
<tr>
<td>37. SAFE-FC worker's decision related to assessing the effectiveness of the SMART case plan and related services is documented in the PCPA and supported by case notes.</td>
<td></td>
<td></td>
<td>No</td>
<td>N/A- Select for items if standard could not be met because caregiver was unavailable.</td>
</tr>
<tr>
<td>38. SAFE-FC worker's decision about the change-focused relationship was based on discussion with the caregiver and on HRI results (and noted discussion with the caregiver about the results of the HRI in case notes).</td>
<td></td>
<td></td>
<td>No</td>
<td>N/A- Select for items if standard could not be met because caregiver was unavailable.</td>
</tr>
<tr>
<td>39. SAFE-FC worker's decision on the PCPA regarding the safety of child(ren) matched ongoing assessments (including impending danger and sufficiency of caregiver protective capacities)</td>
<td></td>
<td></td>
<td>No</td>
<td>N/A- Select for items if standard could not be met because caregiver was unavailable.</td>
</tr>
<tr>
<td>40. SAFE-FC worker's decision regarding the status of caregiver readiness and commitment to SMART goal achievement matches case notes</td>
<td></td>
<td></td>
<td>No</td>
<td>N/A- Select for items if standard could not be met because caregiver was unavailable.</td>
</tr>
</tbody>
</table>
41. If a safety plan is continuing, the worker’s decision on the sufficiency of the safety plan matched case notes.

   - Yes
   - No
   - N/A

42. The SAFE-FC worker’s decision regarding if the CFR have been met is supported by case notes.

   - Yes
   - No
   - N/A

43. The SAFE-FC worker’s evaluation of progress on child outcomes matched case notes.

   - Yes
   - No
   - N/A—There are no child outcomes on the SMART case plan.

Comments—TA needs related to this section:

44. The SAFE-FC worker took appropriate action to revise the SMART case plan and goals if indicated by the PCPA process. (NOTE: answer Yes if appropriate changes were made or if no changes were indicated.)

   - Yes
   - No

45. If the result of the PCPA process suggested an in-home safety plan, the SAFE-FC worker created both a plan for reunification and an in-home safety plan.

   - Yes
   - No
   - N/A—The PCPA process did not indicate an in-home safety plan was possible.

46. If the change of safety plan resulted in reunification, the SAFE-FC worker followed up with caregivers within 3 business days of reunifying and implementing an in-home safety plan.

   - Yes
   - No

47. The SAFE-FC worker consulted with supervisor and received approval on decision to change the safety plan.

   - Yes
   - No
48. The SAFE-FC worker consulted with supervisor and received approval on the following components of PCPA. Supervisor approved:

<table>
<thead>
<tr>
<th>PCPA</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmation of Current Safety Plan</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

49. The SAFE-FC worker consulted with supervisor and received approval on the following component of PCPA. Supervisor approved:

<table>
<thead>
<tr>
<th>Change to Permanency Goals</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Comments—TA needs related to this section:

**Case Closure**

50. Was this case closed?

- ☐ Yes
- ☐ No

51. Did the SAFE-FC worker complete the PCPA process (i.e., evaluate change, hold meeting/event, and complete the PCPA form) prior to closing the case?

- ☐ Yes
- ☐ No

52. Prior to case closure, did the SAFE-FC worker collaborate with the family to identify and implement informal and formal supports and social connections that serve to sustain the safety of the children in the home?

- ☐ Yes
- ☐ No

53. Prior to case closure, did the SAFE-FC worker consult and receive approval from the supervisor?

- ☐ Yes
- ☐ No

54. Case Closure: Identify any needed areas for coaching related to case closure process or decision making
Appendix I: Action Plan

WCDSS SAFE-FC Implementation Drivers Assessment Action Planning Template

Action Planning Team Members: Jim Durand & Dena Negron (WCDSS), Allison Metz (PII-TTAP/NIRN), and Cathy Welsh (PII-TTAP/CSF). Reviewed by the WCDSS ILT on 5-23-13.

*Submission Date: 5-29-13*

Section 1—Competency Drivers

Chart 1: Cross-Site Survey Results

<table>
<thead>
<tr>
<th>Composite Scores and Averages</th>
<th>In Place</th>
<th>Partially in Place</th>
<th>Not in Place</th>
<th>Don’t Know</th>
<th><em>Composite Score (0-2 scale)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency Drivers</td>
<td>55.4%</td>
<td>17.2%</td>
<td>10.2%</td>
<td>17.2%</td>
<td>1.51 (1.68)</td>
</tr>
<tr>
<td>Selection</td>
<td>43.4%</td>
<td>15.8%</td>
<td>19.7%</td>
<td>21.1%</td>
<td>1.30 (1.11)</td>
</tr>
<tr>
<td>Training</td>
<td>80.6%</td>
<td>9.4%</td>
<td>1.4%</td>
<td>8.6%</td>
<td>1.85 (2.00)</td>
</tr>
<tr>
<td>Coaching</td>
<td>67.2%</td>
<td>14.2%</td>
<td>8.2%</td>
<td>10.4%</td>
<td>1.63 (1.83)</td>
</tr>
<tr>
<td>Performance Assessment</td>
<td>39.6%</td>
<td>29.5%</td>
<td>5.4%</td>
<td>25.5%</td>
<td>1.43 (1.78)</td>
</tr>
</tbody>
</table>

* NIRN Initial Drivers Assessment Scores noted in parentheses.
DRIVER: COMPETENCY – Recruitment and Selection of Staff

What data sources are being used for action planning?

1. Washoe County PII Readiness and Organizational Climate Re-Assessment Survey (RYC/December 2012)
2. Initial Implementation Drivers Assessment Survey (NIRN/January 2013)
3. Implementation Capacity Assessment Survey (RYC/May 2012)
4. PII Cross-Site Drivers Assessment (PII-TTAP/March 2013)

What have the data indicated are strengths and challenges related to this Driver?

1. The selection of practitioners, organization staff, and administrators with characteristics needed to complete their roles and job responsibilities are important implementation drivers required for a successful implementation. Results from initial survey indicated that staff from both WCDSS and the Children’s Cabinet (CC) were committed to the field of child welfare/human services, as well as their respective organizations, as indicated by the average scores obtained from the organizational/career commitment subscales. Results from the re-assessment continued to show high levels of commitment by both WCDSS and CC staff; however, attitudes about supervisors’ responsiveness and competence, role overload, and emotional exhaustion were perceived less positively, particularly by WCDSS employees. These findings may be a result of the manner in which workers were selected to participate in SAFE-FC and suggest that caseworkers are finding it difficult to adjust to their changing role(s) to successfully implement SAFE-FC.

2. For the purpose of the evaluation, SAFE-FC workers were randomly assigned to treatment and control positions. Therefore, Washoe did not have the ability to install some best practices for selection. Taking these limitations into account, Washoe still generated some areas for improvement for this driver. It was recommend that Washoe formalize the use of established selection criteria for the replacement rotation and use exit data to feedback to section criteria (and to establish selection processes in the future). It was also noted that Washoe should continue to build on the skill-based, mutual selection process used to hire/redeploy SAFE-FC supervisors. (There has been an emphasis on skill, rather than just “interest” for supervisor positions, and this best practice should be continued.) Finally, it was noted that due to random assignment, Washoe will need to continue to compensate for other characteristics deemed important for SAFE-FC implementation if not present in workers assigned to the SAFE-FC treatment group, including a high level of self-awareness, empathic understanding, optimism and open-mindedness, and motivation.

3. Composite score average 1.11 (0 to 2 range; target is equal or greater than 1.5). In Place = 11%, Partially in Place = 89%.
A significant proportion of respondents are unsure whether various best practices in staff recruitment and selection are in place or not, but responses among those who are familiar with these processes suggest that less than half of the best practices in staff recruitment and selection are fully in place.

There is a high level of agreement among respondents that staff recruitment and selection are very important to the desired outcome of SAFE-FC, yet there is also a significant amount of doubt that qualified staff members who will be able and willing to learn the new intervention will be selected.

**What is the aim or purpose of strengthening this Driver?**

Enhance the agency’s capacity to select and develop staff that have the competency to deliver the intervention with fidelity.

**What is the plan to strengthen the Driver?**

Washoe will need to continue to compensate for other characteristics deemed important for SAFE-FC implementation if not present in workers assigned to the SAFE-FC treatment group, including a high level of self-awareness, empathic understanding, optimism and open-mindedness, and motivation.

<table>
<thead>
<tr>
<th>What will be done (brief description)?</th>
<th>Who will do it?</th>
<th>By when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in the interview process for hiring new employees</td>
<td>Agency supervisors and Division Director</td>
<td>Initial revision has been completed and is being tested in May and June 2013</td>
</tr>
<tr>
<td>Assigning new hires within a 6-week time period to either the assessment or permanency program for ongoing training purposes</td>
<td>Training supervisor, senior social workers, and Division Director</td>
<td>Within a 6-week time period of hire</td>
</tr>
<tr>
<td>How will success be measured?</td>
<td>WCDSS PII Team Members</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>1. Review of retention numbers for new hires</td>
<td>1. At least bi-annually</td>
<td></td>
</tr>
<tr>
<td>2. Exit interviews to determine why the employee may be leaving</td>
<td>2. Per occurrence.</td>
<td></td>
</tr>
<tr>
<td>3. Review of performance assessments to determine their competency, skill, and alignment with the mission of the WCDSS</td>
<td>3. After each review.</td>
<td></td>
</tr>
<tr>
<td>4. New staff will be part of the SAFE-FC fidelity review and performance assessment scores.</td>
<td>4. When new staff are added.</td>
<td></td>
</tr>
</tbody>
</table>

**DRIVER: COMPETENCY – Training**

What data sources are being used for action planning?

1. Washoe County PII Readiness and Organizational Climate Re-Assessment Survey (the RYC/December 2012)
2. Initial Implementation Drivers Assessment Survey (NIRN/January 2013)
3. Implementation Capacity Assessment Survey (RYC/May 2012)
4. ACTION Site Visit Reports
5. RYC Foundational Training Report
6. PII Cross-Site Drivers Assessment (PII-TTAP/March 2013)

What have the data indicated are strengths and challenges related to this Driver?
1. Overall, respondents were ambivalent about whether legitimate reasons and needs existed requiring the implementation of SAFE-FC. On average, the appropriateness subscale score was 4.93 (SD=1.22); however, 67.8% of respondents somewhat to strongly agreed that the children and families of Washoe County would benefit from this change, and 74.3% somewhat to strongly agreed that there were legitimate reasons for Washoe County to make changes.

Responses from the overall satisfaction section indicated that SAFE-FC workers were generally satisfied with training, and 79.3% somewhat to strongly agreed that they had the skills needed to make this initiative work.

2. Best practices are in place for training. No areas for action planning were identified.

3. Composite score average 2.00 (0 to 2 range; target is equal or greater than 1.5). In Place = 100%.

Significant progress has been made toward the development of supports that facilitate staff training, and, uniformly, respondents agree that staff training is very important to achievement of SAFE-FC’s intended outcomes.

What is the aim or purpose of strengthening this Driver?

Sustainability of SAFE-FC demonstrated through the orientation, training, and transfer of learning for staff new to the model, including the basic knowledge of child welfare training and how this is integrated with the SAFE-FC training.

<table>
<thead>
<tr>
<th>What will be done (brief description)?</th>
<th>Who will do it?</th>
<th>By when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation to the model and life of a case for SAFE-FC discussion and guidance to the model. Training materials to include: Practicum with the purveyor</td>
<td>PII Leadership (Jim, Sherri, Dena, and purveyors)</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Assessed and evaluated through competency exams to the core components of the model</td>
<td>Purveyors (RYC and ACTION)</td>
<td>Ongoing throughout the life of the cooperative agreement</td>
</tr>
</tbody>
</table>
**How will success be measured?**

1. Completion of the training process
2. Results of the competency exam
3. Scores in the quarterly fidelity reviews
4. The drivers assessment scores are maintained in this area on the next cross-site survey through ET

**DRIVER: COMPETENCY – Supervision and Coaching**

**What data sources are being used for action planning?**

1. Washoe County PII Readiness and Organizational Climate Re-Assessment Survey (RYC/December 2012)
2. Initial Implementation Drivers Assessment Survey (NIRN/January 2013)
3. Implementation Capacity Assessment Survey (RYC/May 2012)
4. ACTION Site Reports
5. PII Cross-Site Drivers Assessment (PII-TTAP/March 2013)
6. ACTION Site Visit Reports
7. PII Management Reports (e.g., supervisor/worker consultation, worker/caregiver contact);
What have the data indicated are strengths and challenges related to this Driver?

1. Given that most skills needed by successful practitioners can be introduced in training, but are really learned on the job with the help of a consultant/coach, the responses from the Change Efficacy subscale of the Organizational Readiness to Change measure suggest that respondents from both organizations are open to learning, but lack the confidence that they can learn the necessary tasks and skills needed to make the SAFE-FC implementation successful. Specifically, 49.9% of respondents somewhat to strongly agreed that there were some tasks that were required of them in this initiative that they did not think they did well, and 46.7% were experiencing problems adjusting to their work they had in this initiative from a somewhat to strong degree.

WCDSS has compiled many highly knowledgeable and competent coaches and consultants to bring about the necessary practice changes, including a high level of involvement from ACTION for the RHC. However, half of all respondents did not report confidence in their ability to perform successfully or carry out required tasks of this initiative. Additionally, although mid- and upper-level managers and supervisors have been trained to monitor the stages of SAFE-FC implementation and to build their own expertise to individually and collectively support staff to be effective in their implementation of interventions, satisfaction responses suggest that there is a range in Supervisor skill in providing additional support and coaching.

2. Best practices are currently in place for coaching and consultation. Coaching plans have been stage based, and current plans have focused on supporting pre-service activities. Action planning to revise coaching protocols to support in-service work was recommended. Revised coaching plans would connect PCFA baseline knowledge scores and early fidelity assessments to strategies for building competence and expertise with SAFE-FC. It was also recommended that metrics be created for assessing adherence to the Coaching Service Delivery Plan. Washoe can explore how UNITY reports and other data sources can aid in assessing coaching delivery.

3. Composite score average 1.83 (0 to 2 range; target is equal or greater than 1.5). In Place = 83%, Partially in Place = 17%.

4. Most of the best practices in staff coaching are reported to be in place or partially in place, and nearly all respondents agree that coaching is very important to the achievement of SAFE-FC’s intended outcomes.

What is the aim or purpose of strengthening this Driver?
Maintaining best practice from the transfer of coaching from the purveyor to the agency

---


What is the plan to strengthen the Driver?

Action planning to revise coaching protocols to support in-service work was recommended. Revised coaching plans would connect PCFA baseline knowledge scores and early fidelity assessments to strategies for building competence and expertise with SAFE-FC. It was also recommended that metrics be created for assessing adherence to the Coaching Service Delivery Plan. Washoe can explore how UNITY reports and other data sources can aid in assessing coaching delivery.

<table>
<thead>
<tr>
<th>What will be done (brief description)?</th>
<th>Who will do it?</th>
<th>By when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop data reports that measure frequency and intensity of coaching</td>
<td>Jim, purveyors, CC, and UNITY staff &amp; programmer</td>
<td>Initial reports developed and refinements ongoing as reviewed by ILT</td>
</tr>
</tbody>
</table>

How will success be measured?

1. Through purveyor site reports on coaching
2. Reports are available and reviewed with SAFE-FC teams.

---

**DRIVER: COMPETENCY – Fidelity Assessment**

What data sources are being used for action planning?

1. Washoe County PII Readiness and Organizational Climate Re-Assessment Survey (RYC/December 2012)
2. Initial Implementation Drivers Assessment Survey (NIRN/January 2013)
3. Implementation Capacity Assessment Survey (RYC/May 2012)
4. PII Cross-Site Drivers Assessment (PII-TTAP/March 2013)
5. Purveyor and Evaluation Liaison feedback from Performance Assessment Process
What have the data indicated are strengths and challenges related to this Driver?

1. None/TBD.

2. Most of the best practices for fidelity are in place. Due to the adaptations to the intervention model, fidelity criteria have also been modified to accommodate the integration of SAFE and FC. In this regard, fidelity criteria are based on previous research, but correlations with outcomes have not yet been calculated for this particular model. Both content and competency are assessed as part of fidelity. While coaching involves direction observation of practice, resource constraints limit fidelity assessments to direct observation of the record. Finally, Washoe can seek to improve transparency of fidelity assessments with caseworkers and supervisors.

3. Composite score average 1.78 (0 to 2 range; target is equal or greater than 1.5). In Place = 78%, Partially in Place = 22%.

4. A relatively high proportion of respondents are not aware of whether many of the supports that facilitate performance assessment are in place or not, but those who do know report that these practices are the least developed among the competency drivers.

What is the aim or purpose of strengthening this Driver?

Leads to individual coaching plans to improve staff competencies

What is the plan to strengthen the Driver?

Washoe can seek to improve transparency of fidelity assessments with caseworkers and supervisors.

<table>
<thead>
<tr>
<th>What will be done (brief description)?</th>
<th>Who will do it?</th>
<th>By when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share the assessment data for continued practice improvement</td>
<td>PII Leadership Team</td>
<td>Initial review completed in March 2013, and results will be shared ongoing.</td>
</tr>
<tr>
<td>Purveyor is preparing a PowerPoint for May 2013 ILT meeting.</td>
<td>Purveyor/RYC</td>
<td>May 2013</td>
</tr>
</tbody>
</table>
Appendix

How will success be measured?

1. Integrating the fidelity review into the coaching plan
2. Sharing assessment survey and fidelity scores with staff and focusing on improvement

Section 2—Organization Drivers

Chart 2: Cross-Site Survey Results

<table>
<thead>
<tr>
<th>Composite Scores and Averages</th>
<th>In Place</th>
<th>Partially in Place</th>
<th>Not in Place</th>
<th>Don't Know</th>
<th>*Composite Score (0-2 scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization Drivers</td>
<td>50.2%</td>
<td>34.1%</td>
<td>2.7%</td>
<td>12.9%</td>
<td>1.54 (1.08)</td>
</tr>
<tr>
<td>Decision Support Data Systems</td>
<td>42.8%</td>
<td>37.4%</td>
<td>2.3%</td>
<td>17.6%</td>
<td>1.48 (1.09)</td>
</tr>
<tr>
<td>Facilitative Administration Supports</td>
<td>56.3%</td>
<td>32.1%</td>
<td>3.6%</td>
<td>8.0%</td>
<td>1.57 (1.17)</td>
</tr>
<tr>
<td>Systems Interventions</td>
<td>64.7%</td>
<td>26.5%</td>
<td>2.9%</td>
<td>5.9%</td>
<td>1.65 (1.00)</td>
</tr>
</tbody>
</table>

* NIRN Initial Drivers Assessment Scores noted in parentheses.

DRIVER: ORGANIZATION – Decision Data Support System

What data sources are being used for action planning?

1. Washoe County PII Readiness and Organizational Climate Re-Assessment Survey (RYC/December 2012)
2. Initial Implementation Drivers Assessment Survey (NIRN/January 2013)
3. Implementation Capacity Assessment Survey (RYC/May 2012)
4. PII Cross-Site Drivers Assessment PII-TTAP/March 2013)
What have the data indicated are strengths and challenges related to this Driver?

1. Prior research has documented the relevance of organizational culture and climate and organizational readiness to implement system and practice changes in public child welfare agencies. Findings from the initial survey suggested that, in general, there was a positive organizational culture and climate for implementing new interventions to reduce long-term foster care. They also suggested that despite having limited information, most staff were open to the idea that change was needed and seemed motivated to learn more about how this initiative would specifically affect them and their roles in work with children and families. For the re-assessment staff, WCDSS particularly staff were less optimistic and more ambivalent about the change.

2. The data systems to support the SAFE FC are partially in place. A list of reports has been created but not been fully developed by the programmer. It is expected that these reports will be generated in the next few months and that data will be used for decision-making purposes. Washoe can create protocols for how data will be used for continuous improvement by the various implementation teams.

3. Composite score average 1.09 (0 to 2 range; target is equal or greater than 1.5). In Place = 9%, Partially in Place = 91%

4. Many important aspects of the SAFE-FC decision support data system are reported to not yet be fully in place, but most respondents report confidence that data will in fact be used to facilitate decision making that supports the achievement of SAFE-FC’s desired outcomes.

What is the aim or purpose of strengthening this Driver?

To inform agency practice and program implementation

What is the plan to strengthen the Driver?

Washoe can create protocols for how data will be used for continuous improvement by the various implementation teams.

<table>
<thead>
<tr>
<th>What will be done (brief description)?</th>
<th>Who will do it?</th>
<th>By when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop data reports to inform core practice activities</td>
<td>PII Leadership/ILT</td>
<td>Initial reports developed, revisions and review ongoing</td>
</tr>
</tbody>
</table>

### Sharing of data reports and analysis

<table>
<thead>
<tr>
<th>Description</th>
<th>Responsible Parties</th>
<th>Implementation Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing of data reports and analysis is embedded in the joint meeting protocol with the SAFE-FC team</td>
<td>Sherri and Jacquelyn</td>
<td>Will be implemented by June 2013 and ongoing</td>
</tr>
</tbody>
</table>

### How will success be measured?

1. Documented and evidenced by the ILT meeting minutes that the data reports were reviewed by the ILT
2. Data reports have been shared with the SAFE-FC teams through the link in and link out protocol.
3. Trend analysis of ongoing data reports moving in the intended direction; barriers are identified, and solutions are developed.

### DRIVER: ORGANIZATION – Facilitative Administration

#### What data sources are being used for action planning?

1. Washoe County PII Readiness and Organizational Climate Re-Assessment Survey (RYC/December 2012)
2. Initial Implementation Drivers Assessment Survey (NIRN/January 2013)
3. Implementation Capacity Assessment Survey (RYC/May 2012)
4. PII Cross-Site Drivers Assessment (PII-TTAP/March 2013)

#### What have the data indicated are strengths and challenges related to this Driver?

1. "Facilitative administration provides leadership and makes use of a range of data inputs to inform decision making, support the overall processes, and keep staff organized and focused on the desired intervention outcomes. In facilitative administrative organizations, policies, procedures, structures, culture, and climate are given careful attention to assure alignment of these aspects of an organization with the needs of practitioners". Results from these surveys suggest, on average, a decline in worker perception of management support and generally neither agreed nor disagreed with items related to leadership and communication.

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2. Best practices for facilitative administration are, for the most part, partially in place. Washoe seeks to institutionalize communication loops among Implementation Teams to ensure that practice-level information is fed up to the right level of the system and that recommendations are fed back down the system efficiently, effectively and transparently. A new teaming structure was discussed to enhance feedback loops (see graphic below). Establishing a common set of protocols for these teams to use at each meeting and link-in and link-out strategies were identified as important to reducing barriers to implementation. Protocols should be guided by a series of questions about what is (is not) working well and whether particular teams have the information and authority necessary to address identified barriers or whether the challenge needs to be fed up to the next level of the system. Strategies to improve communication across the system were also discussed. For example, enhanced understanding and communication between assessment and permanency staff on the values and expectations of SAFE-FC would be beneficial for reducing barriers to implementation.

3. Composite score average 1.17 (0 to 2 range; target is equal or greater than 1.5). In Place = 17%, Partially in Place = 83%

4. Many of the leadership structures, processes, and protocols that support facilitative administration within SAFE-FC are reported to be in place, and facilitative administration is seen by respondents as being important for achieving the program’s desired outcomes.

<table>
<thead>
<tr>
<th>What is the aim or purpose of strengthening this Driver?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishing a common set of protocols for teams to use at each meeting and link-in and link-out strategies were identified as important to reducing barriers to implementation. Protocols should be guided by a series of questions about what is (is not) working well and whether particular teams have the information and authority necessary to address identified barriers or whether the challenge needs to be fed up to the next level of the system. Strategies to improve communication across the system were also discussed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is the plan to strengthen the Driver?</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are going to improve communication and enhance the teaming structure for SAFE-FC</td>
</tr>
</tbody>
</table>
### What will be done (brief description)?

<table>
<thead>
<tr>
<th>Roles and responsibility group with CC and WCDSS involvement (focusing on adaptive and technical processes):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Safety planning/safety management</td>
</tr>
<tr>
<td>• Confirming safe environments</td>
</tr>
<tr>
<td>• Support services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who will do it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dena and work group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>By when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial plan presented in March to ILT. Draft results presented to ILT on May 23, 2013. Final pending for June ILT.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revised teaming structure through ILT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ILT</td>
</tr>
</tbody>
</table>

| Started February 2013 and ongoing |

<table>
<thead>
<tr>
<th>Included supervisors to be a part of the ILT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ILT; supervisors</td>
</tr>
</tbody>
</table>

| Started February 2013 and ongoing |

### How will success be measured?

1. ILT minutes
2. Teams are meeting as intended and recommended.
3. Link-in and link-out protocol is being followed.
4. Roles and responsibilities are identified at the worker level and brought to leadership for review.
5. Results of future cross-site drivers assessment survey and PII team survey and of readiness and organization climate re-assessment survey
**DRIVER: ORGANIZATION – Systems Intervention**

What data sources are being used for action planning?

1. Washoe County PII Readiness and Organizational Climate Re-Assessment Survey (RYC/December 2012)
2. Initial Implementation Drivers Assessment Survey (NIRN/January 2013)
3. Implementation Capacity Assessment Survey (RYC/May 2012)
4. PII Cross-Site Drivers Assessment (PII-TTAP/March 2013)

What have the data indicated are strengths and challenges related to this Driver?

1. Best practices for systems interventions are, for the most part, partially in place. Washoe seeks to improve ongoing communication with systems partners and key stakeholders. For example, Washoe will work towards communicating more often with provider networks, community partners, and legislatures as planned.

2. Composite score average 1.00 (0 to 2 range; target is equal or greater than 1.5). In Place = 14%, Partially in Place = 72%, Not in Place = 14%

3. Systems interventions, or strategies that enable SAFE-FC leaders and staff to address external issues that affect their ability to provide services, are largely in place, and all respondents believe they are very important to the achievement of the intervention’s intended outcomes. Yet respondents express some doubt that leadership can resolve external issues that might prevent the implementation of SAFE-FC.

What is the aim or purpose of strengthening this Driver?

Improve stakeholder awareness, alignment, and ability to provide supportive services to the project
What is the plan to strengthen the Driver?

Washoe seeks to improve ongoing communication with systems partners and key stakeholders. For example, Washoe will work towards communicating more often with provider networks, community partners, and legislatures as planned.

<table>
<thead>
<tr>
<th>What will be done (brief description)?</th>
<th>Who will do it?</th>
<th>By when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct targeted outreach to the legal community</td>
<td>Agency Director, Division Director in collaboration with purveyors</td>
<td>Started May 2013, targeted completion by August 2013</td>
</tr>
<tr>
<td>Training of community service providers</td>
<td>Agency representative and purveyor participation</td>
<td>June 2013 and July 2013</td>
</tr>
<tr>
<td>Model court participation</td>
<td>Division Director</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Facilitate ongoing communication between CC and WCDSS</td>
<td>Sherri and Jacquelyn</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

How will success be measured?

1. Targeted activities are completed as indicated.
2. Improved satisfaction from staff through surveys
Section 3—Leadership Drivers

Chart 3: Cross-Site Survey Results

<table>
<thead>
<tr>
<th>Composite Scores and Averages</th>
<th>In Place</th>
<th>Partially in Place</th>
<th>Not in Place</th>
<th>Don't Know</th>
<th>*Composite Score (0-2 scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership Drivers</td>
<td>57.3%</td>
<td>30.6%</td>
<td>4.0%</td>
<td>8.1%</td>
<td>1.57 (79%)</td>
</tr>
<tr>
<td>Technical Leadership</td>
<td>53.1%</td>
<td>32.3%</td>
<td>5.2%</td>
<td>9.4%</td>
<td>1.53 (77%)</td>
</tr>
<tr>
<td>Adaptive Leadership</td>
<td>71.4%</td>
<td>25.0%</td>
<td>0.0%</td>
<td>3.6%</td>
<td>1.74 (87%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NIRN Initial Assessment Comparison</th>
<th>*Composite Score (0-5 scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Leadership</td>
<td>4.00 (80%)</td>
</tr>
<tr>
<td>Adaptive Leadership</td>
<td>3.43 (67%)</td>
</tr>
</tbody>
</table>

Note: Due to difference in composite score scales, they were converted to percentages for informal comparisons.

**DRIVER: LEADERSHIP – Technical/Adaptive**

What data sources are being used for action planning?

1. Washoe County PII Readiness and Organizational Climate Re-Assessment Survey (RYC/December 2012)
2. Initial Implementation Drivers Assessment Survey (NIRN/January 2013)
3. Implementation Capacity Assessment Survey (RYC/May 2012)
4. PII Cross-Site Drivers Assessment (PII-TTAP/March 2013)
What have the data indicated are strengths and challenges related to this Driver?

1. The Management Support subscale of the Organizational Readiness for Change measure contained six questions that assessed whether staff perceived the organizations’ leadership and management to be committed to and supportive of, the implementation of SAFE-FC.

In the initial survey, the average score for management support was 5.29 (SD=1.08), placing the average between “neither agreeing or disagreeing” and “somewhat agreeing”, while for the re-assessment, the average score dropped to 4.67 (SD=1.29), moving the average response to between “somewhat disagreeing” and “neither agreeing or disagreeing”. This decline was more prominent for WCDSS respondents for which the average score was 5.06 (SD=1.11) for the initial survey and 4.54 (SD=1.13) for the re-assessment.

Although the respondents from the CC showed a much less noticeable decline, it continues to be important for both agencies, but particularly for WCDSS administration and leadership, to demonstrate leadership and commitment to this initiative by supporting workers as it affects the work that they do.

2. Technical score averaged 4.0 and Adaptive score averaged 3.43 (5 point Likert Scale).

3. Most aspects of technical leadership are in place, and many aspects of adaptive leadership are in place, though these are reportedly less developed. Both types of leadership are recognized as being very important to achieving the intended outcomes of SAFE-FC. There is, however, some doubt among respondents about the likelihood of leadership using strategies effectively to positively affect the implementation of SAFE-FC and effectively addressing issues that affect the implementation of SAFE-FC.

What is the aim or purpose of strengthening this Driver?

To enhance leadership’s awareness of and the ability to manage technical and adaptive challenges within the WCDSS.

What is the plan to strengthen the Driver?

Expand the technical and adaptive leadership skills, capacity, and knowledge beyond the ILT to the agency leadership team

<table>
<thead>
<tr>
<th>What will be done (brief description)?</th>
<th>Who will do it?</th>
<th>By when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Webinar on leadership for agency leadership team</td>
<td>Allison Metz, PhD (NIRN)</td>
<td>Targeted for completion by August 2013</td>
</tr>
<tr>
<td>Developing diversified leaders within all levels of the WCDSS (additional focus on the supervisory level)</td>
<td>Allison Metz, PhD (NIRN )</td>
<td>Targeted for completion by September 2013</td>
</tr>
</tbody>
</table>

### How will success be measured?

1. Completion of the identified activities
2. Leadership has a working knowledge of technical and adaptive challenges through identification of barriers and solutions.
Appendix J: Helping Relationship Inventory—Worker (HRI-W) and Client (HRI-C)

HRI-Worker (HRI-W)

* All of the items are measured with a 5-point Likert-type scale:
  1 (not at all)  2 (a little)  3 (somewhat)  4 (a lot)  5 (a great deal)

1. How much input does your client have in determining how your work together will be approached?
   1  2  3  4  5

2. How much have you and your client discussed the specific problem(s) with which (s)he wants help?
   1  2  3  4  5

3. How clear are you about the specific problem(s) that you and your client are addressing?
   1  2  3  4  5

4. To what extent have you and your client discussed the specific goal(s) you hope to accomplish in your work together?
   1  2  3  4  5

5. How much input does your client have in determining the goals (s)he is working on?
   1  2  3  4  5

6. How clear are you about your client’s goals?
   1  2  3  4  5

7. To what extent have you and your client discussed the specific actions (s)he will take to address his or her difficulties?
   1  2  3  4  5

8. How clear are you about the actions you are taking?
   1  2  3  4  5

9. How much input does your client have in determining how you and your client will assess his or her progress?
   1  2  3  4  5

10. How clear are you about how you and your client are assessing his or her progress?
    1  2  3  4  5
11. Do you explain to your client your understanding of his or her difficulties?
   1  2  3  4  5

12. Is your client’s understanding of his or her difficulties similar to your own?
   1  2  3  4  5

13. Do you enjoy meeting and talking with your client?
   1  2  3  4  5

14. Is your client more organized about resolving his or her difficulties as a result of talking to you?
   1  2  3  4  5

15. Does talking with you have a calming, soothing effect on your client?
   1  2  3  4  5

16. Are you able to handle the emotional aspects of your client’s difficulties?
   1  2  3  4  5

17. Does talking with you give your client hope?
   1  2  3  4  5

18. In general, do you feel you and your client see things in similar ways?
   1  2  3  4  5

19. Do you help your client think more clearly about him/herself?
   1  2  3  4  5

20. Do you feel that you and your client are alike in some ways?
   1  2  3  4  5

**HRI-Client (HRI-C)**

* All of the items are measured with a 5-point Likert-type scale:

   1 (not at all) 2 (a little) 3 (somewhat) 4 (a lot) 5 (a great deal)

1. How much input have you had in determining how the two of you will work together?
   1  2  3  4  5

2. How much have you and your social worker discussed the specific problem(s) with which you want help?
   1  2  3  4  5
3. How much input have you had in determining the specific problem(s) you are addressing in your work together?
   1  2  3  4  5

4. To what extent have you and your social worker discussed the specific goal(s) you hope to accomplish in your work together?
   1  2  3  4  5

5. How much input have you had in determining the goals you are working on?
   1  2  3  4  5

6. To what extent have you and your social worker discussed the specific actions you will take to address your difficulties?
   1  2  3  4  5

7. To what extent have you and your social worker discussed the specific actions your social worker will take to address your difficulties?
   1  2  3  4  5

8. How much have you and your social worker discussed how your progress is going to be assessed?
   1  2  3  4  5

9. How much input do you have in determining how you and your social worker will assess your progress?
   1  2  3  4  5

10. To what extent have you and your social worker discuss your progress?
    1  2  3  4  5

11. Do you feel your social worker pays attention to you?
    1  2  3  4  5

12. Is your social worker’s understanding of your difficulties similar to your own?
    1  2  3  4  5

13. Does talking with your social worker help you get more organized about resolving your difficulties?
    1  2  3  4  5

14. Does talking with your social worker have a calming, soothing effect on you?
    1  2  3  4  5

15. Does talking with your social worker give you hope?
    1  2  3  4  5
16. Does your social worker help you think more clearly about your difficulties?
   1  2  3  4  5

17. Does talking with your social worker help you to believe more in yourself?
   1  2  3  4  5

18. In general, do you feel you and your social worker see things in similar ways?
   1  2  3  4  5

19. Does your social worker help you to think more clearly about yourself?
   1  2  3  4  5

20. Do you feel that you and your social worker are alike in some ways?
   1  2  3  4  5