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Making a Mission Statement a Reality in Child Welfare: Resiliency and Solution-Focused Therapy as Core Strategy

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A major function, as well as challenge, for any training initiative on professional development is to provide directed educational content that is congruent with the learners' work environment and consistent with canons of professional practice. This article describes how the Missouri "Role Demonstration Model" (RDM) provided supervisors in Child Protective Services (CPS) with tools to enhance their workers' strengths-based practice with families, by training them on core principles of resiliency theory and on the basics of solution-focused intervention methods. Throughout the training child safety remained a critical case concern while renewed priority was given to the unique role of the agency as a behavioral change agent. Training addressed how gaining permanent change with families could not be achieved through surveillance alone; therefore, helping clients to internalize positive coping was highlighted as the surest means of ensuring both child safety and family well-being. Outcome indicators on several organizational dimensions showed improved supervisory competence and performance.

CPS Dual Mandates: Family Well-being versus Child Safety

Consult almost any state child welfare agency web-site and you will find a mission statement that incorporates the values and ideology of a strengths-oriented and family- centered approach to working with clients. But a careful examination of practice in these settings may reveal that there is a significant discord between stated aspirations and the actual practice. The presence of a clear and credible policy is important; yet, if a set of carefully defined program activities is lacking, staff are left without a means of *how* to deliver services in a strengths-based manner. For instance, by simply adding strengths questions to an assessment battery, workers may assume they are practicing from a strengths perspective (Blundo, 2006). Yet, the significance of these ideas is lacking in regard to how it might influence their overall practice as they continue to operate from a problem-centered approach.

Operationalizing a capacity-building or strengths model into an empirically-validated strategy of intervention has been slow and difficult to attain. A critical review of the literature on the topic yields few empirical studies with mixed results (IASWR, 2002; RRIHS, 2001; Staudt, Howard & Drake, 2001). The major problem appears to be that the components of these approaches are most often couched as hortatory injunctions, not specific practice dicta. Precise descriptions of the essential components, techniques, worker skills and client contract components necessary for implementation are not specified (Noble, Perkins, & Fatout, 2000). Even in settings where "strengths" are made a priority, the strategy is most frequently limited to the assessment phase of process (Morton, 2003). A list of client/family strengths may appear in the case record but there is no coherent plan that incorporates them into goal development or actions steps.

Within the social work profession there continues to be unresolved conflict over a problem-solving ideology versus a capacity-building approach; although, there is a growing recognition that historically these are not so much polar opposites as matters of emphasis (Green, McAllister, & Tarte, 2004; McMillen, Morris & Sherraden, 2004; Weick, Kreider, & Chamberlain, 2006). In child welfare, for instance, the Missouri Children's Division has for some time espoused a family-centered and strengths-based approach; yet, initial training assessments during the "Role Demonstration Model" revealed that the prevailing practice orientation of CPS was still a medical model/pathology approach to both assessment and intervention. There are a number of concurrent forces undermining the intentions of the child welfare agency's strength-based focus including conflicting mandates between protecting the integrity

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of the family versus protecting children from parental abuse (Denby & Curtis, 2003; Jimenez, 1990). Strengths-based practice becomes a particular challenge within such an environment fractured by competing policies and demands.

At the federal level a strengths and family preservation focus gained impetus in the early 1970s (Myers, 1994) and continued in 1980 with passage of the Adoption Assistance and Child Welfare Act (P. L. 96-272) which stressed children's rights to stability, permanence, and nurturance. This act required that "reasonable efforts" be made to preserve and strengthen families by preventing out-of-home placements and by reuniting children (who were in State custody) with their families in a timely manner. Consequently, certain rights for children and families were created including mandatory written case plans, periodic case reviews, and regular parental visiting. This initiative was furthered by the 1993 Family Preservation and Family Support Services Act (P. L. 103-66). These acts embodied permanency planning and shifted federal government support away from intrusion in the family system and towards placement prevention and family reunification. Yet, by the late 1990s a decided move away from family preservation was evident (Kelly & Blythe, 2000) including dual "reasonable efforts" mandates involving permanency plans that focused on disparate possibilities: a child's adoption along with a child's reunification with his/her family. In 1997 the Adoption and Safe Families Act (P.L. 1105-90) set into motion that any child who had been in foster care for 15 months (out of the most recent 22) must have a petition filed for termination of parents rights while also identifying/approving a qualified adoptive family.

Within public child welfare protecting child safety has often developed separately from promoting family preservation as a means of achieving child well-being. Yet, these conflicting policies and value biases confront the same population and goal: to protect dependent children (Jimenez, 1990; McCurdy, 1994). The Child Abuse Prevention and Treatment Act of 1974 (P. L. 93-247) provided the impetus for State laws to safeguard children (from parents who would misuse their authority) through professional intervention in cases of abuse and neglect. Auspices and sanctions to intervene were founded on an evidence-based legal finding that social/legal canons had been violated and that family-intrusive action based on the doctrine of *parens patria* was warranted. Jurisdiction pertained when the allegations of a petition that a child was "in need of care and treatment" had been sustained by the preponderance of evidence in a court of law. The process was essentially adversarial and accusatory based on the traditions of Anglo-Saxon law. Currently, it is mainly at the disposition phase of court proceedings that "the best interests of the child" tenet is officially applied. In the adjudication process the parent in a child abuse/neglect action is essentially a defendant and the state is mobilized to offer proof that a range of social problems exist within the family that need to be addressed if the child's safety is to be ensured within the parental home. Therefore, despite the prevalence of public mandates that sanction and encourage both strengths-based and family-centered child welfare, the duality of policies, and thus practice are evident.

Missouri Role Demonstration Model for Child Protective Services

Training was used to help supervisors in Child Protective Services (CPS) put into practice the mission and values of its State child welfare agency pertaining to strengths-based and family-centered practice. The challenge facing the training design team was to develop a means of implementing the agency values and mission priorities through a staff development initiative that would ultimately impact total organizational culture. The point of entry for system change was first-line child protection supervisors and three interdependent goals were established:

1. Operationalize the agency values into a regimen of daily practice by modifying the

manner in which supervision of workers was carried out;
2. Introduce a strengths perspective into family/juvenile court proceedings through cogent and consistent case plans and treatment recommendations that placed emphasis on positive assets and growth potential (i.e., resiliency theory);
3. Provide a specific, teachable/usable strategy of intervention (i.e., Solution Focused Brief Therapy) that was practical in addressing both child safety and well-being priorities and remained faithful to the agency values and mission intent.

The staff development initiative grew out of both a long-standing state agency administrative priority to provide clinical training for front line supervisors and evidence of the perceived needs of the workers from research conducted independently by the Southern Region Quality Improvement Center, University of Kentucky (SR-QIC) and the Missouri Children's Division (Training Resource Center, 2002). Workers overwhelmingly reported in both studies that their greatest need was for on-the-job role modeling of clinical intervention techniques. Consequently, when Children's Bureau financial support became available through the SR-QIC, a joint design between the Children's Division and the University of Missouri-Columbia School of Social Work (UMC-SSW) developed the Role Demonstration Model (RDM) of Child Welfare Supervision Training curriculum (Sundet, Mermelstein & Watt, 2003).

The Missouri RDM was designed as an experimental pilot with a detailed quasi-experimental research component to measure comparative impact on a number of variables including child welfare case outcomes, peer record review ratings, preventable staff turnover, consumer satisfaction, worker assessment of supervisor performance and participant focus group feedback (Bolm, Pettit, Kelly & Wolchko, 2003). Two administrative areas were chosen as experimental sites, one metropolitan and the other rural, with comparable sites selected for comparison purposes. All child protective supervisors in the sites (18 in each, 36 total) participated in a three-year professional development program that included didactic training sessions, individualized professional assessment and development plans, and case consultation. Research results and a full description of the project are now in press (UMC-SSW, 2006; Kelly & Sundet, 2006, Sundet & Kelly, 2006; Collins-Camargo, 2006).

Putting Agency Values into Practice

CPS supervisors were provided with a structured model of supervision with associated tasks, behaviors, and identifiable learning goals of which they then employed with their workers. Goals included improving the clinical competence of front-line CPS supervisors and their workers; and thus changing the organizational culture to refocus on a client treatment orientation. The training set out to achieve this by 1) creating a learning community with a clinical focus; 2) recognizing the essential role of the supervisor in establishing the culture of clinical work; and 3) assisting management in understanding the primacy of the teaching role of the supervisor and making necessary organizational accommodations. CPS supervisors were provided with approximately 130 hours of direct face-to-face graduate-level teaching with 27% of the content including clinical strategies and methodology while the remaining 73% focused on principles and techniques of supervision.

The RDM blended instruction with a specific model of case intervention, Solution-Focused Brief Therapy (SFBT); this choice was predicated on the agency's commitment to a strengths-based and family-centered perspective. While there was a general philosophical commitment to these ideals, both workers and supervisors reported that they lacked specific methodology to implement this approach. To provide the necessary professional grounding for the chosen strategy of emphasis, focus was placed on resiliency theory as the human behavior

base for the solution-focused approach. Special attention was given to "real-life" case scenarios provided by the supervisors themselves and to homework assignments carried out between sessions. The central training components of the clinical strategies portion included: 1) resiliency and solution-focused literature and their connection to child welfare practice; 2) resiliency and solution-focused case assessments and treatment plans; and, 3) resiliency and solution-focused practice strategies and techniques. Each of these training components is discussed further, first in regard to resiliency content followed by solution-focused material.

Training Content on Resiliency Theory

Using resiliency theory as a guide to child welfare practice provides a good fit with a strengths-based practice paradigm as they both recognize and appreciate one's potential for growth in the face of adversity (De Jong & Miller, 1995; Saleebey, 2006). In addition, both offer conceptual frameworks for helping that emphasize families' strengths and resources rather than symtomatology and problems. Focusing on resourcefulness taps into clients' resilience and allows for a positive way to work with families that honors their survival skills, strengths, and competencies as opposed to their deficits.

The RDM equipped CPS supervisors with knowledge of resiliency theory, so that they could better identify these sorts of protective factors when attending to their workers' assessment of families. CPS supervisors were provided the following article prior to training, "Uncovering Survival Abilities in Children Who Have Been Sexually Abused,î (Anderson, 1997). This article served as a backdrop for the resiliency content as it gave an overview of the strengths perspective, the resiliency literature, and applied these concepts in working with sexually abused children. Additional literature on resilience provided conceptual sensitivity and highlighted the many ways in which individuals perceive, seek to make sense of, and respond to adverse life situations (Gilligan, 1999; Henry, 2001).

Connecting Resiliency Theory to Child Welfare

Resiliency research delineates protective mechanisms in individuals, their families, and in external support systems that allows one to engage with risk factors in a manner that promotes positive adaptation (Masten, 2001; Fraser, 1997; Werner & Smith, 1992). The training for CPS supervisors addressed the following psychosocial protective factors that develop in response to enduring child abuse and neglect: 1) biological: use of physical senses to alert one to danger; 2) psychological: fantasizing, mentally and physically escaping, and channeling emotional pain through artistic pursuits; 3) social: maintaining a caretaking role with siblings, connecting with adult mentors, having friendships, and participating in extracurricular activities; and, 4) spiritual: believing in a higher power, connecting with a religious community, and participating in spiritual activities and supports. Excerpts from the following memoirs of individuals formerly in foster care were used to highlight each of the protective factors: *Finding Fish: A Memoir* (Fisher & Rivas, 2001); *The Lost Boy: A Foster Child's Search for Love of a Family* (Pelzer, 1997); *Lost in the System* (Dworkin & Lopez, 1996); and *Like Family: Growing up in Other People's Homes* (McLain, 2003).

The text, *The Resilient Self: How Survivors of Troubled Families Rise above Adversity,* (Wolin & Wolin, 1993) was used to demonstrate adaptive developmental trajectories throughout the lifespan. The Wolins (1993) discuss seven themes of resilience — insight, independence, initiative, relationships, morality, creativity, and humor. The development and maturation of each resiliency is presented in three life stages — childhood, adolescence, and adulthood. The training stressed how these survival strengths interact with one another to help individuals overcome adverse experiences. The Wolins (1993) explain that the configuration of

resilience varies for each individual depending upon his/her particular adversity. In addition, they emphasize that resiliency is not limited to people who escape risk with few problems. Instead, they acknowledge that families (including ones that come into contact with CPS) have enduring strengths that probably developed as a means to protect themselves from a troubled environment.

Resiliency-focused Case Assessment and Treatment Plans

After a thorough overview of resiliency research, the next training step included applying this information to "real-life" CPS cases. The Missouri Children's Division provides an overview to workers on strengths-based case assessments including Cowger's (1997) 51-Item list of individual strengths in the areas of cognition, emotion, motivation, coping and interpersonal. Participants were given an updated version (Cowger, Anderson, Snively, 2006) of the now 63-item list as the definition of resilience has broadened to include resistance to oppression and the survival strengths that go along with this; this updated definition helps to go beyond the micro-level and addresses social circumstances.

In addition, training material was presented on how child welfare professionals may assist families to achieve positive outcomes through validating their abilities and mobilizing them into an action plan. Participants were divided into groups of 3-4 members and given case vignettes that asked them to uncover resilient capacities in individuals/families based on the array of protective factors presented during training. The initial case vignette was provided by the trainer; while subsequent case examples were drawn from CPS cases. They were also asked to discuss treatment recommendations that would build upon identified survival strengths. Upon finishing these tasks, the small groups then reported back and additional brainstorming occurred amongst the entire unit. The group took on a energetic life of its own as innovative ways to work with family strengths was generated that went far and beyond the usual assigned case activities of parenting classes, psychiatric evaluations, and therapy. The training reemphasized that the intent is not to deny the real adversity (e.g., child abuse); however, shifting to a resiliency-oriented helping paradigm does deny that people who endure such suffering are incapacitated for life or are unable to achieve their potential. As a result of these training activities, the idea that clients need to know that they can lead successful lives despite adversity was reinforced.

Resiliency-focused Strategies and Techniques

A central component to enhancing resilience becomes the practitioner's ability to uncover client strengths and to make them accessible in a useful way. Resiliency theory provides a mode of viewing and recognizing survival strengths; yet, information is lacking on how to apply this conceptual framework to practice. Therefore, Solution-Focused Brief Therapy (SFBT) was selected as the major clinical strategy to set resiliency theory into action (Corcoran, 1997, 1999; De Jong & Berg, 2001). It was explained that families receiving child welfare services may not be achieving their goals because the array of their abilities has not been expressed. Their skills, talents, and competencies may be obscured by the hardships they have experienced. Therefore, CPS workers may not be making thorough assessments (i.e., not seeing family strengths) leading to faulty decision making and a lack of working towards preserving the family, consequently, resulting in out-of-home placements for children. The training emphasized how SFBT is not a tool that reframes one's problems into positives and denies the reality of people's lives. If that was the case then clients would not have to work to make changes because all that would be needed was to reframe their problems into positive experiences. Instead, the application of SFBT was noted as the practitioner firmly *believing in* and *supporting* clients' aspirations, perceptions, and strengths

despite the problems that are presented. For instance, a mother who screams and verbally belittles her child is not reframed into "a parent who knows how to express herself.î Instead, in using SFBT the worker addresses the problem behavior, along with looking at exceptions of when the parent does not yell and belittle, and illuminates for the mother what is different about these times. SFBT is a clinical strategy that provides techniques (e.g., exception questions) for practitioners to acknowledge, affirm and extend the resilient capacities of families.

Training Content on Solution-Focused Brief Therapy

Connecting SFBT to Child Welfare Practice

Increasingly, child welfare has explored its potential to strengthen the resilience of children and families including adapting solution-focused brief therapy to practice (Berg & Kelly, 1999; Corcoran, 1999; De Jong & Berg, 2001). SFBT is a practice orientation that helps families recognize the individual and environmental resources available to them to make positive changes in their lives. It provides a good fit with the goals of child welfare's strengths-based, family centered-focus as SFBT gives hope about one's potential to achieve positive life outcomes. CPS supervisors were provided with the following article, "Solution-focused Interviewing with Child Protective Services," (Corcoran, 1999) as it gave an overview of SFBT and provided a rationale for using it in child welfare practice. This article was helpful in showing how to apply SFBT with mandated clients who may be less than motivated to change, such as, parents who are defensive or hostile because they fear losing custody of their children. Corcoran's (1999) article emphasizes the importance of joining with mandated clients such as around the goal of getting CPS (or other unwanted helping systems) out of their lives. Another helpful component the article addresses is focusing on times when the "problem is not a problem;" in other words, uncovering circumstances of when the problem could of happened but did not.

Solution-Focused Case Assessment and Treatment Plans

Assessment always involves a perspective or paradigm from which the assessment is made. This notion was underscored through a group activity on family assessment involving a case vignette (i.e., The Shore Family) from Dorfman's (1998) text, *Paradigms of Clinical Practice.* Participants were divided into two groups: one that represented a problem-focused approach (i.e., assessing frequency, duration, and impact of the family's problems); and, one representing a solution-focused approach (i.e., assessing familial goals, resources, and solutions). Participants were told to brainstorm and to even exaggerate their group's perspective in regard to the Shore Family and to record this information on poster board. Upon doing this, each poster was then put on the wall to compare and contrast the two groups' assessments of the Shore family. Feedback on this exercise included participants noting the stark contrast of perspectives (and thus assessments) toward the Shores, so much so that the two groups did not appear to be talking about the same family.

This group exercise highlighted the importance of how helping paradigms can influence how practitioners organize their thoughts, feelings, and actions towards clients. Helping paradigms that operate from a pathology focus are less likely to tap into clients' resilience because "...we can only see and know that which our paradigms allow us to see and know" (Barnard, 1994, p. 137). The Shore Family assessment activity helped participants to understand how if a professional's practice orientation is restricted to the containment of problems; it is difficult to perceive clients as being resourceful. A pathology focus encourages practitioners to perceive clients as having some disorder or deficit that creates negative expectations about their potential to address the stressors in their lives (Saleebey,

2006). The problems (e.g., parental discord) overshadow the strengths (e.g., parental devotion) and, therefore, run the risk of becoming the central focus in case planning.

In addition to the Shore family assessment task, CPS supervisors were given an assignment that offered another opportunity to practice shifting to a solution-focused perspective in assessment. Participants selected an agency assessment "tool" (e.g., a family assessment summary which included genograms, ecomaps, and cycles of problematic behavior) and were asked to change it to become solution-focused. This exercise included: 1) considering the potential risks and benefits of the original tool; 2) discussing where they saw the original tool not fitting with the solution-focused frame; and, 3) changing the tool to be more solution-focused and discussing what they hoped to accomplish with these changes. An example included modifying genograms to identify family strengths and functional patterns of relating in order to discover generational assets rather than deficits.

Solution-focused Strategies and Techniques

Participants were asked to read De Jong and Miller's (1995) article, "How to Interview for Client Strengths," as it provided an overview of SFBT's two main practice activities: developing well-formed goals and using purposeful questions to find solutions. The article's seven characteristics of well-formed goals (e.g., being specific, relevant, present-oriented, etc.) gives concrete examples of how to put SFBT into practice. The group was then given a list of treatment goals and asked to revise them to meet the dimensions of well-formed goals as laid out in the article. It was explained that helping clients refine what it is they "want" as opposed to what they don't want is particularly useful in that this step often makes the difference between success or failure, and feeling competent or discouraged. Participants reported that the article's clarity in designing goals was so helpful that they wanted all workers to review their client case plans and revise client goals to meet the seven criteria.

Although this article cannot cover all of the components of SFBT addressed in the training, one major activity included participants learning to "mine" for exceptions to the problem by practicing different types of question sets (e.g., miracle, coping, scaling, and difference questions). In addition, Walter & Peller's (1992, pg. 64) "Pathways of Constructing Solutions" diagram was presented and discussed in regard to uncovering "real" and hypothetical exceptions to the problem. This helped CPS supervisors to learn how to focus on when the problem is *not* happening and the forces of change that help to prevent it from reoccurring. The child protective services excerpt from the companion video *Interviewing for Solutions* by De Jong and Berg (2002) was shown to model how one can help clients move from understanding mandated expectations to defining what changes they want to have happen for themselves. The video helped to reinforce the strategies and techniques participants were learning and set the stage for roleplaying SFBT with "real" CPS case scenarios.

Results and Implications

Because the "Role Demonstration Model" had a detailed research design, a natural question arising is did this sophisticated instruction on resiliency and solution-focused practice have any practical impact on the goals established at the program onset? The answer is complex because the RDM had many components and attributing an outcome to one particular facet is somewhat risky. There are, however, a number of notable outcomes that can be empirically validated that seem to correlate highly with the shift in paradigm which this component of the staff development initiative sought to emphasize.

Overall, the participants are, by all measures, better clinical supervisors then they were when the project began. On standardized instruments the workers rate their supervisors as significantly

more competent than before and in repeated measures of performance using 360 degree evaluations the supervisors' ratings demonstrated statistically significant growth (paired t-test > .000) on all dimensions, particularly in manager, facilitator and professional roles (for measures used see Bolm, Pettit, Kelly & Wolchko, 2003). CPS supervisors are now viewed by workers as "sources of innovation" who have created a "culture of clinical practice" which has led to increased levels of respect, professionalism and confidence between workers and supervisors.

Focus group feedback from participants and their immediate superiors highlight the importance of resiliency- and solution-focused content and the changes that have resulted in day-to-day practice. CPS supervisors report that SFBT has given them the technology for helping workers shift from a deficit analysis to a strengths-based one during case consultation. In addition, they note that amplifying a strengths-based perspective during assessment has lead to fewer cases being opened and that judges are seeing and supporting these changes. In the case outcome arena, post-training performance shows a lower reoccurrence of abuse, a steady decline in child replacements and greater success rates with intensive in-home service cases (Kelly & Sundet, 2006). The independent Peer Record Review process reports substantial change in the quality of client assessments with greater emphasis on strengths and incorporation of these factors into case plans.

Furthermore, families now seem to view CPS workers as trying to help them (rather than just take their children away) as their assets rather than deficits are emphasized throughout the client-worker relationship. Consumer satisfaction as measured through client surveys shows continual growth with "understanding reason for contact" having the greatest statistical gain (sig. >.05 level).

In numerous jurisdictions Children's Division-Court Services Liaison Committees have either been established or reactivated to provide a forum for case discussions and dialogue about treatment ideology. In the urban demonstration site, joint staff development, focusing on resiliency and solution-focused intervention, is bringing together child welfare and family court personnel to examine new approaches to court mandated treatment plans.

The curriculum developed in this pilot project has now been adopted by Missouri's Children's Division and mandatory clinical training of all first-line supervisors in the philosophy and techniques described above is now underway. In addition, specialized training for all child protective services workers in resiliency and solution-focused treatment will begin shortly.

So it can be demonstrated with high confidence that significant progress has been made toward attaining the original agency goal of operationalizing its values by enhancement of strengths-based case assessments, plans and strategies. Can all of this progress be directly linked solely to the resiliency/solution-focused component of this project? Probably not. However, it is safe to say that the remarkable progress to date would not have been possible without having a coherent and environmentally congruent concept of human behavior and strategy of intervention to build around. The shift to a resiliency-focused form of assessment leading to solution-driven case plans has been gradual but steady. Internalization of this approach is now leading to communicating this new practice orientation to the courts and associated agencies. This has thrust the CD staff, particularly these supervisors, into practice leadership roles rather than passive recipients of externally generated case plans.

Conclusion

Shifting helping paradigms in child welfare (i.e., from problem-centered to strengths-oriented) does not tend to happen simply as a result of changing agency policy. Without the appropriate practice tools, a situation is set up where workers report that

they address clients' strengths to meet agency expectations, but in practice may still operate from a deficit approach. CPS workers may not embrace a new helping paradigm not because they are not interested, but because it is one more thing in which they are not equipped to do. Giving them solution/tools of how to shift paradigms by beginning with resiliency theory and moving into solution-focused techniques provides a means of upholding child welfare's commitment to strengths-based, family-centered practice.

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