

California Social Work Education Center

C A L S W E C

**CULTURALLY SENSITIVE RISK
ASSESSMENT:**

AN ETHNOGRAPHIC APPROACH

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CALSWEC PREFACE

The California Social Work Education Center (CalSWEC) is the nation's largest state coalition of social work educators and practitioners. It is a consortium of the state's 19 accredited graduate schools of social work, the 58 county departments of social services and mental health, the California Department of Social Services, and the California Chapter of the National Association of Social Workers.

The primary purpose of CalSWEC is an educational one. Our central task is to provide specialized education and training for social workers that practice in the field of public child welfare. Our stated mission, in part, is "to facilitate the integration of education and practice." But this is not our ultimate goal. Our ultimate goal is to improve the lives of children and families who are the users and the purpose of the child welfare system. By educating others and ourselves, we intend a positive result for children: safety, a permanent home, and the opportunity to fulfill their developmental promise.

To achieve this challenging goal, the education and practice-related activities of CalSWEC are varied: recruitment of a diverse group of social workers, defining a continuum of education and training, engaging in research and evaluation of best practices, advocating for responsive social policy, and exploring other avenues to accomplish the CalSWEC mission. Education is a process, and necessarily an ongoing one involving interaction with a changing world. One who hopes to practice successfully in any field does not become "educated" and then cease to observe and to learn.

To foster continuing learning and evidence-based practice within the child welfare field, CalSWEC funds a series of curriculum modules that employ applied

research methods to advance the knowledge of best practices in child welfare. These modules, on varied child welfare topics, are intended to enhance curriculum for Title IV-E graduate social work education programs and for continuing education of child welfare agency staff. To increase distribution and learning throughout the state, curriculum modules are made available through the CalSWEC Child Welfare Resource Library (www.csulb.edu/projects/ccwrl).

The module that follows has been commissioned with your learning in mind. We at CalSWEC hope it serves you well.

INTRODUCTION

CONCEPTUAL BACKGROUND

The overall mission of this curriculum is to combine the concepts of systematic risk assessment with those of ethnographic interviewing and then train staff in their application. In the interest of understanding the theoretical underpinnings upon which the curriculum is based, the concepts of systematic risk assessment and ethnographic interviewing are explained within the context of the delivery of child protective services.

The concept of risk assessment is neither new nor revolutionary. Staff have been assessing risk to children since the first worker knocked on the door of the first reported family. However, research in two areas relating to child welfare service paved the way for a more systematic approach that attained prominence in the 1980s. First, the studies investigating decision making in child welfare documented the lack of consistency and apparent randomness of the models being applied, thus pointing to the need for a more systematic approach (Stein & Rzepnicki, 1984). Secondly, research designed to uncover the variables associated with child abuse and neglect mushroomed and as the body of knowledge grew, patterns of factors emerged and a tentative consensus began to develop concerning those factors associated with child maltreatment. As a result of the documented need, researchers and practitioners moved the process one more step to develop systematic risk assessment models and decision-making guides that were based on the existing body of knowledge. While the systems differ in organization, format, and level of complexity, in general they subscribe to the following definition:

Risk assessment is a process used to assess the level of risk to a child who is reported for alleged abuse and/or neglect....It is also a tool which measures and organizes factors present in abuse and neglect situations, and which are considered important in describing the current safety and in predicting the future safety of the child. These factors include the characteristics of the reported abuse or neglect, the child and family involved, and the environment in which the child and family exist (Harris, 1987).

Systematic risk assessment may be distinguished from other assessment approaches in that it is empirically rather than intuitively based. It is structured rather than random. It requires an initial discrete approach to evaluating risk factors followed by a gestalt processing and analysis of the total picture. Systematic risk assessment recognizes that there is tension between the twin goals of protecting children and preserving families and supports risk taking by public agencies in addressing that tension (Sheen, 1991). It is essentially a tool to be used by workers to improve the quality of decision making. It provides a framework for case assessment and documentation and is the driving force behind case planning and service delivery. It also assists staff in identifying those factors that are truly endangering children while also illuminating strengths which may be built upon in order to ameliorate the risk and preserve the family.

The principles behind ethnographic interviewing have long been applied in the anthropological arena. They emerged in the child welfare field in the late 1970s through the work of James Green, James Leigh, and James Anderson, all of the University of Washington School of Social Work. Their work developed in response to a growing

awareness of the importance of cultural differences in the helping process and the right of clients to receive culturally appropriate services.

Ethnographic interviewing, as it will be applied in this project, is based upon three basic premises. The first is that American society has not been a melting pot, but is rather a pluralistic society consisting of a rich patchwork of subgroupings. Within that context, culture is viewed as a broad concept encompassing not only racial and ethnic elements, but also such things as geography, career choice, religion, socioeconomic status, sexual preference, and a wide variety of other factors. The configuration of culturally transmitted traits of any family or individual does not stem from a single subgroup identification, but is rather an expression of many associations and circumstances.

Second, cultural differences are real and profoundly impact upon our world view, our goals and aspirations, and our help and support-seeking behaviors. The beliefs and practices of people of color, of Jews and other persecuted religious groups, of gay men and lesbians, and of the disabled and a wide variety of other oppressed groups may differ from the “majority” culture not only because of oppression or prejudice or exclusion, but because people find their ways of being in the world more satisfying, more fulfilling, and superior to the ways of the “mainstream” (Green, 1982).

Third, ethnic-specific models, dependent as they are on measures of central tendency, may not be helpful in grasping the cultural beliefs and practices of individual families. Indeed, they may lead workers to make assumptions about an individual family that while true for the aggregate, may have little meaning for the family members in question.

While the ethnic-specific research that has been done is extremely useful, it does not fully meet the need. The work done by Terry Cross, Diana English, Charles Horejsi, Norma Harris, and many others around a culturally sensitive approach to risk assessment is invaluable. It has provided many important insights into the ways in which we view risk and has made it impossible to perpetuate the myth that risk assessment is a culturally neutral process. However, for workers practicing within widely diverse populations such as those found within California, the mastery of dozens of sets of caveats may prove impractical, adding to the cautions of applying central-tendency-based measures.

Preliminary work in combining the concepts of systematic risk assessment and ethnographic interviewing was carried out by staff of the Child Welfare Training Project of California State University, Fresno (CSUF). A paper was presented at the International Conference on Child Abuse and Neglect held in Chicago in 1992 and a second paper at the 1994 Risk Roundtable co-hosted by the American Public Welfare Association and the American Association for Protecting Children.

Favorable reaction by colleagues in the child welfare field to this initial work led to a proposal for developing this curriculum. In July 1995, the California Social Work Education Center (CalSWEC) awarded a research grant to the Child Welfare Training Centre at California State University, Long Beach (CSULB). The grant called for CSULB, in consultation with CSUF, to develop this curriculum and to conduct a training for trainers to staff of CalSWEC-affiliated schools of Social Work, and Regional Training Academies. Subsequent to the awarding of the grant, two preliminary papers were presented by the authors in 1995, one at the Child Welfare League of America Regional

Conference in Charleston, South Carolina, and one at the American Public Welfare Association Training Conference in San Francisco, California. Since the completion of the curriculum, the total curriculum was field tested in Los Angeles, California and portions of it were presented in Monterey and Fresno, California; Eugene and Portland, Oregon; and Minneapolis, Minnesota.

In addition to child welfare professionals' confirmation of the need for culturally sensitive risk assessment, demographic evidence demonstrated the inadequacy of current risk assessment practice in preserving families considered outside of the traditional view of the cultural "mainstream."

In Los Angeles County, California, African American children represent 43% of those served by the Department of Children and Family Services, while comprising only 11% of the total child population. Children of AFDC-eligible families constitute 72% of children served by DCFS, while 15% of the total population receives AFDC benefits. A recent statewide study documented that 15% of disabled children reside in out-of-home care compared to 1% of children in the general population (State of California, Department of Developmental Services, 1990). For the increasing numbers of children being born into the drug subculture, the situation is even more dire. They constitute the single fastest growing population of youngsters entering substitute care (North American Council on Adoptable Children, 1990). Furthermore, these children stay in placement longer, move more frequently, and are less likely to be returned to their biological parents. These findings are dramatically magnified for children of color.

Clearly, issues of subculture identification cannot be separated from issues of family preservation. Children of color, of poverty, of substance-involved families, and

those with disabilities are overrepresented among those involved with the child protective services system. They are reported more frequently, enter the system more often, and are placed in out-of-home care with greater regularity. It is incumbent upon the system to respond.

One potentially useful model to address the problem is the joint application of the concepts of systematic risk assessment with those of ethnographic interviewing. Systematic risk assessment guides decision making, mitigates against the biasing effects of worker values and attitudes, and drives the development of case plans which recognize family strengths and direct interventions toward those problems which are truly endangering children. Ethnographic interviewing principles enable workers to recognize the individuality of each family. Family members become cultural guides to their world view; and to interpret risks, strengths, and needed interventions in ways which are culturally appropriate to them.

Thus, by combining the two conceptual frameworks into a joint practice application, it is hoped that family views of risks and strengths will be more clearly explained and that case plans and attendant interventions be more closely matched to what families are able and willing to do.

TRAINING PHILOSOPHY

With this view of the conceptual underpinnings of the curriculum in place, we turn now to the philosophy of training that guided its development. Training programs for child welfare professionals tend to be more positively received if they are reflective of the following five principles (Tabbert, 1992):

1. Are philosophically based,
2. Provide validation for trainees,
3. Reflect a value base,
4. Are pragmatically oriented, and
5. Appeal to varied learning styles.

In the first principle we see that work in child protection is not random but is rather philosophically grounded in the law and public policy, which underpin its practice. Anchoring training in this way provides trainees with a way of placing a variety of work-relevant topics within the gestalt of their accumulated practice wisdom and skills. Introductions of the background, policy, and practice issues related to systematic risk assessment and basic premises and principles surrounding the application of ethnographic interviewing perform this function for this curriculum.

The second principle that should be addressed involves providing workers with validation for what they do and recognition of the difficulties and stresses which are inherent in their work. Maintaining the delicate balance between protecting children and preserving families carries with it the responsibility for making decisions that may be of a life and death nature. It means working with adults and children who are in crisis and who may be facing the compounding effects of poverty, substance abuse, mental illness, addiction, and a myriad of other problems. Child protection is not an easy job and people who work in this field need their training to recognize this fact and to address issues of self-care that are critical to their personal and professional well-being. While this curriculum does not contain a special module on self-care, the exercises that focus on strengths and utilize the knowledge and past experiences of participants

provide validation. A key to effective delivery is to recognize with trainees that while their jobs are difficult, they are also important for children and families.

The third principle concerns the values and attitudes that are intrinsic to the job of child protection. It has been said that our values and attitudes more profoundly affect our work with people than our knowledge and skills. As Elizabeth Cole has said:

There couldn't be anything more important in the training of social workers than to make them confront what they believe. I really think that our values lay at the basis of what we choose to do or not to do with our clients. In most cases, social workers base their judgments on that they believe to be right and wrong. Often the model for goodness is ourselves or those we aspire to be like. Forcing us professionals to confront what we believe and value is important work.

In this curriculum, value issues arise at several junctures. They come into play in how risks and strengths are viewed and the way in which decisions are reached. Issues surrounding ethnographic interviewing, including the broad view of culture and its individual presentation, and the respect for differences for their own sake and for the richness that they bring into our lives, are all heavily value laden.

The fourth principle concerns the need for training to be pragmatically related to the work which participants are expected to do. Training should be practice relevant so that what is learned in training today may be put to use in the field tomorrow. Child welfare workers are frequently overworked and have great demands put upon them. While they are away at training, the work continues to pile up, and training, which is viewed as abstract or theoretical in nature, may be perceived as a waste of time or irrelevant. It has been said that the purpose of education is to prepare one for life. The

purpose of training, on the other hand, is clearly to improve job performance. The government and private agencies that fund training for child welfare personnel have every right to expect that improved job performance will be among the outcomes received for the money expended. The most certain way to assure that this expectation is met is to provide training that is practice relevant. This relevance can best be achieved by combining brief lecturettes with a broad array of experiential exercises designed to demonstrate concepts and to exercise participants in building their knowledge and skill within a safe and accepting environment. The curriculum that follows has been developed around this principle and includes many varied experiential exercises that build upon the content that is presented in more didactic form.

The fifth principle concerns the need for curricula to appeal to a broad array of learning styles. While most people are capable of learning in a variety of ways, each individual tends to have a preferred style that is more comfortable, natural, and generally results in better retention. Some trainees learn best in an auditory fashion. What they hear is absorbed and retained. They relate well to the spoken word and tend to thrive on lecturettes and other types of didactic instruction. Auditory learners are practiced listeners and tend to be excellent telephone communicators. Other people are visual learners. These are the readers, the people who like flip charts, overheads, graphic presentations, and videotapes. Seeing concepts and ideas presented in visual ways makes the spoken word come alive and greatly enhances their ability to learn. Still another group of people are kinetic learners. They are most comfortable when they are physically involved. These are the trainees who are constantly twisting rubber bands, bending paper clips, doodling, or tearing their Styrofoam cups into small bits. They may

appear disinterested or uninvolved, but are actually striving to lessen the physical tension that builds as a result of sitting in one place for a protracted period. Exercises that involve movement, writing, and lively discussion are very attractive to these individuals. The curriculum that follows is designed to have appeal and relevance for individuals representing all of those learning styles. It combines brief lecturettes with overheads that graphically display the concepts being discussed. Many of the exercises are highly interactive, require movement around the training room, and give participants an opportunity to stand, record, or interact informally.

CURRICULUM FORMAT

While this curriculum was designed to have maximum appeal for trainees, thought was also given to trainers in order to make the manual as self-explanatory and easy to use as possible.

The curriculum is divided into four modules:

1. Systematic Risk Assessment
2. Case Planning
3. Ethnographic Interviewing
4. Application

Each module of this manual contains a brief narrative introduction that addresses the major points to be made and tasks to be accomplished in this portion of the training. This is followed by a bulleted summary of focal points, those items that must be addressed if the purpose of this portion of the training is to be achieved. Next is a content outline of the materials to be addressed in the module. Step-by-step instructions for conducting the session follow. The accompanying overheads are in a separate

document where this Curriculum was accessed. They can be printed out to make overhead transparencies or they can be viewed using a computer.

The material provided to trainees can be arranged in dual-pocketed folders. The right side includes the conceptual background section of the introductory chapter plus the introduction, focal points, and content outline for each curriculum module. The left side includes a name tent, a copy of the overheads, and a copy of the handouts and exercises needed for the training.

The *Conducting the Session* part of each module is the trainer's mainstay. It describes needed materials, estimated times, content to be addressed in lecturette form, which overhead to use when, instructions for all exercises, and suggestions for debriefing.

Each trainer task is identified by a marginal notation as follows:

Time	=	Estimated time needed to present the content
Materials	=	Materials needed to present the content
Slide	=	Computer slide or overhead to accompany lecturette, with number and title included
Content	=	Trainer speaking or presenting lecturette content
D & P	=	Debrief and process
Exercise	=	Exercise
Demo	=	Demonstration, interaction with trainer(s)

CURRICULUM PRESENTATION

While this curriculum was originally designed as a 3-day training package, a number of other options are available. For example, the first day of training, which

focuses on the process of risk assessment and the way in which the evaluation of high and low risk factors drives the development of the case plan, can stand alone. This 1-day training is best applied as a review and reinforcement of the processes of risk assessment and case planning for staff with some experience or as an introduction to these practice skills for new personnel.

Likewise, the second and third days of training, which focus on the process of ethnographic interviewing and its application to risk assessment and case planning, can be delivered as a separate training. In this instance, it is important that participants have some experience with risk assessment and case planning or have previously attended the 1-day training described above.

It is important to recognize that the process of ethnographic interviewing is more than applying a predetermined set of techniques to our interactions with clients. It is also a way of thinking about culture and its unique presentation in individuals and families. It forms a pathway to people's world view and their place within it. As such, the skills of ethnographic interviewing, once learned in a particular context, can be easily transferred to other situations.

In this curriculum, the processes of risk assessment and case planning were selected for the focus of the application portion of the curriculum because they are fundamental to the dual mission of child protection—assuring child safety while maintaining family integrity. The skills involved in ethnographic interviewing can also be applied effectively in dealing with foster or adoptive parents and children, or in any other interactive situation.

MODULE I

SYSTEMATIC RISK ASSESSMENT

MODULE I

SYSTEMATIC RISK ASSESSMENT

INTRODUCTION

This module introduces the underlying concepts of systematic risk assessment and allows participants to practice its application. The historical development of risk assessment is briefly reviewed and its place in the decision-making continuum explicated. The policy and practice issues applicable to risk assessment are discussed, and systematic risk assessment is contrasted with more traditional assessment models. Participants are introduced to the decision-making process in child protective services and to the systematic risk assessment protocol currently being trained in California. The module concludes with an exercise that allows trainees to use the protocol to assess risks and strengths in a case vignette.

FOCAL POINTS

- Background that led to the development of systematic risk assessment
- The role of risk assessment in the decision-making continuum
- Policy issues in risk assessment
- Practice issues in risk assessment
- Contrast between systematic and more traditional risk assessment models
- Decision making in child protective services
- Introduction of the risk assessment protocol and factors
- Application of the risk assessment protocol

CONTENT OUTLINE

- A. Origins of risk assessment
 - 1. Decision-making research—illuminated need
 - 2. Factors associated with child abuse and neglect—provided knowledge
- B. Risk assessment defined
 - 1. Process to assess level or risk, tool that measures and organizes factors in abuse and neglect situations
 - 2. Assists in describing current safety of a child
 - 3. Helps in predicting future safety of child
 - 4. Factors include characteristics of the abuse/neglect, child/family involved, child/family environment
- C. Role of risk assessment in the decision-making continuum
 - 1. Intake allegation evaluation
 - 2. In-person investigation
 - 3. Case opening
 - 4. Case review
- D. Policy issues in systematic risk assessment
 - 1. Likelihood of reoccurrence and severity of risk
 - 2. Standard is minimum sufficient level of care
 - 3. Same standards applied throughout the life of the case
 - 4. Continuum of risk
- E. Practice issues in systematic risk assessment
 - 1. Utilized throughout the life of a case
 - 2. Helps to minimize effects of bright spots and blind spots
 - 3. Improves consistency of decision making within and between cases
 - 4. Depends on professional judgment and skill
 - 5. Is both a discrete and gestalt process
- F. Summary
 - 1. Empirical vs. intuitive
 - 2. Structured vs. random
 - 3. Discrete and gestalt
 - 4. Recognizes tension between child protection and family preservation
 - 5. Addresses biases
 - 6. Improves quality and consistency of decision making
 - 7. Provides a framework for assessment, documentation, and case planning
- G. Decision making in child protective services
 - 1. Decision-making exercise
 - 2. Steps in decision making

- H. Introduction of the systematic risk assessment protocol
 - 1. Precipitating incident factors
 - 2. Child assessment factors
 - 3. Caretaker assessment factors
 - 4. Family assessment factors/stresses
 - 5. Family/Agency interaction
- I. Application of systematic risk assessment to case material

CONDUCTING THE SESSION

Time: 4 hours

Materials: Name tent for each participant
Resource Handbook for each participant
Slides/Overheads: #1-16
Computer slides/Computer or Overhead projector/Overheads
Projection screen
Overhead pen (if using overheads)
Easel stand and flip chart
Magic markers

Slide #1: Culturally Sensitive Risk Assessment: An Ethnographic Approach

Content: Welcome participants to the session and introduce the topic and yourself.

Slide #2: Goals

Content: Briefly review the goals of the training:

1. Systematic Risk Assessment
2. Case Planning
3. Ethnographic Interviewing
4. Application

Slide #3: Introductions

Content:

1. Ask participants to introduce themselves including their name, agency, job, and one-word associations with risk assessment and cultural sensitivity. Record these associations on separate flip chart sheets. Make sure that everyone has completed his or her name tent.
2. Following the introduction of participants, summarize the one-word associations with risk assessment and cultural sensitivity. Look for themes, similarities, and differences in responses. If there are negative or positive trends, pick up on them and discuss.
3. Introduce trainees to the organization of their resource materials. The right side of their packets contain the conceptual background section of

the introductory chapter, plus the introduction, focal points, and content outline sections for each module. The left pocket includes a name tent, a copy of the slides/overheads (which can be used for note taking), and a copy of all handouts and exercises needed for the training.

INTRODUCTION TO RISK ASSESSMENT

1. The fundamental purpose of child welfare services is to remove risk from children rather than remove children from risk.
2. For years, child welfare practice relied on the process of removing abused and neglected children from “bad” parents, placing them in the care of “good” foster parents, and concluding that the best interests of the child had been served.
3. Today’s child welfare philosophy and practice and the public policy which supports them are clearly focused on the preservation of families and protection and permanency for children: “Children should remain with their families unless they are so harmed or threatened by harm that they cannot” (Annin & Black, 1987).
4. However, when harm or the threat of harm reaches a critical level, the children must be removed for their own protection. The fundamental and most difficult question is...what constitutes this critical level?

TRANSITION:

In recent years, in order to assist social workers in determining this critical level, two basic lines of inquiry were initiated.

Slide #4: Origins of Risk Assessment
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Content: A. Origins of systemic risk assessment

1. The first were the studies designed to determine the kinds of decision-making models that social workers were using.
 - a. The notion was to study practice and thereby induce the factors that influenced decision making and the processes which were followed.

- b. However, researchers found that they couldn't complete their task. There appeared to be no consistency in the ways in which workers reached their decisions.
 - c. Even in those cases where professionals reached the same conclusions, they often did so for different reasons.
 - d. These studies highlighted the need for a more systematic approach to decision making.
- 2. The second set of studies attempted to uncover those variables that were associated with child abuse and neglect.
 - a. As the body of knowledge grew, patterns of variables began to emerge and a consensus developed on a national level as to what factors were associated with child maltreatment.
 - b. These studies provided the knowledge base needed to develop systematic risk assessment protocols.

TRANSITION:

Once the need for more systematic decision-making models and the needed knowledge base were established, a variety of different professionals began to develop risk assessment models.

Slide #5: Risk Assessment Defined

Content: B. Risk Assessment Defined

While these models differ in organization, format, purpose, and level of complexity, in general, they subscribe to the following definitions:

- 1. Risk assessment is a process used to assess the level of risk to a child who is reported for alleged abuse and/or neglect. It is also a tool that measures and organizes factors present in abuse and neglect situations.
- 2. It assists us in describing the current safety of a child.
- 3. It also helps us in predicting the future safety of the youngster.

4. The factors include characteristics of the reported abuse or neglect, the child and family involved, and the environment in which the child and family exists (Harris, 1987).

TRANSITION:

With this overview of the meaning of systematic risk assessment, it is important to see where risk assessment fits in the continuum of decision making in child welfare services.

Slide #6: Child Protective Services: Decision-Making Paradigm

Content: C. Role of risk assessment in the decision making continuum.

Go through overhead with participants, using the more detailed paradigm that appears below.

Decision points	Central questions	Role of risk assessment	Possible action
I. Intake allegation evaluation (screening)	Does the allegation meet the requirements for CPS in-person investigation, and if so, what is the level of urgency?	Complete the Emergency Response Protocol using risk factors to guide information gathering.	Assess out Assess out & refer Assign for in-person investigation
II. In-person investigation	Is the allegation founded/substantiated? Did the alleged event occur? Is the child safe for the immediate future?	Begin risk assessment, letting risk factors guide information gathering to support reasonable efforts toward family preservation. Safety is assessed in light of strengths & risks.	Close case Close case & refer Open service case
III. Case opening	What is the likelihood that the substantiated event/s will continue or reoccur? What actions need to be taken to ensure child safety & family integrity?	Risk Assessment Protocol completed in full. High risk factors identify areas endangering children & low risk factors identify the strengths to be built on in case plan development.	Close case Close case & refer Continue services delivery
IV. Case review	Has the relationship between risks & strengths changed so that the case plan should be modified or the case closed?	Risk Protocol reapplied to assess changes	Close case Close case & refer Continue current services Modify case plan & continue services

TRANSITION:

Now that we see where systematic risk assessment fits in the continuum of decision making, it is important to examine some of the policy issues involved in applying these models.

Slide #7: Policy Issues

Content: D. Policy Issues

There are three major policy issues connected to systematic risk assessment.

1. The first is that both severity of the current incident as well as predicting the likelihood of a future occurrence are important and are not necessarily related. While it may, on initial examination, appear incongruous to separate risk of future abuse from the severity of the injuries that the child has sustained, consider the following two scenarios:
 - a. Tom, a 12-year-old boy, was admitted to the hospital with multiple fractures of the right arm and a severe concussion. Investigation revealed that the injuries were sustained when Tom's father pushed him from the back porch of the family home after having discovered Tom smoking cigarettes. The father admitted pushing Tom in his frustration over his son's smoking and his worry about fire. The family home is an old wooden structure. The father lost a family member to a fire in his youth. The family usually functions well and Tom's father has repeatedly expressed his remorse for his angry outburst and recognition that his behavior was inappropriate.
 - b. Jennifer, a 17-year-old single parent, was reported by a neighbor for spanking her 6-month-old daughter, Susan. Investigation revealed no visible bruises or marks on Susan. While the child appeared somewhat lethargic and according to the mother suffered from colic, her general health, growth, and appearance seemed normal. Jennifer reported feeling isolated, angry at her circumstances, and hopeless about finding a way out. Jennifer believed the child to be "willful and stubborn, just like her father."

Clearly, in these two instances the injuries suffered by Tom were much more severe than those sustained by Susan. However, in Tom's case the future risk is probably very low, compared to a moderate-to-high risk for Susan. What is critical to understand is that risk assessment, while considering past and present events, is really a future-oriented process. It attempts to answer the question, "What is the likelihood that this child will be severely neglected or physically or sexually abused in the future?"

2. Historically, the standard against which decision making was applied was the "best interest of the child" rather than the minimum sufficient level of care.
 - a. This pattern of thinking has justified many unnecessary out-of-home placements under the rationale that placement was "best" for the child. It has also required a level of parental perfection that is unrealistic and unethical.
 - b. The role of the state in intervening in family matters must be confined to those instances where a child is truly at risk rather than any time when the parenting and care provided are less than ideal.
 - c. The trauma of separation and loss, which placement frequently causes, is often far more severe than that resulting from less-than-ideal parenting.
 - d. Additionally, the increasing magnitude of reported cases makes it impossible for the public child welfare system to respond and intervene in any but those cases where a real risk to a child is present.
3. In addition to this change in the standard against which risk is assessed, current practice also requires that the same standard be used throughout the life of the case.

Slide #8: Continuum of Risk

Content: 4. Continuum of risk

- a. If we view risk as a continuum ranging from low to high, at what point might we make the decision to place a child in protective custody? [If you are using transparencies, place a dot on the

transparency somewhere toward the high end. If you are using a computer, point toward the high end of the slide on the projection screen.]

- b. Ask the group when you would make the decision to return the child home. [Place a dot slightly lower on the continuum than the one already there or point to a lower spot on the screen.]
- c. Point out that families should be reunited when the level of risk is reduced to the point where the child would not have been removed in the first place.
- d. Too often in the past, different standards were employed depending on the position of the case in the process. For example, one set of standards was employed when the decision to remove a child was made.
- e. Yet, before the decision to return the child was considered, parents were expected to make changes and improvements that far transcended a minimum sufficient level of care.
- f. By contrast, acceptable practice today suggests that a child should be returned home when risk has been reduced and stabilized at a level that would not have required the initial out-of-home placement.

TRANSITION:

In addition to these policy considerations, there are a number of practice issues involved as well.

Slide #9: Practice Issues in Systematic Risk Assessment

Content: E. Practice Issues in Systematic Risk Assessment

There are five basic practice issues associated with the process of systematic risk assessment.

1. The first concern is the fact that we view risk assessment as being used through the life of a case.
 - a. Much of the material written about risk assessment (and some risk assessment models) focuses almost exclusively on the

intake process. This curriculum presents an ongoing process of risk assessment beginning at the initial report and continuing through assessment, case planning, the provision of services, and termination of the case.

- b. To be most useful, a risk assessment system should enhance the opportunities to involve family members in identifying problems and developing culturally congruent service plans, and should have applicability at each critical decision point throughout the life of the case.

TRANSITION:

Let's take a look at what some of these critical decisions are.

Slide #10: Decisions

Content: Risk assessment, for example, can assist with any or all of the following case decisions:

- Whether the child is in immediate danger or future risk of maltreatment,
- Which social services, worker actions, or support systems are necessary to protect the child during the investigation,
- Whether or not the child must be removed from the home for his/her protection,
- What initial case plan will address the factors that are placing the child at risk,
- What modifications, if any, must be made to the case plan to further reduce risk and enhance the safety of the child,
- When it is safe to return a child home if the child has been removed, and
- When a minimum sufficient level of care is being provided that would support case closure.

- Content:**
2. A second practice issue concerns the fact that risk assessment can help us to overcome the bright spots and blind spots that tend to cloud our judgment when we view families.
 - a. All of us in this business have things that really bother us (bright spots)—things that when we see them tend to impair our ability to look further or to identify strengths. For some of us it is sexual abuse, for others filth and vermin, and for others something else.
 - b. Conversely there are things that we tend to consistently ignore (blind spots), that we miss for whatever reasons.
 - c. Systematic risk assessment, by forcing us to examine a predetermined set of factors, can mitigate against the biasing effects of these bright spots and blind spots.
 3. The third practice issue has to do with the consistency of our decisions.
 - a. The use of systematic risk assessment, by guiding us through a similar decision-making process, can improve consistency within and between cases.
 - b. By applying the model at all key decision points within the life of a case, we are much more likely to utilize consistent standards at different points in time.
 - c. It is also likely that consistency will be improved between cases because workers will be following similar processes in reaching their decisions.
 4. The fourth practice issue concerns the importance of professional judgment in the risk assessment process.
 - a. No risk assessment matrix or computerized decision-making program will be able to replace worker judgment and a thorough assessment of child and family functioning.

- b. Rather, what is required is the application of a set of guidelines designed to provide informed decision making within the interactive arena of worker, child, family, and community.
 - c. Risk assessment is not a static process, but rather a way of thinking, a process for approaching assessment and reassessment.
 - d. To be skilled at risk assessment requires sound interviewing skills in order to obtain all necessary information.
 - e. It necessitates the ability to assess the meaning of the information for the child and the family in ways that are culturally and geographically appropriate. In this manner, individual, family, and community differences are respected.
 - f. It demands analytical thinking to ensure that the dynamic interaction of all the factors infringing upon the situation be processed and organized.
 - g. Above all, it requires sound professional judgment, which must, when circumstances demand, be allowed to take preeminence over any form, rating scale, guideline, or numeric system inherent to the model. This judgment is key to maintaining the delicate balance between protecting children and preserving families.
 - h. Application of the above professional skills should be made within the context of sound supervisory consultation. Additionally, other professionals and community resources should be involved whenever appropriate. No one individual or professional group knows all or has a monopoly on child abuse and neglect. Personal and professional strengths and values can best be applied, and biases and blind spots overcome, within the context of shared decision making and responsibility.
5. Finally, it must be recognized that risk assessment is both a discrete and gestalt process.
- a. Initially, each factor is evaluated as a discrete variable independent of all others.
 - b. When this process is complete, then the gestalt is viewed to determine the overall level of risk and begin to plan needed interventions.

- c. This is frequently the most difficult part of risk assessment for staff.

TRANSITION:

With this background and overview of systematic risk assessment, I now want to summarize how application of these models differs from the more traditional kinds of assessment.

Slide #11: Summary

- Content:**
- F. In summary, there are several things that distinguish systematic risk assessment from more traditional models. Risk assessment is nothing new or revolutionary in the delivery of child welfare services. Staff have been assessing risk to children since the first worker knocked on the first door on the first reported case. The following are differences between a systematic risk assessment model and more traditional means of assessment.
 - 1. It is empirically rather than intuitively based.
 - 2. It is structured rather than random.
 - 3. It is both a discrete and gestalt process.
 - 4. It recognizes that there is tension between the twin goals of protecting children and preserving families, and supports risk-taking by public agencies in addressing that tension.
 - 5. It is a way of addressing bias and getting beyond our bright spots and blind spots.
 - 6. It is a tool to be used by workers to improve the quality and consistency of decision making, both within cases (at different decision points) and between cases.
 - 7. It provides a framework for case assessment and documentation and is the driving force behind case planning and services delivery. It is neither perfect nor a panacea; it is not a fail-safe method for avoiding the tragedies of child death, injury, or dissolution of health and spirit and sense of self. It is rather one more tool which, when combined with professional skill and judgment, can bring us closer to our ultimate goal of protecting children while preserving families.

TRANSITION:

This concludes our discussion of the background and policy and practice issues that underlie the application of systematic risk assessment models. We turn now to look at the decision-making process, first in general, and then as it applies to the use of a risk assessment protocol.

Slide #12: Decision Making Exercise

Content: G. Decision Making in Child Protective Services

Exercise: 1. Ask participants to take the Decision Making Exercise (Handout 1) out from the left-hand side of their packets.

Read the directions with them and clarify any questions. Be sure to clarify that 1 is the most risky situation and 10 the least and that each description should be given a single ranking 1 through 10.

Content: When participants have completed the exercise, which usually takes about 15 minutes, record their responses on an overhead transparency or flip chart.

Rather than examining every vignette, it is usually preferable to focus on the five or so which reflect more divergence of opinion.

Elicit from the group why they gave the situation the rankings that they did. Contrast the highs and lows.

This exercise is designed to illustrate the following points:

- a. While there is some consensus on which cases are the most risky, there is also a great deal of variation even among staff with extensive experience.
- b. Even when people reach the same decisions, they may do so for different reasons.
- c. The rationales we use come directly from our value system, which can cause blind spots in our decision making.

TRANSITION:

While we usually have more information available when we make decisions than was the case in this exercise, there are a series of steps we follow in the decision-making process.

Slide #13: Steps in Decision Making

Content: 2. Steps in Decision Making

- a. Information must be gathered using criteria that enable the practitioner to sort data into categories of relevant and irrelevant information.
- b. Rules are then applied to give differential weight to categories. For example, in cases where non-supervision is alleged, parental behavior should be differentially weighted according to a child's age and self-help skills.
- c. In cases where the evidence is not clear-cut, professional judgment must be applied to reach a decision.
- d. Once we have made an important decision, we tend to look for reinforcement of our judgment. This is one of the functions of supervision, case conferencing, and consultation.

TRANSITION:

Using examples from the exercise we just completed, we are now ready to take a look at the actual risk assessment protocol.

Slide #14 Family Assessment Factor Analysis (page 1)

Content: H. Introduction of the Systematic Risk Assessment Protocol

Instruct participants to take out the Family Assessment Factor Analysis (Handout 2), Family Assessment Risk Variables (Handout 3), and Exercise I (Handout 1) from the left-hand pocket of the trainee materials packet.

Refer back to the vignettes in the Decision Making exercise and ask participants to evaluate one factor in sections C through F.

1. Item C.-3, location of injury, can be assessed using vignette I. (eye injury).
2. Item D.-5, child's age, can be assessed using vignette D. (Valium to a 2-year-old).

Slide #15: Family Assessment Factor Analysis (page 2)

- Content:**
3. Item E.-14, caretaker's substance/alcohol abuse, can be assessed using vignette H. (3-week-old, positive tox screen).
 4. Item F.-20, presence of a parent substitute in the home, can be assessed using vignette F. (special walks).

As you move through the form, process participants' ratings and rationale for their decisions.

TRANSITION:

With this brief introduction of the risk assessment model, we will now apply it to a more complete and detailed case vignette.

I. Application of Systematic Risk Assessment to Case Material

- Exercise:** Instruct participants to take the Stoddard case out from the left pocket of the trainee materials folder (Handout 4). They should also have the form and factors they used during the previous exercise.

Ask trainees to number off by fours to create small groups for this exercise. Everyone is to read the entire Stoddard case and complete the Family Assessment Factor Analysis in groups.

- Group 1 will complete Section C
- Group 2 will complete Section D
- Group 3 will complete Section E
- Group 4 will complete Section F

**Return to
Slide #14: Family Assessment Factor Analysis (page 1)**

- Exercise:** Record the groups' ratings on the overhead Family Assessment Factor

Analysis form (if using overheads; if using computer slides, note them on a sheet of flip chart paper).

If differences of opinion are expressed discuss these and attempt to come to consensus.

In this exercise, if differences of opinion persist remind participants that the process is more important than consensus in the ratings.

Review the brief narrative assessments for each section.

**Return to
Slide #15: Family Assessment Factor Analysis (page 2)**

Record the groups' ratings on the overhead risk assessment form (if using overheads; if using a computer, note them on a sheet of flip chart paper).

If differences of opinion are expressed, discuss these and attempt to come to consensus.

In this exercise, if differences of opinion persist remind participants that the process is more important than consensus in the ratings.

Review the brief narrative assessments for each section

Slide #16: Family Assessment Factor Analysis (page 3)

Demo: Summarize the numbers of risk factors that fall into each category of risk and complete section H of the form.

Elicit from the group the strengths of this family and record them in section I. Point out that low risk factors may point to strengths which can be built upon in problem resolution.

To arrive at the overall risk rating, ask participants to assess the level of risk when only the precipitating incident is examined. Next look at child assessment factors and determine if risk levels increase, decrease, or remain the same.

Repeat this process for sections E through G and then assign an overall risk rating to complete section J.

Reemphasize with the group that numbers of high risk factors do not necessarily determine overall risk levels. We must apply our professional judgment and look at the synergistic interaction of factors as well as mitigating circumstances.

For example, a case with 15 or 20 high risk factors which has grandma moving in to care for the children may be low risk as long as grandma is in the home.

Conversely, a case with only three high risk factors—the presence of a medically fragile infant, a history of severe neglect, and excessive parental drug abuse—would signal a high risk situation for the infant.

Complete section K with the group.

TRANSITION:

This concludes our overview of systematic risk assessment. We will move now into the case planning process and examine how risk assessment drives the development of the case plan.

MODULE II

CASE PLANNING

MODULE II CASE PLANNING

INTRODUCTION

This module demonstrates how the risk assessment protocol drives the development of the case plan. Factors rated as high risk indicate those areas where work must be done to reduce danger to children. Factors rated as low risk indicate areas of potential family strength, which can be built upon to address problem areas.

The section is introduced with a discussion of why we plan and the roadblocks to planning. It examines the 10 steps to case planning and provides participants with an opportunity to apply their planning skills to case material.

FOCAL POINTS

- Reasons why planning is important
- Major roadblocks to planning
- Steps in the case planning process
- Application of case planning skills to case material

CONTENT OUTLINE

A. Why we plan in our own lives—COPE

1. Achieve **C**ontrol
2. Bring **O**rder out of chaos
3. Gain or restore **P**ower to our lives
4. Effect desired **E**nds

B. Why planning is important for clients

1. They may be out of control as evidenced by the abuse or neglect
2. They may have little order in their lives and chaos reigns
3. They may feel powerless
4. They may not have had time, energy, or opportunity to learn the skills necessary to think about goals, ends, or opportunities.

C. Rationale for case planning. Case planning:

1. Reduces likelihood of trial and error approach
2. Provides a connection between a problem and strategies for resolution
3. Means accountability
4. Provides clear communication of problems and goals
5. Is judicially mandated and documents reasonable efforts

D. Major road blocks to planning

1. Focusing on problems rather than strengths
2. Doing for rather than empowering clients
3. Labeling rather than describing behavior
4. Using vague language

E. Introduction to the steps in case planning

1. Developing a written case plan
2. Use case plan to engage clients and road map for professionals
3. Progress tool for documenting problems, client participation, goals, etc.
4. Trying to solve crises can be a barrier to developing a plan

F. Steps to case planning

1. Involve the client from the first contact
2. Explore client needs and problems
3. Explore client strengths and resources
4. Select problems to address

5. State positive objectives—SMART objectives
 - a. **S**pecific
 - b. **M**easurable
 - c. **A**chievable
 - d. **R**elevant
 - e. **T**ime limited
6. State planned actions—SMART activities
7. Adopt timetable
8. Clarify consequences
9. Negotiate other agreements
10. Sign and distribute

G. Application exercise

CONDUCTING THE SESSION

Time: 75 minutes

Materials: Resource Handbook for each participant
Computer Slides/Computer or Overheads/Projector
Slides #17-22
Projection screen
Easel stand and flip chart
Markers

TRANSITION:

We are now moving into one of the most critical phases of work with families—case planning. To introduce the topic let's think about why we plan in our own lives. Ask the group for reasons for planning in their own lives and put them on a flip chart.

Slide #17: Why Plan

Content: A. Why we plan in our own lives—**COPE**

1. Achieve **C**ontrol
2. Bring **O**rder out of chaos
3. Gain or restore **P**ower to our lives
4. Effect desired **E**nds

Demo: Use overhead or flip chart to summarize the responses of the group. Underline the C in control, O in order, P in power, and E in ends to point out that we plan in order to help us cope more successfully with our lives. Use examples from the group comments to illustrate each point.

Still using the overhead/flip chart, point out that planning may be particularly important for clients because these things may be missing in their lives.

Content: B. Why planning is important for clients

1. They may be out of control as evidenced by the abuse or neglect
2. There may be no order and chaos reigns
3. Clients may feel powerless
4. There may not have been the time or energy or opportunity to learn the skills necessary to think about goals or opportunities to effect desired ends

TRANSITION:

While the previous discussion has looked at some of the reasons why we plan in our own lives and why it might be important for clients, there are some very specific reasons for case planning in the child welfare system.

Slide #18: Rationale for Case Planning

Content: C. There are clear rationales for making an investment in the case planning process in child protective services.

1. A case plan reduces the likelihood of a trial and error approach to intervention. It has been said if you don't know where you're going, any map will do. Too often we go about providing services based on readily available resources rather than looking at the problems troubling the family, their strengths, the goals we want to achieve, and the activities necessary to achieve them.
2. Planning provides a connection between a problem and strategies for its resolution. A complete case plan describes problems, goals, intended outcomes, what behaviors will look like, when desired changes have been made, and what the various participants will do to achieve these desired outcomes.
3. Planning means accountability for clients, foster parents, social workers, and others involved. It lists who will do what and when and makes us accountable to each other.

4. A clear plan can be easily communicated. Everyone knows what we're working toward and who is to do what to get there. We can communicate with other service providers, the courts, and social workers new to the case if it is transferred.
5. Clear plans are judicially mandated by law and in regulations. They are a great help in documenting reasonable efforts.

TRANSITION:

While case planning is critical to providing services to children and families, there are some roadblocks to planning which must be addressed.

Slide #19: Roadblocks to Planning

Content: D. Major roadblocks to planning

1. There is an almost overwhelming temptation to focus on problems rather than strengths. While problems can't be ignored, to focus on them to the exclusion of family resources puts clients in a very bad place. They then feel overwhelmed, confronted, and unsupported. It feels like an attack on them and their self-esteem and leads to resistance.
2. Frequently we do for clients rather than try to empower them to do for themselves. Sometimes it is easier to just do it—to make the phone calls, to provide the transportation, to help the child with her homework, rather than helping the parent to do it. While this accomplishes the immediate task, it doesn't contribute to growth or to achieving the case goals.
3. We label rather than describe behavior. We say that this client is an alcoholic, that one is paranoid, and another is immature. These labels are pejorative, of little help in establishing goals, and easily misunderstood. They mean different things to different people and are often confusing to clients.
4. We often use vague language in our case plans. We say things like, "will improve parenting skills," or "go to counseling," or "parenting classes," without clarifying the why or the outcomes that we wanted.

TRANSITION:

With this overview of the rationale for planning in general and case planning as it applies to child protective services, we are now going to go through the steps in the case planning process.

E. Introduction to the steps in case planning¹

1. While the completion of the case plan form is a necessary step in providing services to families, the process of developing a case plan involves use of a problem-solving approach and should be differentiated from perfunctory completion of forms. Developing a case plan agreement as described below is an important process whether the goal is prevention of placement, family reunification, adoption, or another permanent plan.
2. The benefits of the use of a written case plan agreement are numerous. The case plan agreement can be a useful tool in engaging clients and serving as a road map for caseworkers, family members, and others. As a road map, it points the direction, the surest and fastest route, and helps avoid detours.
3. The plan also serves as a reference point from which to review progress. It is a tool for documenting problems, client participation, goals, services offered and provided, and efforts made and barriers to progress. The case plan also assists in supervision, as it conveys in a concise way where the family's difficulties lie and where agency service efforts should be directed.
4. Trying to solve the immediate crisis can become a barrier to taking the time to develop a complete case plan.

TRANSITION:

As we move into a discussion of the steps in case planning, it is important to recognize that they may be accomplished over a period of several interviews and may overlap. However, each step builds on prior ones and should be completed in order.

¹ Adapted from Peg Hess, ACSW, for the Indian State Department of Public Welfare Continuum of Care Child Welfare Training, 1994.

Slide #20: Steps in Case Planning

Content: F. There are 10 steps that guide the case-planning process

Step 1: Involve client from the beginning:

- a. Define agency and caseworker's role,
- b. Explain the purpose of the case plan agreement,
- c. Explain that the plan can later be changed if necessary,
- d. Explain that the case plan agreement is part of the record and progress will be monitored and evaluated, and
- e. Explain consequences; what will happen if the objectives are met and the case plan goal is reached, and what will happen if they are not.

Step 2: Develop an understanding of the client's needs/problems related to the minimum sufficient level of care and other problems perceived by the clients:

- a. With client participation, list all problems/needs, including those they perceive and those you observe.
- b. Ask for examples; clarify who perceives what as a problem.
- c. Explore the client's previous attempts to solve problems and the results.
- d. Share own observations regarding needs/ problems.
- e. Define needs/problems specifically and behaviorally.

Step 3: Understand client's strengths and resources. Find something to credit the client for and build on, such as: a sense of humor, values..., loves his/her children, is interested in..., has pride in..., has problem-solving ability (often seen as manipulation), takes responsibility for own actions, is able to maintain relationships (church, neighbors, friends), is able to discuss feelings, is healthy, openly wants to be good parent

Step 4: With clients, select 1-5 problems from among the list of problems developed (Step 2); use the following criteria:

- a. Problems which are of high priority in reaching the case plan goal, that is:
 - Meeting the child's protective needs in the home, and
 - Meeting the child's protective needs in out-of-home care while preparing the parents to meet the child's protective needs when (s)he returns home.
- b. Problems clearly and directly related to the minimum sufficient level of childcare.
- c. At least one problem that has a high likelihood of successful and speedy resolution. Success assists in encouraging, motivating, and building trust.
- d. Selecting too many problems overwhelms both clients and service providers. Deferred problems can be tackled in subsequent agreements.

Step 5: For each problem, select a positive goal for the case and objectives which contribute to goal attainment

- a. Goals and objectives are both outcome-oriented statements designed to provide direction to the intervention. A goal is a broad statement of intent (not to be confused with the agency "mission," which is to protect children while preserving families). A goal is the purpose toward which an activity or service is directed. A goal is the desired outcome.
- b. For every goal, there will probably be several objectives.
- c. Objectives are focused on results, on outcomes, on the end products we wish to see, and goals may be determined by state or local policy

Slide #21: SMART Objectives

Content: Using overhead, go over the S.M.A.R.T. (Texas Department of Protective and Regulatory Services (n.d.) criteria for objectives:

- a. **S**pecifically outcome oriented
- b. **M**easurable
- c. **A**chievable
- d. **R**elevant
- e. **T**ime limited

**Return to
Slide #20: Steps in Case Planning**

Step 6: Determine services and case management activities, which will help the client achieve the objectives, and thus reach the case plan goal.

- a. Too many caseworkers begin with this step! Services can only be useful when they clearly relate to the client's identified needs/problems, strengths/resources, and goals.
- b. Mutually identify community services and informal resources that will assist the clients in meeting identified needs and resolving problems.
- c. Spell out the case management activities in detail—who will do what, when, where, and how!
- d. Task statements focus on process—who will do what.
- e. Tasks and responsibilities for all the principals should be included.
 - Client's task and responsibilities
 - Worker's tasks and responsibilities.
 - Others' tasks and responsibilities (e.g., service providers, foster parents).
- f. Task statements should also follow the SMART guidelines. The difference is they focus on process not outcomes.

Step 7: Determine a timetable for the overall case plan agreement and for each objective. Laws and regulations usually govern the

timetable for the overall case plan agreement.

Step 8: Clarify consequences of compliance or non-compliance. Explain the consequences in greater detail using the specifics of the case.

Step 9: Discuss and include other necessary agreements, such as:

- a. Tell how the case plan agreement can be changed if needed.
- b. Review how the agreement will be monitored and how, when, and by whom it will be evaluated (e.g., the next scheduled court or administrative review).
- c. Note the parent's responsibility to maintain contact with the agency, notify the social worker of his/her current address, telephone number, etc.

Step 10: Sign and provide copies to all parties:

- a. Research has suggested that when parties sign the case plan/service agreement, the likelihood of success is increased. When parents are unable to read, assure that they understand the content of the plan.
- b. Clients may react strongly to seeing the formal written case plan/service agreement. This reaction is less likely when the clients have participated in the development of the plan and have had opportunities for reactions and questions throughout the process.

Slide #22: Risk Assessment Case Planning Worksheet

Content: G. Application Exercise

Exercise: With this background in place, we need to try to apply what we have learned to the Stoddard case

Either have participants return to their prior small groups, if they worked well, or create new ones by asking people to number off.

While recognizing that case planning is always done with the family, ask the small groups to complete the Case Planning Worksheet for the

Stoddard case. The worksheet (Handout 5) can be found at the end of this document and in the left pocket of the trainee materials packet.

Ask each small group to report their findings.

Begin by recording responses on flip charts and later transfer group consensus to the overhead (if using).

TRANSITION:

Summarize the day with a brief recap and respond to questions and concerns. Indicate that the ethnographic interviewing portion of the training will begin tomorrow morning.

MODULE III

ETHNOGRAPHIC INTERVIEWING

MODULE III

ETHNOGRAPHIC INTERVIEWING

INTRODUCTION

This module introduces the premises, principles, and concepts underlying ethnographic interviewing and guides participants in practice application. It is based on the work of James Green, James Leigh, and James Anderson, School of Social Work, the University of Washington. We are especially indebted to James Green (1995) for his work in *Cultural Awareness in the Human Services: A Multi-Ethnic Approach*.

This module examines the difficulties our society has had with the concept of culture and introduces a broader view of cultural heritage than that traditionally presented. It discusses some of the elements of culturally sensitive practice and explores the importance of language to the process. This module introduces concepts such as global questions, cover terms, and descriptors, which are critical to placing clients in the role of cultural guides to their world view. It provides opportunities for participants to practice these skills within the realm of their own experience.

FOCAL POINTS

- Our society has a difficult time with the concept of culture
- The underlying premises surrounding the concept of culture can help sort out this confusion
- The need for ethnographic interviewing
- Culturally sensitive social work practice
- The properties of words
- The role of language
- The ethnographic process

CONTENT OUTLINE

- A. Transition from risk assessment and case planning to ethnographic interviewing
 - 1. Originally, risk assessment was claimed to be culturally neutral
 - 2. That proved to be a myth
 - 3. Ethnic-group-specific work was done
 - 4. While important, it did not fully meet the need
- B. Need for ethnographic interviewing
 - 1. Our society is a pluralistic one
 - 2. A generic model is needed
 - 3. Skills can be taught
- C. Our society has a difficult time with the concept of culture
 - 1. Perpetuates the melting pot myth
 - 2. Minimizes differences
 - 3. Maximizes sameness
 - 4. Still practices all the “isms”
- D. Basic premises behind the concept of culture
 - 1. Culture is a broad concept
 - 2. Cultural differences are real and important
 - 3. A culture finds its beliefs more functional and satisfying than those of the mainstream
- E. Where does culture come from?
 - 1. Ethnicity—What's My Ethnicity? exercise
 - 2. Family transmission—Cold exercise
 - 3. Subgroup membership, adaptations, and experience—What Is Culture? exercise
 - 4. Variety and strength of subgroups—Group Strengths exercise
- F. Culturally sensitive social work practice
 - 1. Barriers to culturally sensitive social work practice
 - 2. Empathy
 - 3. Empathy within the context of culturally sensitive practice
 - 4. Components of culturally sensitive practice

G. Properties of words

1. Never say everything
2. Emphasize similarities
3. Meaning depends on who says them
4. Meaning depends on when they were said

H. Language is the primary tool of the profession of social work

1. Language constructs reality
2. Categorizes and organizes
3. Language supersedes objective reality
4. World filtered through cultural lens

I. The ethnographic process

1. Introduction
2. Ethnographic model
3. Ethnographic interview
4. Ethnographic interview practice application

CONDUCTING THE SESSION

Time: 7½ hours

Materials: Resource Handbook for each participant
Slides/Computer or Overheads/Projector
Slides #23-46
Projection screen
Easel stand and flip chart
Magic markers
Sticky dots for "What Are Our Strengths Exercise"—12 different colors
12 posters—each with a large circle for displaying sticky dots.

Content: A. Transition from risk assessment and case planning to ethnographic interviewing

With this brief overview of risk assessment and case planning, we turn now to how ethnographic interviewing can assist us with these processes.

1. The original developers of risk assessment models believed them to be culturally neutral. It was thought that the beliefs and practices of various cultural groups had no impact on risk assessment.
2. However, the phrase “culturally neutral” is an oxymoron. Everything we do, the values we carry, the language we speak, is culturally bound.

As staff began to experiment with systematic risk assessment models in the field, they came to the same conclusion and questioned whether risk assessment was culturally neutral.

- a. For example, what about the 5-year-old Native American child who has been trained and supervised in how to light and tend a ceremonial fire? Is this neglectful lack of supervision or inclusion in a cultural ritual?
- b. What about coining in the Southeast Asian community? Is this physical abuse?
- c. Does visiting the herbalist or curendero or utilizing other native healers to the exclusion of Western medicine constitute medical neglect?

- d. These and dozens of other similar cases have led us to conclude that risk assessment must be viewed through a cultural lens.
- 3. The response from the field was to develop caveats for various ethnic groups. Work was done to explore the meaning of risk in the Asian, Black, Hispanic, and Native American cultures.
- 4. However, this work, good as it was, did not fully meet the need, especially for staff working in culturally diverse communities.

It was the need for risk assessment to be conducted in a culturally sensitive and responsive manner that led to the development of this curriculum.

Slide #23: Need for Ethnographic Interviewing

Content: B. Need for Ethnographic Interviewing

- 1. The U.S. is not a melting pot, but can be more accurately defined as a pluralistic society.
 - a. For example, an anthropologist identified over 70 practicing ethnic groups in California's San Joaquin Valley.
 - b. If you ask any group of trainees in a metropolitan area to list out the different ethnic groups that comprise their caseloads, the list will quickly grow to 30 or 40.
 - c. In one regional office in Los Angeles, there were 51 different languages and dialects spoken by clients.
 - d. Add to that the other dimensions of culture, such as geography, religion, and socioeconomic status, and the combinations become infinite.
- 2. A generic model is needed.
 - a. While the ethnic-group-specific work that has been done is extremely valuable, it does not fully meet the need for workers dealing with a multicultural population.
 - b. This work has provided many valuable insights and made it

impossible to perpetuate the myth that risk assessment is culturally neutral.

- c. In diverse areas such as Los Angeles, or even California as a whole, there are three problems with application of ethnic-specific information to risk assessment.
 - Looking at ethnicity alone represents too narrow a view of culture.
 - Workers with diverse caseloads couldn't possibly master 20 or 30 sets of ethnic-group-specific generalizations.
 - Ethnic-specific models, dependent as they are on generalizations pertaining to certain groups of people, may not be helpful in grasping the cultural beliefs and practices of individual families. Indeed, they may lead workers to make assumptions about an individual family, which while true for the aggregate, have little meaning for the family in question.
3. Ethnographic interviewing is a generic approach that will help workers understand a wide variety of cultural differences. These interviewing skills that influence the overall evaluation of risk can be isolated and taught.

The central theme of ethnographic interviewing is to recognize that the culture of each family is unique and the key to their uniqueness is to allow the family to become our cultural guide to its view of the world and how family members see themselves in that world.

C. Our society has had a difficult time with the concept of culture

1. We try to perpetuate the myth of the melting pot. We try to tell ourselves that ours "is a society without the disruptive divisions of class, caste, or provincial interests that plague people and governments in other parts of the world" (Green, 1995).
2. We have great difficulty with the concept of difference and cannot seem to value it for its own sake, for the richness and variety that it brings into our lives.
3. We continue to believe that under the skin we are all essentially the same, wanting and seeking similar goals. In this context, ethnic, racial, and regional differences become nuances of only minor

significance to the common ground we all share as Americans (Green, 1995). These mistaken beliefs lead us to ignore the very fundamental differences that people of different cultural backgrounds bring into the social arena.

4. In spite of these efforts at normalization and universalization, we still practice racism, sexism, ageism, and all the other “isms” on both personal and institutional levels.

Slide #24: Basic Premises of Culture

Content: D. Basic premises behind the concept of culture

If we are to work our way through the maze of myths about cultures and the paradox between belief systems and behaviors, we need to consider three basic premises:

1. Culture is a broad concept--
 - a. Culture encompasses not only racial and ethnic elements, but also such things as geography, career choice, religion, and sexual preference. We all have a culture.
 - b. Culture does not come from one subgroup association but rather from a broad cross-section of group associations. As such, culture is individualized in its presentation.
2. Cultural differences are real and some of them are fundamental to our world view, our goals and aspirations, and our help and support-seeking behaviors.
 - a. A song from the Temptations talks of "the way we do the things we do" and in each culture we do things differently. We celebrate different holidays or the same ones in different ways. We favor different foods, music, and sources of entertainment. We have different ideas about childrearing, the roles of men and women, and the place of the elderly in society.
 - b. These differences are real and important and strongly influence the ways in which we live our lives.
3. The beliefs and practices of people of color, of Jews and other persecuted religious groups, of gay men and lesbians, the disabled, and a wide variety of other oppressed groups may differ from the

majority culture, not just because of oppression or prejudice or exclusion, but because we find our ways of being in the world more satisfying, more fulfilling, than the ways of the so-called mainstream. We like doing things the way we do them.

TRANSITION:

Before addressing the ethnographic interviewing model, we will participate in a series of exercises that demonstrate some of the properties of culture.

Note to Trainer: the following exercises lead participants through four different aspects of the development of culture:

- Ethnicity
- Family (transmission and adaptation)
- Subgroup membership
- Variety and strengths of subgroup membership

E. Where does culture come from?

1. Ethnicity

One of the major associations we have with culture is ethnicity. Although we understand that not everyone in a particular ethnic group is the same, we make some immediate, unconscious decisions about an individual based on what we believe is their ethnic identity.

Exercise: What Is My Ethnicity?

Ask participant to guess your ethnicity.

Record their responses on the flip chart.

Invite participants to ask 4 or 5 questions that may clarify their thinking (Where were you born? What holidays did you celebrate growing up? How were older family members treated? How many siblings do you have?).

You may want your co-trainer to ask the first question. If training alone, give one piece of information.

Ask the group for consensus on your ethnicity.

Describe your background to the group.

If your ethnicity holds no surprises, you may want participants to guess your college major, or the size of your family, or make some other judgment about you based on just seeing you.

What did this exercise show about first impressions and how we get to know each other and what misconceptions we may arrive at?

TRANSITION:

With this individual view of ethnicity, we look now at how the family influences our culture.

2. Family

Exercise: The Cold

Think back to your childhood. What did your parent or caretaker do for you when you had a cold? What were the remedies in your household?

a. Record the group responses on a flip chart.

The group will want to have fun with this. Let them. Feel free to add in a couple examples of your own. (Vicks and a cloth on the chest, honey with tea or whiskey, a vaporizer, soup, herbs tied on the forehead, etc.).

b. Once everyone who wants to share has had an opportunity, ask the group, "How many of you still use some of these remedies when someone in your family has a cold?" And then, "How many of you do some other things as well?"

POINTS TO BE MADE

- Since there is no known cure for a cold, what we've been talking about represents a culturally transmitted solution to a health problem.
- Our responses showed both similarities and differences.
- That we still do some of the things our parents did demonstrates, in microcosm, how culture is transmitted.

- That we also do some things differently shows how learned cultural responses may be altered, erased, or reinforced by education, life experience, or new associations.

TRANSITION:

With this introduction to the role of family to cultural, let us move now to the influences of sub-group identification.

3. Subgroups

SLIDE #25: Culture

Culture represents "Those sets of shared views and adaptive behaviors derived from simultaneous membership in a variety of (social) contexts" (Celia Joes Falicov by kind permission of the Institute of Human Services, Columbus, Ohio).

- a. To get at this concept in more detail, ask for a participant to assist you. Ask someone who appears comfortable with themselves and differs from you in an obvious way (sex, ethnicity, age, etc.).
- b. Ask the group what social contexts you and this person may share and record these on the arrows on the overhead (e.g., both social workers, both tall, same age or sex, live in same city).
- c. Then explore some similarities the group didn't mention (you'll need to ask for information from your volunteer). Are you both parents (involved in soccer, PTA, scouts), married, of same religion, wearing glasses? Gently explore some areas you may have in common while respecting the comfort level of the volunteer in sharing personal information.

POINTS TO BE MADE

- Culture is not something that the other "has" such as a specific value or a physical appearance, but is rather the "perspective" that guides our behavior.

- Culture and ethnicity are not essential or innate properties of persons. They are the meanings people act on in a specific relationship, no matter how brief the encounter.
- It is not so much about who we are in the world (i.e., young, black male or elderly, white female), but much more about how we are in the world.
- This emphasis on relational rather than essentialistic aspects of culture may be the only useful way to think about cultural differences in a complex, pluralistic society such as our own.

TRANSITION:

We each have adaptive behaviors we have developed as a result of membership in various social contexts. Now we'll look at the strengths we bring to any group as a result of just a few of these subgroup identifications.

Exercise:

4. Group Strengths Exercise

We now want to examine the strengths that we share by virtue of our subgroup identifications.

- Post circles labeled with the various subgroup names around the room, allowing space for people to group near each poster.
- Ask all the men to gather near the circle labeled "men" and the women near the circle labeled "women." Since we all share the same work focus (families and children), ask each group to discuss and select one strength (although there are many) that their group brings to the work place by virtue of their membership in this subgroup. (Women will often say "sensitivity" or "nurturing" and men frequently select "male role model" or "orderliness").
- Give each man five sticky dots of one color and each woman five sticky dots of another color.
- Have each subgroup report out their selected strength and record it.
- Ask the participants to place one of their dots on the appropriate flip chart that you have posted (see diagram on page 47).

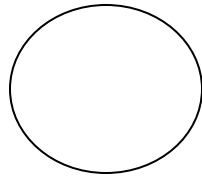
- Now ask participants to regroup based on whether they grew up in an urban, suburban, or rural environment and select the strength that their group brings to the work place.
- Give each participant four sticky dots (a different color to each group).
- Ask the participants to place one dot of each color they have (e.g., one for sex, one for where they grew up) in the circle.
- Record the strength for each group.
- Repeat this process for age and ethnicity.

POINTS TO BE MADE

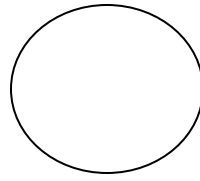
- Ask participants to place the remaining one dot of each color on their name tents.
- Then ask them to look around the room. Does anyone else have the same combination of colored dots? If so, form groups of same combinations.
- Ask follow-up questions until all groups are dissolved.
- While most of us have some things in common with each other, our individualized presentations of strength are quite unique.
- Walk by the posted charts and note how the circles change as more sub-groups are added.
- Ask the group what they see by looking the series of circles.
- Point out that as we add each new social context, the circles become more diverse and the strengths represented by the colors more varied.

TRANSITION:

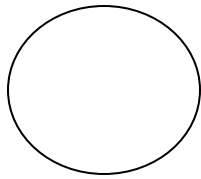
With this overview of culture and some of its origins in mind, we will move to look at culturally sensitive social work practice.



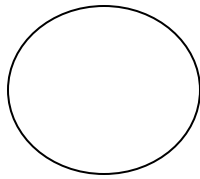
MALE



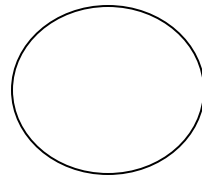
FEMALE



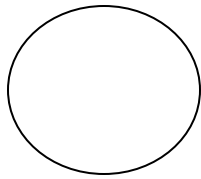
RURAL



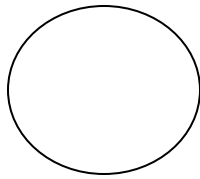
SUBURBAN



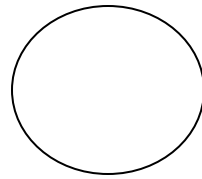
URBAN/CITY



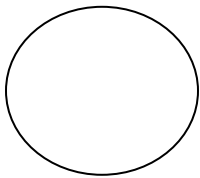
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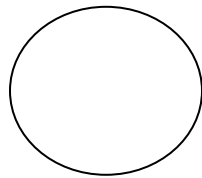
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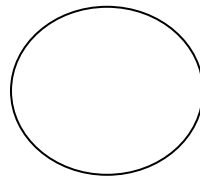
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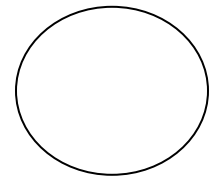
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LATINO/A



ASIAN



OTHER

F. Culturally Sensitive Social Work Practice

While much attention is currently being given to culturally sensitive practice, it is not an easy goal to achieve. There are five barriers to a culturally sensitive approach.

Slide #26: Barriers to Culturally Sensitive Social Work Practice

Content:

1. Barriers to culturally sensitive social work practice
 - a. Many workers know little about the cultural characteristics and practices of the clients they serve. We have relied on media coverage, research studies, or testimonials of minority group representatives for information about ethnic groups.
 - Each of these sources is flawed.
 - Media representations tend to reflect generalized biases. The media tells us what we want to hear.
 - Research studies focus on the aggregate, not individual family groupings or members.
 - Representatives of minority groups can only give us their personal view of what it's like to be poor or gay or Hispanic or disabled; they cannot speak for the group.
 - For well-meaning social workers who are striving for cultural sensitivity, the best source of information is always the client.
 - b. Problem solving with clients who are culturally different from us can be stressful and frustrating.
 - We want to be sensitive and treat clients appropriately.
 - Our ignorance may paralyze us or lead us to behaving in very insensitive ways.
 - c. A colleague was involved in recruiting Orthodox Jewish foster homes in Los Angeles County. She is Catholic and obviously not familiar with all the issues in the Orthodox community. She established a liaison with the director of the community's counseling program and with him planned a recruitment meeting

that was widely publicized in the community. The colleague did everything she could to make the meeting, and the recruitment effort, a success. She had guest speakers, a representative from state foster home licensing, and she had received permission to modify both fingerprinting and CPR training procedures so there would be no conflict with Orthodox law. She arrived early on the night of the recruitment meeting and welcomed each couple with a hearty handshake, a smile, and thanks for attending the meeting. Unfortunately, in the Orthodox community, men are forbidden to touch women other than their wife. Within the first 15 minutes, this colleague had violated Orthodox law with every man in the room—certainly not an auspicious beginning! Although she wanted to be sensitive to this community, her ignorance led her to be quite insensitive.

- d. Do any members of the group have similar stories?
- e. Institutional forms of insensitivity and discrimination exist.
 - Much of the American legal structure and the institutions that it supports are grounded in the British traditions of the first wave of immigrants.
 - White male thinking still dominates policy-making bodies on national, state, and local levels.
 - While public policy and institutions do change, overcoming the inertia of tradition is a slow and agonizing process.
- f. Social workers have a language all their own; one of power, authority, and exclusiveness.
 - The language of social workers is often esoteric and jargonistic, a ritual unique to a professional culture which protects professional turf, gives us pretensions to specialized knowledge, and fosters the assertion of authority over clients.
 - How we talk and think about a client affects our behavior toward them. Jargon that presumes professional expertise maintains our power differential and denies an equal place to the client's voice in the interview. Because of this, social workers should be self-conscious about the language they use.

- Similarly, client language defines boundaries, conceals “insider” information, and helps preserve a sense of specialness and dignity.
- g. One of our traditional clinical methods of “helping” is Carl Rogers’ person-centered theory of counseling.
- This model emphasizes self-awareness, self-esteem, and acceptance.
 - By adopting Rogerian theory as a way to interact with clients, we presume that these cultural values are the best, or at least preferred, values.
 - This “theoretical ethnocentrism” ignores the fact that many communities value the welfare of the group—family, kin, ethnic or linguistic compatriots—as more important than the welfare of the individual.
 - Other paradigms, such as the concept of self-determination or independence, are valued by social workers as desirable behavior for their clients, even if that behavior is not valued, or is the exact opposite of a valued behavior, in a specific community.
 - For example, Americans tend to value individualism and see standing out from the crowd as desirable, while an old Japanese proverb states, “The nail that stands up gets hit hard.”

2. Empathy

- a. We have learned, through education and experience, that social workers must develop rapport and empathic relationships with their clients if they are to be helpful.

Slide #27: Effective Communication Goals

- Content:**
- b. The goals of training social workers in effective intervention skills generally include:
- Empathic understanding that results from putting oneself in the other's place.

- Warmth and unconditional positive regard for the other.
 - Genuineness in the therapeutic relationship—what one seems is what one is.
- c. The drawback is in believing that these are specific techniques that can be utilized at certain times with clients in order to help them. Empathy should not be viewed as a technique but rather one of the ways in which effective professionals deal with others all the time.

Slide #28: Counterfeits of Accurate Empathy

Content:

- d. Simplistic application of these communication goals during a client interview may produce "counterfeits of accurate empathy."
- Inaccurate responses to the client because the social worker is excessively focused on technique.
 - Inattentiveness because the social worker is mentally planning ahead what to say next, rather than listening to the client.
 - Assumption made that the client will understand the worker's validating gestures and affirming "uh huhs."
 - Restatement of what the client has said may look like the worker has nothing to say and is just repeating the client's conversation.
- e. To avoid counterfeit empathy, we must look for the core messages in what the client is saying. Strategies of empathy are inadequate in comprehending either what is troubling a person or knowing how they can be helped. We need a way to identify and learn the significance of our clients' core messages—especially with clients whose cultural background we know little about.

Slide #29: Empathy

Content: 3. Empathy and cultural sensitivity

- a. Empathy, as we have described it, is a communication event. It includes effective communication and common understanding with people from different cultural backgrounds.
- b. For ethnographic interviewing, the model of empathy adopted by Roger Squire is most useful. It puts forth that empathy has two components.
 - Perspective taking—the worker shows both a willingness and ability to hear the client's understanding of his or her needs. It is primarily information gathering. But it also includes validating that the client has been heard and his or her input is vital in developing a case plan.
 - Affective responsiveness is the feeling tone associated with this information exchange. The worker shows genuine interest in the words and thoughts the client expresses—the seriousness one shows to what the client is saying is the core of empathy. Empathy is seen as a specific communication event, not an emotional engagement.

Slide #30: Affective Responsiveness

- ### **Content:**
- c. The difference between the traditional model of empathy and the Squire's model is the amount of emphasis placed on communication and emotional engagement.
 - Empathy is typically viewed as a focus on feelings:
 - The worker's intent is an urge to emotional engagement,
 - This expression of feelings is seen as a natural human event, and
 - The focus is on emotional expressions, how the client is feeling about his/her situation.

- Squire's view of empathy is that the major focus should be placed on the words that the client says.
 - The expression of empathy is a communication event in which the client is assured that his/her words are heard.
 - It is a cultural experience in that the worker is attempting to fathom the client's world view.
 - The purpose is to filter out core messages which the client is trying to express; those things that are critical to the client's life.

The following demonstration shows how each model might be applied.

Demo: Empathy Demonstration

Note to trainers: This dramatization is designed to be delivered ad lib by the co-trainers. The script below is just a suggestion.

Vignette I

SW: "Hello, I'm _____ from the Department of Social Services and we've heard that there's been some trouble here with your daughter."

Client: "Yes, there's been trouble with Chris, that's our daughter, she totally out of control. Her father/mother and I are at our wits-end. She's been staying out to all hours and threatening to run away. We've locked her in her room but she just gets out after we're asleep. I even tried to beat some sense into her, but she just cursed at me."

SW: "It sounds as though you're feeling pretty upset about this."

Client: "Upset doesn't even come close, I feel like I'm going crazy. I just don't know what to do anymore."

SW: "I can see that you're really having a hard time with this."

Client: "Yes, my feelings are all over the place. I'm angry and hurt. We've always been a close family, but now everything seems to be falling apart."

D&P: This much dialogue should serve to demonstrate that while the classic approach accesses the parent's feeling, you have learned little about the daughter or how the current situation developed.

The second dramatization, which applies empathy quite differently, illustrates a very different result.

Demo: ***Vignette II***

SW: "Hello, I'm _____ with the Department of Social Services and we've heard that there's been some trouble here with your daughter.

Client: "Yes, there's been trouble with Chris, that's our daughter. She's totally out of control. Her father/mother and I are at our wits-end. She's been staying out to all hours and threatening to run away. We've locked her in her room but she just gets out after we're asleep. I even tried to beat some sense into her but she just cursed at me."

SW: "What's it like for you when someone in your family is out of control?"

Client: "It's horrible. We've always been a close family but now everyone's upset. She screams at her younger brother and sister and they don't know what to do because she is so different. My husband/wife and I are both so upset, we don't have any patience with them or each other."

SW: "You say Chris is different. Did something happen or was there some change that seemed to effect Chris?"

Client: "Well about 4 months ago she started getting serious about this boy Michael. He's 19 and much too old for her and that's when all the trouble started."

SW: "What does it mean for you when you say Chris started to get serious about Michael?"

Client: "Well, I know they're having sex because I caught them, right here in our home. I haven't told my husband/wife, he/she would just die if he/she knew. You must not tell him/her."

D&P: This should be enough dialogue to demonstrate that this approach has elicited far more information than the former, information that provides significant clues about the needed intervention.

Slide #31: Components of Culturally Sensitive Social Work Practice

Content: 4. Culturally sensitive practice requires that social workers acquire and develop at least five basic skills.

1. Awareness of self-limitations—each of us is culturally bound to our own subgroup identifications including those of the social work profession and the agency for which we work. Practicing in a culturally sensitive way may require us to rely less on our degrees, educational background, or professional expertise and power and more on our clients as a source of information and solutions.
2. Openness to cultural differences—a genuine and open appreciation of cultural differences, without condescension and without patronizing gestures is critical for the development of a culturally sensitive professional style.
 - Clients are the lenses through which our helping behaviors must be filtered.
 - Their individualized strengths are the source of the solution.
- c. Willingness to be taught by clients—while people in our business are here because we want to help, we tend to believe that we can do that best by instructing or counseling or advising or any number of other dominant roles.
 - To be helpful in a culturally sensitive context we need to be willing to be taught by clients about their situations, their world views, and their help-seeking behaviors and resources.
 - Culturally sensitive practice depends on the assumption that clients, no matter how plagued by personal problems or uncertainties, know a great deal about what is happening to them.

- d. Openness to the utilization of cultural resources—if you ask a group of child welfare workers to make a list of available community resources, you may get mental health, public health, law enforcement, drug and alcohol treatment, parenting classes, and schools.
 - Help clients draw on the natural strengths inherent in their own traditions and communities, reducing when possible their dependence on services provided by outsiders and impersonal bureaucrats.
 - The more numerous and strong the subgroup affiliations of the individual client, the more likely it is that these informal networks can be of assistance in addressing the problem.
- e. Acknowledgment of cultural integrity—in the context of culturally sensitive practice, cultural integrity does not mean that a cultural group has been unaffected by the pressures of assimilation, technological change, geographical moves, or any other number of other factors.
 - Throughout history groups have expanded their cultural repertoire to adapt to changing situations.
 - Subgroups continually expand their cultural repertoire to adapt to changing situations, or as they come in contact with other cultures and subgroups.
 - These adaptations are often incredibly creative and complex. To acknowledge that fact is to recognize the integrity and capability inherent in the traditions and values of a particular cultural group.
 - All immigrant and uprooted groups have faced these challenges and made their own kinds of required adaptations.

Exercise: Professor Exercise (Handout 6)

Because time is required to tally the responses for this exercise it should be completed prior to lunch, but debriefed following the objective reality section of the discussion on language. Explain this to the participants.

Because half of the participants receive one version of the professor exercise and the other half a different version, this exercise is given out as a handout and is not included in the participant materials.

Both versions of the form follow.

Give Version 1 of the professor exercise to half of the group and Version 2 to the other half. Do not let participants know there is any difference.

Ask participants to complete the exercise and turn it in.

ASSESSING THE PROFESSOR (Version 1)

INTRODUCTION: Dr. Nielson is a Professor of Social Work at a local college. His primary interest is in the relationship and application of social work belief systems to a variety of contemporary issues in society. He has taught for over 10 years at two different institutions. He is now 35 years old, married, and has three children and a black Labrador Retriever. His friends describe him as industrious, warm, critical, practical, and determined. He likes to read, take walks, and attend plays.

DIRECTIONS: To the best of your ability, evaluate Dr. Nielson on the following characteristics by circling the appropriate number for each quality.

Knows his stuff	1	2	3	4	5	6	7	Doesn't know his stuff
Considerate of others	1	2	3	4	5	6	7	Self-centered
Modest	1	2	3	4	5	6	7	Proud
Sociable	1	2	3	4	5	6	7	Unsociable
Self-assured	1	2	3	4	5	6	7	Uncertain of himself
Generous	1	2	3	4	5	6	7	Ungenerous
Warm	1	2	3	4	5	6	7	Cold
Humorous	1	2	3	4	5	6	7	Humorless

ASSESSING THE PROFESSOR (Version 2)

INTRODUCTION: Dr. Nielson is a Professor of Social Work at a local college. His primary interest is in the relationship and application of social work belief systems to a variety of contemporary issues in society. He has taught for over 10 years at two different institutions. He is now 35 years old, married, and has three children and a black Labrador Retriever. His friends describe him as industrious, cold, critical, practical, and determined. He likes to read, take walks, and attend plays.

DIRECTIONS: To the best of your ability, evaluate Dr. Nielson on the following characteristics by circling the appropriate number for each quality.

Knows his stuff	1	2	3	4	5	6	7	Doesn't know his stuff
Considerate of others	1	2	3	4	5	6	7	Self-centered
Modest	1	2	3	4	5	6	7	Proud
Sociable	1	2	3	4	5	6	7	Unsociable
Self-assured	1	2	3	4	5	6	7	Uncertain of himself
Generous	1	2	3	4	5	6	7	Ungenerous
Warm	1	2	3	4	5	6	7	Cold
Humorous	1	2	3	4	5	6	7	Humorless

Content: G. Properties of Words

When we discussed empathy and culturally sensitive practice, we noted the importance of the words we use. Let's take a look now at the general properties of words.

Slide #32: Properties of Words

1. Words never say everything.
2. Emphasize similarities rather than differences.

3. Have different meanings depending on who says them.
4. Have different meanings depending on when they are said.

To illustrate these properties of words we are going to do a few simple exercises.

Slide #33: What Is a Chair?

Exercise: This exercise illustrates the first two properties that words never say everything and that words stress similarities rather than differences.

Ask the group to define the word chair (a seat, typically having four legs and a back for one person—[Websters]).

Record their definition on a flip chart.

Ask the group to pick out the chairs in the overhead.

Why isn't the desk a chair—you could sit on it.

Why isn't the bed a chair—you could sit on it.

How about the balloon and the tack?

Do we want to change our definition in any way?

We generally understand what is meant by the word chair and can pick out the chairs in the overhead.

However, the word doesn't tell us everything, for example, how it would be used, in what room you would be likely to find it, and so on.

The word chair stresses similarities not the differences between the many types of chairs.

Return to Slide #32: Properties of Words

Exercise: Who Said It?

The meaning of words depends on who says them.

Ask the group what would I want if I asked you, "Where could I get a lift?" (A ride)

What would a Londoner want if they asked the same question? (An elevator)

If I said to you, "Boy am I pissed," what would I mean? (I am angry)

If a New Zealander said the same thing, what would it mean? (I'm drunk)

Exercise: When Was It Said?

Ask the group what the word lozenge means.

Record their definition on a flip chart.

On the same flip chart record the history of the meaning of the word.

- A saying, an adage
- Became a diamond-shaped (<>) inscription on a tombstone.
- Someone made a diamond-shaped cough drop and it became a lozenge.
- Now any cough drop is a lozenge.

Given the properties of words, not exploring their meaning with the clients can lead us to make critical mistakes.

For example, say we are talking with a client about her extended family in order to discover sources of support for an overwhelmed single mom. At one point the client says, "I really favor my Aunt Jean." Given our goal of developing a support base, we may jump to the conclusion that the client really likes Aunt Jean and she may be just what's needed. We call Aunt Jean and set up a meeting with the client and it's a disaster. They argue and fight the whole time.

If we had followed the principles of ethnographic interviewing and tried to get the client's meaning this could have been avoided. For example, the client says, "I really favor my Aunt Jean." The worker replies, "Oh, you and your Aunt Jean have a good relationship." The client responds, "No, we fight like cats and dogs, maybe because we look so much alike."

H. Language

Language (made up of words) is the primary tool of social workers. It is through language that we perform our helping and change agent functions. We've also seen that how we use language is a major factor in culturally sensitive practice. Let's look at why our conscious use of language is so important.

Slide #34: Language is a Tool for Constructing Reality

- Content:**
1. Language gives us the ability to think about, describe, and define our reality. We learn about the world around us (our reality) through language, and the words used in our language frame our reality for us. Because we think in a language, we perceive and construct reality differently.
 - a. For example; if I were in the kitchen and dropped a glass and broke it, I would say, "I dropped the glass and broke it." In some other languages the same event would be described by saying, "the glass fell and broke." Could this reflect the tendency of speakers of English to assign individual responsibility for events, to put the blame somewhere?
 - b. After taking years of French in high school and college, a student was shocked when the professor said that a French preschooler had a more extensive vocabulary and a better command of the language than she did after years of study. That child is learning the world through language; the student was learning to translate her world into French.
 - c. People who speak different languages are describing different social realities.

Slide #35: Language

- Content:**
2. As a constructor of reality, language helps us to organize and categorize perceptions of our world. Probing the meanings of these organizational systems is a means of accessing the client's culture, their world view, and the way in which they see themselves within it. Some examples may help to clarify this point.

- a. Tribes of Native Americans who were nomadic grounded their language in geographic terms. Sentences would be preceded with "up north", or "by the big river" or "in the mountains to the east." Where the tribe was communicated a lot. For example, the season of the year, the activities of the tribe, and what holidays were being celebrated.
- b. Eskimos who live much of the year in the cold have over 50 words for snow. The words describe snow that differs in texture, rate of falling, moisture content, etc. These differences may have little or no meaning for those of us who occasionally see snow, but for people whose lives revolve around snow, these differences are crucial and need to be communicated specifically.
- c. Because language is so critical to our perceptions of reality and so important to the way in which we organize and categorize our lives, certain other characteristics of language emerge.

Slide #36: Language

- 3. Language is so powerful that the name of something, regardless of objective reality, influences our behavior. We pay more attention to what we call something than to what we know to be so.
 - a. Jim Green relates an incident when employees worked around gasoline storage drums that were labeled full or empty. While they were very careful about not smoking or striking matches around the drums labeled full, they paid no attention to safety around the drums labeled empty. The power of words overcame their knowledge that the fumes in the empty tanks were as dangerous as those in the full ones.

Slide #37: Assessing the Professor Exercise

D&P:

- b. Assessing the Professor exercise

It is at this point that the Assessing the Professor exercise should be debriefed.

Post a flip chart sheet or show Overhead 37 filled out with the average scores of group 1 (warm) and group 2 (cold) already completed.

Ask the group what they observe about the scores. Group 1 scores should be uniformly lower (more favorable) than Group 2.

Point out that the only difference between the descriptions was the word "warm or cold."

What does this tell us about the power of words?

While the description of the professor answered none of the questions directly, except for the one labeled warm or cold, that one word shift clearly influenced all of your other judgments.

Imagine how the words we use to describe clients can impact on their own and others' views of them. For example, if we see clients as hostile, how does that impact the way in which we view their other characteristics?

Slide #38: Language

4. The world is not objectively known, but is filtered through a cultural lens.
 - a. Even speakers with a shared language and vocabulary may mean very different things using the same words. They may experience very different mental images from hearing the same statements and may perceive the same incident in very different ways.

A college student invites her mother to dinner saying, "Oh, Mom we'll have a real feast."

The mother imagines prime rib, fresh asparagus, and a baked potato and eagerly accepts. The "feast" turns out to be a pot of grayish unidentifiable vegetables served over brown rice by a new and inexperienced vegetarian. The mother and daughter had very different mental images of what constitutes a "feast".

- b. Semantic labels are also part of the reality-defining process.

A client receives an unexpected \$50.00 and spends the money to throw a party. The social worker may label this as the client's "inability to defer gratification" thereby implying a host of judgments. In reality, the client may figure it's best to use the money today since tomorrow is as uncertain as yesterday.

TRANSITION:

With this background, let's turn now to the ethnographic interview.

I. The Ethnographic Process

Content: 1. Introduction

The interview is "the most consistently and frequently employed social work technique" (Kadushin, 1972). In the interview, social workers gather data about the client, the problem, and possible solutions by asking questions. The critical issue is asking the right questions.

Slide #39: Does Your Dog Bite?

There is a funny scene in the Pink Panther movie with Peter Sellers as Inspector Clouseau. He goes into an inn in the French countryside; he sees a cute little dog. Before he pets it, he asks the innkeeper, "Does your dog bite?" The Innkeeper replies, "No, he doesn't." The Inspector reaches down, pets the dog and...the dog bites him! Inspector Clouseau yells at the innkeeper, "I thought you said your dog doesn't bite." "He doesn't," says the innkeeper. "That's not my dog."

This is a humorous way of pointing out that we need to make sure we are asking the right question. We may be gathering information that is not accurate if we aren't asking the right questions and using language that is meaningful to the client.

TRANSITION:

One way of helping us to ask the right questions is to utilize the elements of ethnographic interviewing.

Slide #40 The Ethnographic Model

2. The Ethnographic Model

- a. The overall goal of applying the ethnographic process is to help us to understand and appreciate the experiences and world views of people who differ from us.
- b. When applied to social work practice, it helps us get a description of the problem from the client's point of view.
- c. The easiest way to truly understand another experience is to invite the client to become your cultural guide to their world view.
- d. We believe that if the model is applied correctly it will result in:
 - An equalization of power between worker and client,
 - A more accurate assessment of risk that includes the client's views, and
 - Case plans which are more culturally congruent, make more sense to the client, and are more likely to be accomplished resulting in reduced risk to children.

Slide #41: Ethnographic Interview

3. Ethnographic Interview (Handout 7)

- a. There are three concepts that are fundamental to the ethnographic approach:
 - Global questions.
 - Cover Terms
 - Descriptors

Slide #42: Global Question

- Content:**
- b. Global questions are generally open-ended questions that focus on some client's life or experience which you find puzzling.
 - They are general in nature so that they allow clients to proceed as they see fit.
 - They are planned in advance to the extent that is feasible, although global questions may arise spontaneously during the course of an interview.
 - Global questions are used to open an interview, and convey the message that we are interested in the client and his/her views and experience.

Slide #43: Examples of Global Questions

Demo: Read through the examples with the group.

Ask them for other examples.

Slide #44: Cover Terms

- c. Cover terms are shorthand ways of communicating ideas and concepts that may be complex and culturally specific.
 - When doing an ethnographic interview we usually write down cover terms verbatim.
 - It is not our job to interpret or diagnose them, but rather to ask the client for interpretation.
 - Examples. Without further information about such terms as "going to get it" and "home based" we may have different ideas of what is meant.

Slide #45: Descriptors

Content: d. Descriptors are the words used by clients to describe the cover terms they use. They give outsiders an insider's view by describing what actually happened, how it was done, under what circumstances, and the feelings it evoked.

Demo: Demonstration of an Ethnographic Interview

The purpose of this exercise is for the co-trainers to demonstrate how an ethnographic interview might proceed.

Return to the "What Is My Ethnicity" Exercise (page 42).

Have the co-trainer who was not the object of this exercise ask a global question related to the information revealed during this experience.

Before your co-trainer responds to the global question ask the group to record cover terms that are mentioned.

Ask the group to share the cover terms they observed.

Record these on a flip chart.

Ask the group to select the one cover term they would like to explore.

Have the group discuss what they think that cover term might mean.

Ask your co-trainer to explain what it really means.

POINTS TO BE MADE

Many cover terms emerged during just a brief interchange.

Each term could mean a variety of things.

Without clarification we make erroneous assumptions and judgments.

4. Ethnographic Interview Practice Application

Exercise: a. Ethnographic Interview

Ask the group to pair up, preferably with a person they do not know well.

Ask trainees to go to The Ethnographic Interview I (Handout 7, page 2) and review it including the directions and questions.

Allow each dyad about 20 minutes to conduct their interviews with each other. Have the partners switch roles after 10 minutes.

POINTS TO BE MADE

Ask the group to share their experiences, with the permission of their partners.

Ask them to share any global questions, cover terms, or descriptors that were particularly helpful or illuminating.

Discuss how this type of interviewing may be helpful in working with their clients.

Slide #46: Summary

- Content:**
- e. In the context of child protective services, ethnographic interviewing skills can be used to:
 - Engage and empower clients in the risk assessment process,
 - Get feedback from the family on their views about the things that place the child at risk, and
 - Develop culturally congruent case plans that specify the means to change behavior that places a child at risk; that make sense to the client; and fit, whenever possible, with their help-seeking behaviors.

- Exercise:**
- f. Ethnographic Interview—Problem Focused

Ask the group to form new pairs.

Instruct them to remove The Ethnographic Interview II (Handout 7, page 3) and review it including instructions and questions.

Allow each dyad about 20 minutes to conduct their interviews with each other, have partners switch roles after 10 minutes.

POINTS TO BE MADE

Ask the group to share their interviewing experiences with the permission of their partners.

What global questions, cover terms, or descriptors were used that helped the process along?

Discuss how this type of interviewing may be helpful in working with their clients.

TRANSITION:

We have all had some experience now with the ethnographic interviewing process and how it works from both interviewer and interviewee perspectives. Now we want to move to how this process operates within the risk assessment and case planning activities of the child welfare worker.

MODULE IV

APPLICATION

MODULE IV APPLICATION

INTRODUCTION

This module gives participants an opportunity to jointly apply the concepts of systematic risk assessment and ethnographic interviewing. Because the ethnographic process is dependent upon our own experience and world view, traditional training techniques, such as role plays or use of case material, are not appropriate.

Consequently, this module is dependent upon simulated techniques. Participants are divided in half and each group is taught a fabricated culture and then given an opportunity to interview each other around a child abuse complaint. Interviewers always act as their real, social worker selves and complete a risk assessment protocol. A second interview is also conducted to check out the parents' view of risks and strengths and to begin work on a case plan.

FOCAL POINTS

- Application of the techniques of ethnographic interviewing to systematic risk assessment
- Application of the techniques of ethnographic interviewing to case planning

CONTENT OUTLINE

- A. Explaining the rationale for this module
- B. VISAS: An Interviewing Guide
 - 1. Values
 - 2. Interactions
 - 3. Social contexts
 - 4. Aims of child rearing
 - 5. Strengths
- C. Learn and practice an alternative culture
 - 1. Aldoonian
 - 2. Omkazian
- D. Exercise: Application of Ethnographic Interviewing to Risk Assessment
- E. Evaluate and Separate

CONDUCTING THE SESSION

Time: 5 Hours

Materials: Resource handbook for each participant
Slides/Computer or Overheads/Projector
Slide #47
Projection screen
Easel stand and flip chart
Markers
Omkazian (1/2 of the group) and Aldoonian (1/2 of the group) cultural summaries, referrals, and client information
Risk assessment protocols (1 per participant)
Case planning form (1 per participant)
Evaluation form (1 per participant)

Content: A. Explain the rationale for this module

1. Point out that the remainder of the training will focus on applying the principles of ethnographic interviewing to the risk assessment and case planning process.
2. As you have observed during the first two ethnographic interviews in which you have participated, the success of the model depends on being able to tap the real experiences, values, and world view of the interviewee.
3. As a consequence, typical training techniques, like the use of case material and regular role playing, will not work as well as usual.
4. Therefore, we are going to teach you a new culture and allow you to practice it in order to internalize its values and practices into your own experiences.
5. Half of the group will be taught one culture and the other half another. You will then interview each other and complete a risk assessment form.
6. Finally, you will interview each other a second time to review the risk assessment and initiate a case plan.

TRANSITION:

Before breaking into groups we want to review with you the general

aspects of the culture that you will learn. This outline also serves as a useful guide for recording material that you learn from your interviews.

Slide #47: VISAS—An Interviewing Guide

B. VISAS—An interviewing guide (Handout 8)

The VISAS can help you in two ways:

It can help you to learn about the values, interactions, social support, and aims of child rearing which characterize the culture groups with which they identify, and

It will help you to learn how the client may have adapted these cultural features to accommodate their individual needs and life situation. In this context, it is important to know if a client's adaptations reflect or conflict with the values of their larger culture group.

1. Values—the thrust here is to discern the major values of clients that guide their behaviors and world views.

FOR EXAMPLE: A Maori client tells you that the Maori culture values group ownership of assets. She has purchased a car, which she sees as her personal property. This has brought her into conflict with some members of her family who have asked to use the car and been refused.

2. Interactions—in this area you want to look for the culturally motivated social behaviors that are evident in the client's interpersonal relationships.

FOR EXAMPLE: A client tells you that she has always been taught that making direct eye contact with elders or authority figures is rude. Although she knows that most mainstream Americans like direct eye contact, she just can't do it. In this case, the client's behavior reflects her culture even though it may put her in conflict with the mainstream.

3. Social Supports—The purpose here is to gain a grasp of the client's sense of community and appropriate help-seeking behaviors.

FOR EXAMPLE: A newborn Hmong child is diagnosed as brain dead and the hospital ethics committee recommends termination of life supports. When the parents are unable to make a decision, the ethics committee calls in Hmong elders who examine the child and pronounce it dead. With this support and approval, the parents are able to make the decision to withdraw life supports.

4. Aims of Child Rearing—the key to this part of the guide is to find out what clients believe is important to teach their children and how they think children should be raised.

FOR EXAMPLE: A client reports that she was raised to keep a low profile and not excel in school or in any other group. She believes this has put her at a disadvantage in today's competitive job market and is determined to raise her daughter otherwise. She has been severely criticized by her parents and other relatives for this.

5. Strengths—the point here is to understand the client's strengths that can be built on to address the problem. Factors that are rated as low risk may point to some of these.

FOR EXAMPLE: Your risk assessment reveals that a Samoan client is well connected to her church. Other church members might be a resource to help her learn other methods of discipline rather than the harsh physical punishment she has been using.

C. Learn Your Alternative Cultures

Note to Trainer: The previous evening you and your co-trainer should have purposely divided your group in half depending on how easily you believe each participant can relate to either the Aldoonian or Omkazian cultures. For example, it would be very difficult, for a quiet, modest, nurturing person to fit in as an Omkazian. Conversely, an aggressive, individualistic woman may find it difficult to behave as an Aldoonian.

Wearing the appropriate colored sticky dot, the Aldoonian co-trainer should present all Aldoonians with a sticky dot of the same color, which they are to wear. The Omkazian trainer should do the same.

One culture group should remain in the training room while the other moves to a separate breakout group. The use of two rooms is important.

In each group, give participants a copy of the cultural summary appropriate to that group (Aldoonians, Handout 9; Omkazians, Handout 10).

Trainers should refer to the appropriate "Teaching" sheets in order to teach their group about its new culture.

1. Teaching the Aldoonian Culture

Review the Aldoonian Cultural Summary Sheet with your group and answer any questions they have.

Demo: Greeting a Female

- A female trainer should ask another woman to assist her.
- Warmly greet the other with smiles and hugs.
- Ask your partner about her dad.
- Ask her to ask you about your dad.
- Explain that he had a rough time after your mother's death but is doing well with all the help and support he received from family and the community.
- Have your partner ask you if there's anything she can do to help.
- Nod (remember this means no) and say "he's just fine."

Demo: Greeting a Male

- A female trainer should ask a man in the group to help her.
- Let the male take the lead in the greeting. If he hugs, hug back. If he pats your arm or shoulder, pat his in return.
- Ask your partner about his son.
- Ask him to ask about your son.
- Tell him how proud you and your husband are of him because his soccer coach has told you he's a team player, really there for the whole group, not just himself.

Note: If the trainer is male, the approach strategies are the same for both men and women. The man takes the lead. However, the process described above for the female should be explained.

Ask the group to pair into dyads.

Have them act out meeting on the street and then plan to have coffee together. They should interact as friends and feel free to talk about whatever they wish but in an Aldoonian fashion. They should feel free to correct each other if one partner or the other acts in an inappropriate (for Aldoonian) manner. The object is to get comfortable with their culture.

Assemble the entire group of Aldoonians and tell them that they are at a cocktail party at the Aldoonian center.

Exercise: Ask people to mix as they would at any cocktail party. All members should try to chat with everyone else. This is another opportunity to practice the culture.

The trainer should get involved and also attend the cocktail party and offer encouragement and suggestions on appropriate Aldoonian behavior.

2. Teaching the Omkazian Culture

Review the Omkazian Cultural Summary Sheet with your group and answer any questions they have.

Demo: Greeting someone

- Ask someone to be your partner and help you demonstrate Omkazian greetings.
- In an assertive and confident manner, greet your partner.
- Tell your partner how happy you are to see them because you are so eager to tell them all the wonderful things that have happened in your family. Your son just won an award at school, your daughter is in the finals of a competition, and your spouse is up for a big promotion at work.
- Whenever your partner mentions anything about their family, give them only the smallest amount of recognition and move back quickly to your family and its accomplishments. If possible, try to top anything your partner says. Feel free to brag about everything; your house, your pets, your car—everything!

- When your partner does get a chance to talk, cross your fingers to show your impatience and that you want to move on. Although you are pleasant when your partner begins to talk, you are soon bored.

Exercise: Ask the group to pair into dyads.

Have them act out meeting each other on the street. They should talk about whatever they want, but in an Omkazian fashion. They should feel free to correct each other if one partner or the other acts in an inappropriate (to Omkazians) manner. The object is to get comfortable with their culture.

Assemble the entire group of Omkazians and tell them they are at a cocktail party. This is difficult for Omkazians because they don't usually associate with other Omkazians. However, they should circulate and mix with people, trying to chat with everyone at the party. This is another opportunity to practice the culture. This exercise will usually become loud and boisterous as everyone tries to best everyone else.

The trainer should also attend the cocktail party and offer encouragement and suggestions on appropriate Omkazian behavior.

D. Techniques of Ethnographic Interviewing Applied to an Initial Risk Assessment Interview.

Exercise: Stage 1

In this part of the exercise, those participants who learned the Aldoonian culture are the clients; those participants who learned the Omkazian culture are now, as their true selves, social workers.

1. Ask the Aldoonian clients to take a seat in the training room. Make sure there is room for a social worker to join them. Have them review the Aldoonian Client information (Handout 11).
2. Give social workers the Aldoo Referral to read (Handout 12).
3. Have social workers choose an Aldoonian to interview and approach them as if they are at the front door of the client's home. Direct social workers to interview their clients. They are gathering information to assess risk. They should not yet develop a case plan. Remind social workers to use the VISAS guide (Handout 8).

Allow 15 minutes for the interview.

Exercise: Stage 2

In this part of the exercise, those participants who learned the Omkazian culture are the clients; those participants who learned the Aldoonian culture should revert to their true selves as social workers.

Break out the group by culture.

4. Have the Omkazians briefly review the Omkazian Cultural Summary (Handout 10). Have them read the Omkazian Client Information sheet (Handout 13) and ask them to take a seat in the training room.
5. Remind the social workers they are acting as themselves and give them the Omkazian Referral (Handout 14) to read. Follow Step 3 instructions.
6. After the interview, break out the large group in two rooms by culture. The trainer for each group should list on a flip chart the VISAS issues participants discovered about their clients. This will help them in assessing risk and developing a case plan. Reassemble the group in the training room.
7. Have each participant work on the risk assessment protocol² based on their interview.

Exercise: Stage 3

Participants should assume their roles as in Stage 1.

8. Ask social workers to make another home call to the same client as before. They should share their risk assessment with the client and engage them in developing a case plan.

Exercise: Stage 4

Participants should assume their roles as in Stage 2.

² This instrument is no longer included with this module as it is out of date and no longer in use. The risk assessment protocol was replaced by the Structured Decision Making[®] model (SDM[®]). To find out more about SDM[®], see the CalSWEC curriculum module, *Structured Decision Making[®] and Child Welfare Service Delivery Project*, located where this module was accessed.

9. Repeat Step 8.

D&P:

10. The entire exercise is debriefed.

- Cross-cultural knowledge is shared.
- Risk Assessments from both cultural groups are discussed.
- Case plans are reviewed.
- Feelings and thoughts about the interview and the risk assessment process are shared.

D&P:

E. Evaluate and separate.

- Have participants complete training evaluations (Note: not included here).
- Process trainees' reactions to training.

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REFERENCES

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HANDOUTS

DECISION MAKING EXERCISE

TASK: The following is a list of situations that have been observed by our staff while on the job or when making home visits. Rank them on a scale of 1 to 10 according to those situations that you feel involved the highest (1) to lowest (10) risk.

- A.____ A 5-year-old child of Eastern European parents has been locked in his room every day after school for 6 weeks as a punishment for bad behavior.
- B.____ A 4-year-old child often has bruises and welts as a result of discipline by his mother for lying and behaving just like his “no-good father.” The mother is developmentally delayed.
- C.____ The parents of two youngsters, ages 5 and 6, both spend most of their time out of the house due to job responsibilities and often don’t return home until 7 or 8 p.m. The children are able to let themselves into the apartment, and a neighbor “keeps an eye” on them.
- D.____ Upwardly mobile yuppie parents give Valium to a 2-year-old to keep him quiet in the evening because he tends to run around and pester them at night.
- E.____ A Laotian child of 4 is not allowed to eat with the rest of the family and is rarely spoken to by the parents.
- F.____ A 5-year-old child whose family just moved from the rural south has told her teacher that her step-daddy takes her on “special walks” in the woods and “plays with her down there.”
- G.____ Three children, ages 7, 5, and 3, are seen running around a swimming pool while their parents sleep on a couch in the apartment. Parents are unemployed and have a known history of cocaine use.
- H.____ A 3-week-old baby who was born with a positive toxicology screen is otherwise healthy. The mother has a history of cocaine abuse but refuses treatment.
- I.____ A 55-year-old stepfather struck his 5-year-old for knocking over a glass of milk. The child sustained a serious eye injury from the heavy ring the father was wearing. The injuries have been medically treated, and the child has just returned to school.
- J.____ The parents, who have relocated to a large urban area from rural Appalachia, fight frequently due to financial problems. The father is in the habit of hitting the mother in front of the three children, who hide and cry.

Adapted from: U.S. Department of Health, Education, and Welfare Office of Human Development Services, Administration for Children, Youth and Families, Children’s Bureau, National Center on Child Abuse and Neglect. (1995). *We can help: A curriculum on child abuse and neglect: Leaders manual* (Rev. ed.). Washington, DC: Author.

A

Case Name _____
Open Service Case: () Yes () No

B

Risk Assessment Codes

NA = Not Applicable
I = Insufficient Information
L = Low Risk
M = Moderate Risk
H = High Risk

Child(ren) in Household Name	Age	Sex
Child 1		
Child 2		
Child 3		
Child 4		
Child 5		
Child 6		

C

Precipitating Incident Factors (1-4)							Highest Risk Code
1	2	3	4	5	6		
1. Severity and/or Frequency of Abuse							
2. Severity and/or Frequency of Neglect							
3. Location of Injury							
4. History of Reported Abuse/Neglect							
Observations:							

D

Child Assessment Factors (5-9)							Highest Risk Code
1	2	3	4	5	6		
5. Child's Age, Physical, and/or Mental Abilities							
6. Perpetrator's Access to Child							
7. Child's Behavior							
8. Child/Primary Caregiver Interaction A							
B							
9. Child's Interaction with Siblings/Peers/Others							
Observations:							

Primary A. B. Secondary C. D.

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E					Highest Risk Code
Caretaker Assessment Factors (10-16)					
10. Caretaker's Capacity for Child Care					
11. Caretaker/Child Interactions Child's Name					
1.					
2.					
3.					
4.					
5.					
6.					
12. Caretaker/Caretaker Interaction					
13. Caretaker's Parenting Skills/Knowledge					
14. Caretaker's Substance/Alcohol Use					
15. Caretaker's Criminal Behavior					
16. Caretaker's Emotional and Mental Health					
Observations:					

F					Highest Risk Code
Family Assessment Factors (17-21)					
17. Family Interactions/Relationships					
18. Strength of Family Support Systems					
19. History of Abuse/Neglect in Family					
20. Presence of a Parent Substitute in the Home					
21. Environmental Condition of Home					
Observations:					

G					Highest Risk Code
Family/Agency Interaction (22 and 23)					
22. Caretaker's Cooperation with Agency Staff and/or Service Plan					
23. Progress of Child/Family in Treatment (Comment in Observations)					
Observations:					

H		
Summary of Assessment Codes		
a. High Risk ____	b. Moderate Risk ____	c. Low Risk ____
d. Insufficient to Assess ____	e. Not Applicable ____	

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I	Family Assessment
	Strengths:
	Problems:
	Additional Information Needed:

J	Overall Risk Rating (As of _____)	a. Low Risk	b. Moderate Risk	c. High Risk
	date			

K	Service Recommendation (Circle One)
	a. No services with no referral
	b. No services with referral to another agency
	Case Plan Goal
	c. Meet the child's protective needs in his/her own home (family preservation/maintenance)
	d. Meet the child's protective needs in out-of-home care while preparing the parent(s) to meet the child's protective needs when (s)he returns home (family reunification)
	e. Meet the child's protective needs in out-of-home care while arranging for adoptive parents, legal guardians, or long-term caretakers (permanent placement)

L	1. Worker's Name (print) _____ Signature _____
	2. Supervisor's Signature _____ Date _____

Resource Material

FAMILY ASSESSMENT Risk Variables*

**California State University, Fresno
School of Health and Social Work**

**Sponsored and Funded by
California State Department of Social Services**

*** Adapted from Illinois Department of Children and Family Services. (1989; Rev. 8/94). *Risk assessment training manual*.**

FAMILY ASSESSMENT FACTOR ANALYSIS

Precipitating Incident Factors (1-4)

1. Severity and/or Frequency of Abuse
2. Severity and/or Frequency of Neglect
3. Location of Injury
4. History of Abuse or Neglect

Child Assessment Factors (5-9)

5. Child's Age, Physical, and/or Mental Abilities
6. Perpetrator's Access to Child
7. Child's Behavior
8. Child/Caretaker Interaction
9. Child's Interaction with Siblings, Peers, or Others

Caretaker Assessment Factors (10-16)

10. Caretaker's Capacity for Child Care
11. Caretaker/Child Interaction
12. Caretaker/Caretaker Interaction
13. Caretaker's Parenting Skills/Knowledge
14. Caretaker's Substance/Alcohol Misuse
15. Caretaker's Criminal Behavior
16. Caretaker's Emotional and Mental Health

Family Assessment Factors (17-21)

17. Family Interactions/Relationships
18. Strength of Family Support Systems
19. History of Abuse/Neglect in Family
20. Presence of a Parent Substitute in the Home
21. Environmental Condition of Home

Family/Agency Interaction (22-23)

22. Caretaker's Cooperation with Agency Staff and/or Service Plan
23. Progress of Child/Family in Treatment

RISK ASSESSMENT DECISION-MAKING PROCESS

- Assessment of risk is an evaluation of a constellation of child, caretaker, and family factors that serve to identify the level of risk in a family.
- Risk assessment should not be viewed as a one-time only determination, but rather as an ongoing evaluation that recurs every time a new piece of information is obtained and analyzed.
- The risk assessment decision-making process enables caseworkers and supervisors to focus on family strengths as well as risk concerns.
- By making important distinctions among a discrete number of risk factors, the resulting risk assessment should in effect "drive" the intervention strategy selected to alleviate the recognized risk.
- It is important that all documented assessments be based on factual behaviors, statements, or professional opinions that can be substantiated by case documentation or contact with collateral sources.
- Caseworkers completing the worksheet must view the risk variables as only suggestive guidelines or parameters, as caseworkers need to assess risk and service needs appropriate to the circumstances of each case.
- To arrive at an overall assessment of risk, there must be: (a) a review of the most critical areas of risk, (b) examination of family strengths and a weighing of their interaction with critical risk factors, and (c) a consideration of available service resources.

FAMILY ASSESSMENT RISK VARIABLES

1. SEVERITY AND/OR FREQUENCY OF ABUSE

HIGH RISK	MODERATE RISK	LOW RISK
Severe physical injury (emergency medical treatment or hospitalization required); abuse of a sibling that resulted in death or permanent dysfunction of organ/limbs; weapon or instrument used; sadistic, violent patterns of behavior	Moderate physical injury	No physical injury or minor injury (nothing more than simple home treatment required)
Serious injuries at different stages of healing	Minor injuries/bruises at different stages of healing	No evidence of prior injury; most likely an isolated incident
Severe emotional harm/damage	Moderate emotional harm/damage	No discernable emotional harm/damage
Any evidence of sexual abuse		No evidence of sexual abuse, exploitation

2. SEVERITY AND/OR FREQUENCY OF NEGLECT

HIGH RISK	MODERATE RISK	LOW RISK
Caretaker is clearly not able to meet minimum food, shelter, hygiene, educational, and medical needs of child	There is some evidence that caretaker is failing to meet minimum food, shelter, hygiene, educational, and medical needs of child	Child's minimum food, shelter, hygiene, educational, and medical needs are being met
Child has suffered physical harm or illness from marginal health/safety/housekeeping standards of home	Child shows physical indications of trauma due to marginal health/safety/housekeeping standards of home	Child appears unaffected by marginal health/safety/housekeeping standards of home
Child is ignored, belittled, and/or shunned by caretaker	Child receives little attention, affection, or nurturing, but is not belittled or shunned by caretaker	Child's emotional needs are being met at a minimum level (receives attention, affection, praise, nurturing, etc., from caretaker)
Child has been frequently left unsupervised, resulting in injury/illness, or clear and present danger to the child	Child has been occasionally left unsupervised, in a potentially dangerous situation	Child has not been left unsupervised; there is no pattern of leaving child unsupervised

3. LOCATION OF INJURY

HIGH RISK	MODERATE RISK	LOW RISK
Head, face, neck, anus, genitals, abdomen, groin, evidence of internal injuries	Back, arms, thighs, feet	No injury, or injury on buttocks or bony body parts: knees, elbows, shins, hands, fingers

4. HISTORY OF REPORTED ABUSE OR NEGLECT

HIGH RISK	MODERATE RISK	LOW RISK
Pending child abuse/neglect investigation; previous report of serious abuse/neglect or multiple Child Protective Agency reports involving child, family, or perpetrator; report(s) substantiated	Previous report of abuse/neglect to Child Protective Agency unsubstantiated, but not unfounded	No previous reports of abuse/neglect to Child Protective Agency; unfounded report(s)

5. CHILD'S AGE, PHYSICAL, AND/OR MENTAL ABILITIES

HIGH RISK	MODERATE RISK	LOW RISK
Less than 5 years of age	5-9 years of age	10 years of age and over
Child has severe/chronic physical/mental handicap or disability that totally restricts his/her daily activities	Child has moderate physical/mental handicap or disability that restricts some daily activities	Child has no physical/mental handicap or disability
Child is severely/chronically ill, requiring specialized or continual medical care; medically fragile	Child has chronic illness that is not life threatening, but requires regular medical care	Child is generally healthy; any minor health problems are being addressed adequately
Child is significantly delayed in one or more developmental areas and may not recover even with treatment	Child is delayed in one or more developmental areas, requiring some treatment by specialist	Child exhibits no evidence of developmental delay
Child is moderately or severely mentally retarded	Child is mildly mentally retarded	Child is not mentally retarded
Child is totally unable to care for and protect self	Child needs frequent adult assistance to care for and protect self	Child is mature enough to care for and protect self

6. PERPETRATOR'S ACCESS TO CHILD

HIGH RISK

Perpetrator is in home, complete access to child; other adult will not predictably deny access; multiple perpetrators are present, perpetrator has unrestricted visitation rights and/or unsupervised visits

MODERATE RISK

Perpetrator is in home, but access to child is limited; a nonperpetrating adult is in the house; nonabusing parent/other adult is able to protect child, but is ambivalent

LOW RISK

Perpetrator is out of home, has either no access to child or access only during closely supervised visits; nonabusing parent/other adult is able and willing to protect

7. CHILD'S BEHAVIOR

HIGH RISK	MODERATE RISK	LOW RISK
Infant has severe colic; has extremely irregular eating/sleeping patterns; cries frequently and for prolonged periods of time	Infant is fussy; has irregular eating/sleeping pattern; cries frequently for no obvious reason	Infant is calm, easy to care for; has regular eating/sleeping patterns; cries only for obvious reasons
Child's behavior is extremely violent, disruptive, or dangerous; child demonstrates chronic/severe hyperactivity or other serious behavioral problem	Child's behavior is disruptive or difficult to control; shows occasional pattern of mild hyperactive behavior; exhibits infantile behavior which negatively impacts interactions with others	Child's behavior appears age-appropriate; child shows no evidence of hyperactivity; minor behavior problems are being addressed adequately
Child has chronic diagnosed mental illness; history of suicide attempts; current suicidal ideation; self-destructive tendencies	Child has mental health condition which currently affects his/her ability to function adequately (i.e., mild symptoms of depression/anxiety)	Child has no history of mental illness or psychiatric treatment, or current symptoms
Child has demonstrated chronic truancy; has run away frequently and for long periods of time (rarely returns voluntarily)	Child has history of periodic tardiness and/or truancy; has run away for short periods of time (returns voluntarily)	Child has record of normal school attendance; has made only verbal threats of running away
Child has admitted or diagnosed drug and/or alcohol dependency	Child has occasionally used mood-altering drugs and/or alcohol which impairs his/her decision-making abilities	Child has no known history of drug/alcohol misuse
Child has previous record of or current involvement in dangerous/violent criminal/delinquent behavior	Child has previous record of or current involvement in nonviolent criminal or delinquent behavior	Child has no record of criminal/delinquent behavior

8. CHILD/CARETAKER INTERACTION

HIGH RISK	MODERATE RISK	LOW RISK
Child's interaction is extremely disruptive, violent, or unpredictable; child is unable/unwilling to form more positive relationship with caretaker; child does not accept or respond to caretaker as an authority figure; infant does not appear bonded and is unresponsive to caretaker	Child's interaction with caretaker is occasionally disruptive, conflictual, or disrespectful; child does not appear highly motivated to change; child has some accumulation of resentment; infant appears marginally bonded and only occasionally responsive to caretaker	Child responds/relates to caretaker in age-appropriate manner; child engages in positive interaction with caretaker; child/caretaker minor conflicts are easily resolved, with no accumulation of resentment; infant appears highly bonded and very responsive to caretaker
Child is either extremely passive, fearful, or openly hostile and defiant toward caretaker; child never displays affection; child is extremely guarded toward caretaker	Child shows ambivalence, apprehensiveness, or suspicion toward caretaker; child only rarely displays affection; child is fearful or mistrustful at times; child is overly compliant	Child is able to develop trusting relationship with caretaker; child openly displays affection
Complete role reversal has occurred, with child assuming majority of caretaker functions and responsibilities	Some significant role reversal evident; child has assumed an inappropriate number of caretaker functions and responsibilities	Child/caretaker roles are age-appropriate

9. CHILD'S INTERACTIONS WITH SIBLINGS, PEERS, OR OTHERS

HIGH RISK	MODERATE RISK	LOW RISK
Child is abused or frequently exploited by siblings, peers, or others; child is ostracized or scapegoated; child engages in sibling rivalry of an aggressive or violent nature, requiring constant caretaker intervention	Child is victimized by or victimizes siblings, peers, or others to the point of being stressful, but not abusive; child's interactions are limited to siblings and peers somewhat younger than self	Child interacts with siblings, peers, or others in age-appropriate manner; sibling conflict or rivalry minor; child is too young to interact with others outside the family
Child has no friends; child's interactions are described as unpredictable and violent; peer interactions are nonexistent	Child's friendships are transient; relationships in general are problematic or stressful, with a negative impact on the family	Child is able to develop and maintain friendships easily
Child's interaction with siblings, peers, or others is largely negative due to current criminal activity, delinquency, drug abuse, truancy, or other socially unacceptable behavior	Child withdraws from interactions with siblings, peers, and others; displays frequent hostility or oppositional behavior toward most authority figures	Peer interactions have been negative in past, but there is no current indication of problems affecting the family; child interacts appropriately with siblings, although he/she may not relate as well to peers or others

10. CARETAKER'S CAPACITY FOR CHILD CARE

HIGH RISK	MODERATE RISK	LOW RISK
Caretaker has a diagnosed acute or chronic illness or disability that severely impairs his/her childcaring capacity, posing a serious risk to the child	Caretaker appears to have a physical or intellectual disability that interferes somewhat with his/her ability to provide adequate child care; illness or disability is untreated and/or caretaker's condition is deteriorating to the point that he/she requires supplementary services to maintain care role; caretaker has serious communicable disease that poses health threat to the child, although it does not impair childcaring capacity	Caretaker has no observable illness or disability which limits his/her ability to provide adequate child care; in spite of minor physical/intellectual limitation which impairs caretaker's ability to provide child care, with appropriate services he/she has been able to maintain childcare responsibilities and demonstrates a continued desire to do so
Caretaker has severe intellectual limitations that preclude him/her from providing minimal child care	Caretaker has a reported intellectual limitation which adversely affects his/her ability to provide minimal child care and protection, and no immediate improvement is expected, even with specialized treatment	Caretaker is viewed as competent; no intellectual impairment is evident

11. CARETAKER/CHILD INTERACTION

HIGH RISK	MODERATE RISK	LOW RISK
Caretaker demonstrates complete absence of behaviors indicating attachment, affection, or acceptance of child; exhibits no evident bonding, especially with infant; has extremely limited physical contact, if any at all	Caretaker only occasionally demonstrates attachment, affection, and acceptance of child; appears marginally bonded with child, especially infant; is uncomfortable with physical contact	Caretaker demonstrates appropriate attachment, affection, and acceptance of child; appears highly bonded with child, especially infant; exhibits frequent and appropriate physical contact; may be loving, without ability to be highly demonstrative
Caretaker views child as outsider in family; sees child as something evil and bad; actually hates child; constantly overemphasizes perceived faults of child; has adopted view of child as an appropriate target of exploitation; demands perfect behavior or total obedience to harsh and unreasonable rules; views child's presence as personal threat; states an inability to control child's behavior	Caretaker blames child for family's problems; views child as a disruptive influence, or labels child in a derogatory manner which seriously undermines the caretaker-child interaction; expresses disapproval or criticism of child more often than necessary; speaks to and about child in resentful, vindictive, or angry manner; only occasionally expresses any acceptance of child	Caretaker speaks positively of child; expresses approval often and spontaneously; views child as unique individual requiring love and protection; may occasionally view child as disruptive, different, or bad, in response to child's behavior, but such perceptions are generally situation specific

12. CARETAKER/CARETAKER INTERACTION

HIGH RISK	MODERATE RISK	LOW RISK
Caretakers demonstrate no positive affection or attachment and are openly hostile toward each other	Caretakers rarely display affection or have diminishing emotional ties, but are not openly hostile to one another	Only one caretaker is present; caretakers demonstrate positive affection and emotional support in their interactions
Violent arguments and threats of harm represent the only reported form of communication between caretakers; dominant caretaker uses authority/power to intimidate or verbally abuse the other caretaker, who is viewed as property or servant, or as unequal	Caretakers' communication is characterized by frequent periods of shouting, yelling, or extended arguments; one caretaker dominates the interaction, with the other assuming a submissive role; one caretaker has assumed all authority/power in childrearing practices	Caretakers communicate in positive manner with each other; caretakers verbalize and exhibit appropriate sharing of authority/power in childrearing responsibilities
Overly hostile custody/court proceedings have negatively affected the interaction of caretakers to the point of escalating physical violence or threat of violence; injuries may have occurred in these disputes	Caretakers are in direct competition for child's affection or are engaged in heated custody/court proceedings; caretakers rarely demonstrate support for each other in important matters or decisions concerning child	Caretakers indicate no ongoing custody conflicts or disputes; caretakers support each other in most important decisions and rarely engage in verbal conflict/arguments concerning child
The marital relationship is characterized by violence, with serious injuries inflicted by one or both caretakers; there are hostile separation/divorce proceedings with no possibility of reconciliation; primary caretaker displays pattern of entering into multiple short-lived or unstable primary relationships	Caretakers engage in frequent episodes of physical contact/fighting, but there are no documented reports of serious injuries or objects used; there is a mutually agreed upon separation, with reconciliation anticipated by both parties	Caretakers' communication occasionally is disrupted by episodes of verbal conflict; there are minor breakdowns in the authority/power structure related to childcare responsibilities; caretakers admit to rare instances of minor physical discord in marital disputes

13. CARETAKER'S PARENTING SKILLS/KNOWLEDGE

HIGH RISK	MODERATE RISK	LOW RISK
Caretaker's level of care or supervision plan has repeatedly exposed child to danger, and harm has occurred; caretaker refuses to develop/implement corrective care or supervision plan	Caretaker's level of care or supervision plan places child at some risk, but child has never been actually injured as a result	Caretaker's level of care or supervision plan is adequate for child's age/special needs
Caretaker repeatedly administers discipline that is inappropriate, excessive, or harsh in relation to child's age or misconduct; physical discipline is caretaker's only response to misconduct; pattern of physical discipline is escalating in severity; violent/sadistic tendencies are evident	Caretaker's methods of verbal and physical discipline are administered inconsistently; some disciplinary forms are not appropriate to child's age or misconduct (e.g., verbal discipline that is used with a very young child or physical discipline that is applied for an involuntary physiological response)	Caretaker's methods of verbal and physical discipline are consistent with and appropriate to child's age and misconduct; sometimes caretaker is too rigid or permissive, but generally controls discipline
Caretaker demonstrates completely inadequate knowledge of age-appropriate child behaviors and does not recognize stages of child development; usually makes unrealistic demands of child; consistently sets expectations of child too high or too low (allowing child's behavior to become unmanageable); appears unlikely to acquire needed knowledge in this area or to be able to change expectations of child significantly	Caretaker demonstrates only minimal knowledge of age-appropriate child behaviors and only occasionally recognizes stages of child development; frequently makes unrealistic demands of child; seems capable of acquiring knowledge in this area and changing expectations of child with assistance	Caretaker demonstrates adequate knowledge of age-appropriate child behaviors and recognizes stages of child development; makes generally realistic demands of child; sets expectations for child that are neither too high nor too low
Caretaker demonstrates completely inadequate knowledge of child's basic needs, including nutrition, shelter, clothing, medical care, etc.; appears unlikely to acquire such knowledge	Caretaker demonstrates only minimal knowledge of child's basic needs including nutrition, shelter, clothing, medical care, etc.; appears capable of acquiring such knowledge with assistance	Caretaker demonstrates adequate knowledge of child's basic needs, including nutrition, shelter, clothing, medical care, etc.

14. CARETAKER'S SUBSTANCE/ALCOHOL MISUSE

HIGH RISK	MODERATE RISK	LOW RISK
Current drug/alcohol misuse or dependence has been admitted or verified and this dependence poses an immediate threat to the supervision of the child	Current drug/alcohol misuse or dependence has been admitted or verified, but does not constitute an immediate danger to child, although risk is present	No history of drug/alcohol dependency or misuse has been admitted or verified; former substance abuser has successfully completed a recognized treatment program (or has been actively involved in AA/NA); past or current alcohol abuse poses no risk to child
Caretaker's life revolves around the use or attainment of drugs or alcohol, endangering the child; substance misuse poses risk to family's financial resources and negatively affects caretaker's ability to meet basic needs of the child	Caretaker is currently experimenting with or using several substances; use tends to be episodic with no serious consequences or significantly reduced ability to parent; drug/alcohol abuse is not physically/psychologically addictive at this time, but pattern of misuse may be escalating	Alcohol is consumed only in moderation and caretaker is in control of his/her actions
Caretaker needs treatment in order to satisfactorily care for child and refuses treatment or is a chronic treatment dropout; maintains frequent contact and/or strong identification with suspected drug/alcohol abusers, which endangers the child	Caretaker admits to current substance abuse and is reluctant to seek treatment; caretaker is periodically incapable of caring for child due to drug/alcohol misuse; ability to make or assure adequate childcare arrangements is deteriorating	Caretaker has admitted to substance abuse, but is actively participating in recognized treatment program (or AA/NA); drug or alcohol misuse is present, but is not escalating and does not constitute any risk to the child

15. CARETAKER'S CRIMINAL BEHAVIOR

HIGH RISK

Caretaker has a confirmed arrest record involving use of force or violence against children; has a previous history of violent crimes perpetrated against a member of immediate family; habitual criminal activity that severely impairs caretaker's current ability to provide minimal child care; habitual criminal and/or gang-related activity repeatedly exposes child to immediate danger from high-risk environment; child may have been actually harmed

MODERATE RISK

Evidence of current participation in felonious criminal activity of a nonviolent nature; has a previous record of violent crimes perpetrated against non-related adult victims; is involved in habitual criminal activity that currently interferes with his/her ability to provide minimal child care; is involved in habitual criminal and/or gang-related activity that presents a risk to the child, although child has never actually been harmed

LOW RISK

No evidence of any past or current caretaker involvement in criminal activities; previous criminal history poses no current risk to child or previous record of arrests is for nonviolent crimes that did not involve the child; caretaker is on probation and meeting all requirements of probation

16. CARETAKER'S EMOTIONAL AND MENTAL HEALTH

HIGH RISK	MODERATE RISK	LOW RISK
Caretaker has a history of acute psychiatric episodes which have and/or are currently affecting his/her ability to provide minimal child care or supervision	Current indicators of psychological problems or mental illness appear to be present and if not monitored or evaluated, may pose risk to the child	There is no evidence or history of psychological disorder or mental illness; caretaker has no observable symptoms or indicators of mental illness; previous history of mental illness does not pose current risk to child
Caretaker's current psychological state appears to pose a high level of risk to the child; caretaker is unwilling and/or refuses to seek psychiatric treatment and/or evaluation; caretaker has a history of suicide attempts and/or makes current suicide gestures that place child at high risk and create high level of emotional distress for family; caretaker currently is making verbal threats of harm to child during episodes of psychiatric distress; caretaker has demonstrated inability to function independently due to a major mental disorder	Caretaker is currently exhibiting behaviors which may be a sign of deteriorating mental health, and treatment is not being sought; caretaker admits to current psychological or psychiatric problem, but is reluctant to seek treatment; caretaker exhibits difficulty in functioning in a child-caring capacity or in assuming tasks essential to family functioning	Current psychological disorder or mental illness is viewed by mental health professional as transitory and/or does not impair caretaker's ability to provide minimal child care; caretaker is receiving appropriate treatment which is proving successful
Caretaker shows extreme immaturity, self-absorption, low self-esteem, lack of empathy, impaired judgment, dependence, lack of impulse control, or irresponsibility which places child at substantial risk for abuse/neglect	Caretaker exhibits signs of self-absorption, impaired judgment, lack of impulse control, or irresponsibility which place child at increased risk for abuse/neglect	There is little evidence of personality traits which place child at risk for abuse/neglect

17. FAMILY INTERACTIONS/RELATIONSHIPS/STRESSORS

HIGH RISK	MODERATE RISK	LOW RISK
Family members display hostility, aggression, and/or anger to each other in most interactions; almost no affection or attachment is observed among family members; constant disorganization in relation to household tasks is creating an atmosphere of chaos, confusion, and mistrust	Family is disorganized; frequent conflict is causing family problems or dysfunction; there is some isolation of family members, resulting in unsupportive interactions and indifference among family members; a minimal level of attachment and affection is observed; sharing of family responsibilities is problematic	Positive family interactions are observed; family appears close, supportive, and caring; family unit is currently stable; family conflicts are resolved without further incident; sharing of responsibilities among family members is age-appropriate; only occasional relationship problems or disorganization occurs
Family is totally overwhelmed by any form of stressors, regardless of how minor	Family copes adequately only with minor stressors, and shows some signs of deterioration in functioning	Family appears to cope well with stressors
Family structure is constantly in flux; family is totally overwhelmed by such transitions; primary caretaker's marriage or relationship with partner has completely deteriorated and consists of primarily negative interactions highly disruptive to family functioning	Family structure has recently changed or appears likely to change in the near future; family adapts poorly to such transitions; primary caretaker has unstable marriage or relationship with partner, but some interactions remain positive	Family structure is intact; primary caretaker has stable marriage or stable relationship with partner; if changes have occurred, family is adapting well

18. STRENGTHS OF FAMILY SUPPORT SYSTEMS

HIGH RISK	MODERATE RISK	LOW RISK
Family is isolated; few, if any, support systems are available in any form, or interactions are generally negative; no concrete assistance or emotional aid is available without professional intervention, which family is not likely to accept	Support systems such as extended family, neighbors, friends, and/or cultural, ethnic, or religious associations (formal and informal) are inconsistently available, or limited; support systems are only minimally committed to providing concrete assistance and emotional aid if needed to resolve intrafamilial stress and/or conflict	Support systems such as extended family, neighbors, friends, coworkers, and/or cultural, ethnic, or religious associations (formal and informal) are available; support systems are committed to providing concrete assistance and emotional aid, if needed, to resolve intrafamilial stress and/or conflict
Family is clearly in need of assistance from external support system, but intentionally avoids seeking any help and alienates anyone offering aid; family is isolated from ethnic group, and cultural/language differences appear as a significant barrier to family's receiving assistance	Family requires some assistance from external support systems, but is new to community and has not established viable support system as yet (or is not generally inclined to do so), but is likely to do so if required to meet child's basic needs; cultural/language differences of family present difficulty in acquiring assistance, but family is not totally isolated from ethnic group	Family requires no external support systems to resolve child protection issues or to cope with stress
Family lacks sufficient income and material resources to meet child's basic needs, and professional intervention is not likely to result in resolution of crisis due to family's extreme social isolation	Family lacks sufficient income and material resources to meet child's basic needs, but professional intervention is likely to result in resolution of crisis	Family has sufficient income and material resources to meet child's basic needs

19. HISTORY OF ABUSE OR NEGLECT IN FAMILY

HIGH RISK	MODERATE RISK	LOW RISK
One or more previous incidents, both serious and frequent in nature, in which child sustained serious injury or substantial emotional trauma	Several previous incidents that are becoming increasingly serious in nature in terms of caretaker actions and potential harm to child; some emotional scars may be evident	No previous history of child protection intervention in this family or no current risk to child despite reports of minor concerns; previous incidents left no known emotional scars
Same child is repeatedly targeted for abuse/neglect by same caretaker(s)	At least one prior incident involving same caretaker/child or multiple child victims and/or multiple perpetrators	No previous history of abuse/neglect involving same caretaker/child
Abuse of sibling resulted in death or permanent dysfunction of organ/limbs	Minor to severe abuse of sibling past or present (no permanent damage)	No known abuse of sibling, past or present
Caretaker reports a personal history of serious, ongoing maltreatment as a child which resulted in severe injury and emotional scars; agency records or collaterals may confirm past CWS involvement with caretaker as a child	Caretaker reports a personal history of ongoing maltreatment by parents or other adult caretakers with only minor injuries or emotional trauma; agency records or collaterals may confirm past CWS involvement with caretaker as a child	Caretaker reports no more than minor incidents of abuse/neglect in his/her childhood history

20. PRESENCE OF A PARENT SUBSTITUTE IN THE HOME

HIGH RISK	MODERATE RISK	LOW RISK
Parent substitute resides with the family and is the alleged perpetrator; parent substitute has an extremely detrimental influence on the primary caretaker's level of child care	Parent substitute is in the home on an infrequent basis and assumes only minimal caretaker responsibility for the child; or is in the home on a regular basis and has somewhat negative influence on primary caretaker's level of child care	Child's primary caretaker is biological parent(s); parent substitute in the home is supportive/stabilizing influence

21. ENVIRONMENTAL CONDITION OF HOME

HIGH RISK	MODERATE RISK	LOW RISK
Home environment is hazardous, dilapidated, or poorly maintained and problems pose an immediate threat to child's well-being; home is dangerously unsafe, beyond repair, or condemned; living conditions are barely suitable for providing shelter; no functional utilities and no plan for reinstating them	Home environment has physical/structural problems, inoperable utilities, or sanitation problems, and requires immediate remediation; repairs are being accomplished or can be arranged; some utilities shut off but are currently unnecessary due to weather conditions or substitutes in place	Home environment is adequately maintained and structurally sound; utilities are available and functional
Home environment is filthy and/or hazardous to child, posing immediate and serious risk to child	Home environment presents minor housekeeping problems and/or safety hazards posing some risk to child	No serious housekeeping problems or safety defects observed in home environment
Home environment has serious overcrowding, necessitating adults--related or unrelated--and children of varying ages and opposite sex to occupy same bedroom space	Home environment is overcrowded and lacks some privacy for family members; children of varying ages and opposite sex may have to occupy same bedroom space	Home environment is no more than slightly overcrowded, but privacy is maintained for family members

22. CARETAKER'S COOPERATION WITH AGENCY STAFF AND/OR SERVICE PLAN

HIGH RISK	MODERATE RISK	LOW RISK
Client vehemently denies problems or responsibility for them; is evasive, verbally hostile, or physically assaultive/ threatening to agency staff and/or service provider	Client denies seriousness of problems, but is generally cooperative, not openly hostile	Caretaker recognizes problems, takes responsibility for actions, shows guilt or remorse, has made commitment to cooperate and/or is willing and able to protect child from abuse
Caretaker refuses to cooperate at every stage of service planning or treatment; caretaker actively or passively resists all service-related agency contact or involvement; caretaker actively sabotages service objectives/ treatment when coerced into using it	Caretaker accepts services verbally, passively resists cooperating or is argumentative at many stages of service planning/treatment; participation only obtained through prodding and constant intervention	Client accepts and adheres to most service objectives; any initial denial of problems has diminished; involvement with agency staff and outside service providers is generally voluntary, regardless of any court-ordered treatment plan

23 PROGRESS OF CHILD/FAMILY IN TREATMENT

In this section, no rating is required. Rather, record progress in narrative form using the guidelines below.

In assessing this factor, caseworkers must rely on the assessments or opinions of outside professional staff involved in treating or providing services to the family. *Progress is defined as* the degree to which protection-related treatment goals and objectives have been achieved. The more problematic and conflictive the child's or family's conduct is in treatment, the higher the level of risk to the child. Staff must be cognizant of the fact that this assessment can have a significant bearing on the monitoring or future planning of treatment goals and objectives.

In determining whether there is a real and significant risk to the child, caseworkers should assess whether:

- The caretaker has demonstrated the commitment and ability to cooperate fully with the treatment plan.
- There is a history of stressful, conflictive, or unsuccessful participation in protection-related treatment plans.
- Clear evidence exists that the child's or family's conduct is directly responsible for the lack of progress in achieving treatment goals and objectives.
- The child or family has assumed inappropriate roles in his or her participation in the treatment plan.
- The child's or family's lack of progress in achieving treatment goals and objectives has created a real and significant risk to the child.

DERRY STODDARD CASE

The emergency response on-call worker received a call from Huntington Memorial Hospital Social Services regarding four children who had been brought to the emergency room by paramedics. A fire had broken out while the children were sleeping.

The hospital social worker indicated that three of the children, Hank, age 8, Gloria, age 6, and Susan, age 4, had mild smoke inhalation and after emergency treatment are doing very well. The oldest child, Sean, age 10, is being treated for second and third degree burns on his shoulder and chest. The mother, Mrs. Stoddard, was not at home when the fire started; she arrived at the hospital with police shortly after the children.

The on-call social worker immediately went to Huntington Hospital and met first with the hospital social worker. Information from the emergency room doctor and the police who had responded to the fire indicated that firefighters were called to a local shelter for abused women because of a fire that had broken out in Mrs. Stoddard's room. The room was locked from the outside and when the door was broken down the four unattended children were found. In the hospital, Sean had explained that a hot plate cord had started smoking and a towel nearby had caught fire; when he tried to smother it with another towel, both the towel and the T-shirt he was wearing caught fire.

When Mrs. Stoddard returned to the shelter and found that the children had been taken away, she became distraught and hysterical, fearing that she had lost the children. The police on the scene tried to reassure her and took her to the hospital. Mrs. Stoddard calmed down when she discovered that the three younger children were fine and were waiting for her. According to staff at the hospital Mrs. Stoddard again became hysterical when she saw the extent of Sean's injuries.

The hospital social worker added that the emergency room exams found all four children to be well nourished and in good health. Computerized medical records indicate that each of the four children is current with pediatric shots and regular pediatric appointments have been kept. It has been consistently noted that there is a warm and close relationship between the mother and all the children. Mrs. Stoddard holds and caresses the children, makes eye contact when speaking with them, and uses language they can understand. It is apparent that Mrs. Stoddard loves her children and they are happy and comfortable with her. At the hospital, Mrs. Stoddard was loving and comforting to the three youngest children; her concern over Sean's injuries is apparent but somewhat frightening to him.

The CPS worker met privately with the mother. For the past month the family has been staying in a shelter for abused women where Mrs. Stoddard had gone after the most recent in a series of beatings by her husband, the father of her youngest child. Although

the children have never been harmed, she was concerned that her husband might become violent toward them.

Mrs. Stoddard stated that after being in the shelter for 4 weeks she felt "cooped up" and needed to go out. She went with her sister and a girlfriend to a local bar that had a live band. Mrs. Stoddard thought the children would be safe in the shelter; she locked the room so the children would stay in, but more importantly, so that they would be safe from older rowdy kids in the shelter. She was particularly concerned about Gloria who is developmentally delayed and has been teased and led into trouble by these older kids in the shelter. Mrs. Stoddard left the key to the room with another woman who was in a room down the hall. The mother claims she has never left the children except for brief trips to the market when she has left Sean in charge. She has never locked them in before. When firefighters arrived, the woman with whom Mrs. Stoddard had left the key called her at the bar. When Mrs. Stoddard arrived at the shelter the paramedics had left with the children.

Mrs. Stoddard is an attractive, 30-year-old Caucasian. She reports that she did not finish high school and she has had only temporary minimum-wage jobs. Her main source of support has been AFDC. Each of her children has a different father. Gloria's father is Caucasian and the Sean's, Hank's, and Susan's are Black. Although she lived briefly with each of these four men, and married Hank's and Gloria's fathers, none of her relationships have been long standing. Neither Mrs. Stoddard nor the children have contact with any of the fathers and she does not know their whereabouts. She is aware that Hank's father has been incarcerated for armed robbery.

Mrs. Stoddard described her childhood as being "okay." Although she was never physically abused, she witnessed her mother being severely beaten throughout her childhood. She said her mother never talked about the abuse to anyone and never asked for help from her daughter or friends—Mrs. Stoddard says she doesn't think her mother ever even considered calling the police for help and seemed to assume that being beaten was part of being a wife.

During the interview the social worker noted that Mrs. Stoddard has a quick temper, frequently uses profanity, and generally presents in an angry, hostile manner. Mrs. Stoddard appears to be distrustful and suspicious; it is unclear what her willingness is to accept intervention services or to take steps to change her behavior. Two major concerns would be Mrs. Stoddard's understanding of the need to provide adequate supervision for her children and to gain awareness of her participation in abusive relationships and the danger this poses both to her and to her children. She does want to protect her children from being physically abused but she shows no understanding of the emotional damage her children may suffer by witnessing violence against her. She admits that she has refused previous offers of referrals to domestic violence counseling and that she has no interest in being involved in any such therapy. Her major goal is to be left alone by public agencies.

Subsequent contacts with the children's schools revealed that the three older children are enrolled and have good attendance. The third child, Gloria, suffers from moderate developmental delay and attended a center for special education until the move to the shelter. Since then, Gloria has had no transportation to the center.

A records check shows that there have been two previous CPS referrals. One referral was 3 years ago when law enforcement intervened after neighbors complained of a loud disturbance in the home—probably domestic violence—with both parents intoxicated. CPS arrived and found everyone calm and the children looking fine. The allegations were unsubstantiated and the case was closed. A second referral was made last year alleging that the mother was drunk and had caused a disturbance with a neighbor. Again, the allegations were unsubstantiated and the case was closed.

RISK ASSESSMENT

Case Planning Worksheet

Assessment Summary

(Problems requiring attention...What needs changing?)

Behaviors causing the substantial risk or harm to the child

Specific Simple Prioritized

Service Recommendations

Objectives

Behaviors which would indicate changes have been made

Specific Measurable Achievable Relevant Time Limited

Planned Actions

Who will do what, when, where, and how to accomplish objectives

Specific Measurable Achievable Relevant Time Limited

CSUF, CWTP, June 1991

ASSESSING THE PROFESSOR

INTRODUCTION: Dr. Nielson is a Professor of Social Work at a local college. His primary interest is in the relationship and application of social work belief systems to a variety of contemporary issues in society. He has taught for over 10 years at two different institutions. He is now 35 years old, married, and has three children and a pet black Labrador. His friends describe him as industrious, warm, critical, practical, and determined. He likes to read, take walks, and attend plays.

DIRECTIONS: To the best of your ability, evaluate Dr. Nielson on the following characteristics by circling the appropriate number for each quality.

Knows his stuff	1	2	3	4	5	6	7	Doesn't know his stuff
Considerate of others	1	2	3	4	5	6	7	Self-centered
Modest	1	2	3	4	5	6	7	Proud
Sociable	1	2	3	4	5	6	7	Unsociable
Self-assured	1	2	3	4	5	6	7	Uncertain of himself
Generous	1	2	3	4	5	6	7	Ungenerous
Warm	1	2	3	4	5	6	7	Cold
Humorous	1	2	3	4	5	6	7	Humorless

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THE ETHNOGRAPHIC INTERVIEW

ASSUMPTIONS

Language is the help provider's most important tool in understanding the needs and wishes of those needing assistance.

Language communicates. However, it's most important function may be to define, categorize, and establish the meaning of experience.

Language is a cultural product. Cultures vary, and so does language and the way language is used to organize and define the meaning of experience.

Language is a "window" to the reality defined and experienced by others.

To understand and interpret the experiences and sense of reality of others, one must know how they use language; language is a form of behavior.

Knowing how clients use language in clinical encounters is the most efficient way of learning about them, their concerns, and cultural factors which influence their behavior.

In the ethnographic interview, the interviewer guides the discussion using language patterns supplied by the person seeking assistance. The interviewer is in control of the *structure* of the interviewing event. The person being interviewed is in control of the *cultural* content of the event. The interviewer is a learner, the interviewee a teacher, in an open-ended but highly structured interview format.

DEFINITIONS

Global Question: A general open-ended question about some aspect of the interviewee's life that the interviewer finds personally or professionally puzzling. Global questions are planned in advance and used to open the interview. An example of a global question used in an interview might be "I don't often meet people from the American Indian community in my work; can you tell me why you left Alaska to live in Seattle?"

Cover Term: A linguistic label used by the interviewee to identify some important aspect of his or her experience. A cover term literally "covers" a range of culturally significant meaning which may be critical to assessment or treatment. A cover term is the language "window" to the cultural reality of another person. An example of a cover term that might appear in a medical interview with a Spanish-speaking person could be: "We don't usually bring these kinds of problems to doctors. They don't know about Susto, unless they are Latino, and they don't take it seriously anyway. But I think my child's problem is only partly that." [Susto is a folk illness with strong psychological

overtones defined as a "fright sickness" and (literally) a loss of soul from the body.]

Descriptor: The culturally meaningful information associated with a cover term. A descriptor is supplied by the interviewee to explain to cultural outsiders an "insider's" view of some aspect of his or her culture. An example of a descriptor elicited by a social worker might be as follows:

Interviewer: "You told me some foods are 'hot' and some are 'cold.' In your life, what would be some examples of 'hot' food?"

Interviewee: "That is something I think you Americans do not have but it is important to us and how we feed babies when they are sick. Sometimes they get sick when they do not have a balance, when they have too much bile, or too much wind. That is how you know what to feed them. Bile is 'hot' so I give her 'cold' food to make a balance. Bananas are 'cold' so it is good to give her that when she complains that way. But I don't know about that medicine the nurse gave me, so I don't use it."

ETHNOGRAPHIC INTERVIEW PROTOCOL I

This form is to assist you in practicing an ethnographic interview. It provides a general pattern for *planning and conducting* an interview. As with all interviewing, it should be culturally sensitive information that will assist you in making a culturally responsive and responsible assessment, intervention, and case plan. The protocol is shortened for use in a brief, practice session.

1. Ask your partner to tell you something about their “difference,” their cultural uniqueness—what make them “special.” Note the information in the space below. (Use the interviewee’s own words as much as possible.)

2. Underline any cover terms in the above statement.

3. Develop the descriptor for one of the cover terms identified above. Enter the descriptor below. Use the interviewee’s own words as much as possible.

ETHNOGRAPHIC INTERVIEW PROTOCOL II

This form is to assist you in practicing an ethnographic interview. It provides a general pattern for *planning and conducting* an interview.

1. Ask your partner to share with you a problem (either work related or personal) that they have had recently. Note the information in the space below. (Use the interviewee's own words as much as possible.)

2. Underline any cover terms in the above statement.

3. Develop the descriptor for one of the cover terms identified above. Enter the descriptor below. Use the interviewee's own words as much as possible.

VISAS INTERVIEWING GUIDE

VISAS is a guide that will help you apply the ethnographic approach to client interviews and to case recordings.

VISAS can help you in two ways.

The first is to learn from clients their views about the dominant values, interactions, social support, and aims of child rearing which characterize the cultural groups with which they identify.

The second is to learn how the client may have adapted these cultural features to accommodate their individual needs and life situation. In this context, it is important to know if a client's adaptations reflect or conflict with the values of their larger cultural group.

VISAS

- V Values
- I Interactions
- S Social Supports
- A Aims of Child Rearing
- S Strengths

Values: What are the major values of this client that guide his or her behavior and world view? For example, a Maori client tells you that the Maori culture values group ownership of assets. She has purchased a car, which she sees as her personal property. This has brought her into conflict with some members of her family who have asked to use the car and have been refused.

Interactions: What are the culturally motivated social behaviors that are evident in the client's interpersonal relationships? For example, a client tells you that she has always been taught that making direct eye contact with elders or authority figures is rude. Although she knows that most mainstream Americans like direct eye contact, she just can't do it. In this case, the client's behavior reflects her culture even though it may put her in conflict with the mainstream.

Social Supports: What is the client's sense of community and what help-seeking behaviors do they see as appropriate? For example, a newborn Hmong child is diagnosed as brain dead and the hospital ethics committee recommends termination of life supports. When the parents are unable to make a decision, the ethic committee calls in Hmong elders who examine the child and pronounce it dead. With this support (and approval) the parents are able to make the decision to withdraw life supports.

Aims of Child Rearing: What does the client believe is important to teach his or her children; how does he or she think children should be raised? For example, a client reports that she was raised to keep a low profile and not to excel in school or in any other group. She believes that this has put her at a disadvantage in today's competitive job market and is determined to raise her daughter otherwise. She has been strongly criticized by her parents and aunts and uncles for this.

Strengths: What are the client's strengths that can be built upon to address the problems? Factors that are rated low risk on the risk assessment form may point to some of these.

GLOBAL QUESTIONS

COVER TERMS

DESCRIPTORS

V (Values)

I (Interactions)

S (Social Supports)

A (Aims of Child Rearing)

S (Strengths)

ALDOONIAN CULTURAL SUMMARY

The following list summarizes the major characteristics of Aldoonian culture. These are the things you need to remember in the series of exercises we will do.

VALUES

1. Aldoo is a patriarchal society where male relatives and males in general are highly valued and esteemed.
2. Group welfare and identification are valued above individual wants and needs.
3. Competition is disapproved of because it is seen as a threat to the community.

INTERACTIONS

1. Conversations are marked by inquiry about and discussion of male relatives and general group welfare.
2. Physical contact, hugging and toughing, is encouraged and expected.
3. When you meet a non-Aldoonian, even if he or she is a stranger, it is expected that you touch them at least three times during your conversation.
4. Aldoonians are very respectful of authority figures, even those outside the community.
5. Nodding of the head means disagreement.
6. Aldoonians always speak very softly.

SOCIAL SUPPORTS (SENSE OF COMMUNITY)

1. Aldoo is a very close-knit community.
2. Members tend to live close together and have frequent contact.
3. Aldoonians are expected to both give and receive help and support from their community members.

AIMS OF CHILD REARING

1. Children are taught to be mannerly and treat their elders with respect.
2. Children are taught to carry on Aldoonian traditions.
3. Even minor misbehavior of a child brings shame to the family.

OMKAZIAN CULTURAL SUMMARY

The following list summarizes the major characteristics of Omkazian culture. These are the things you need to remember in the series of exercises we will do.

VALUES

1. Omkazians value achievement, success, and recognition above all else.
2. Self-sufficiency and the welfare of the individual are primary.
3. Competition is highly valued as a means of attaining success.

INTERACTIONS

1. Conversations are marked by discussion of parental and child achievements.
2. Omkazians will accept help from authority figures only if they are convinced of the benefit.
3. Relationships with others are marked by aloofness and self-absorption.
4. The crossing of fingers means you are frustrated and would like to move on.
5. Omkazians always stand for 2-3 minutes after seating a guest in their home.

SOCIAL SUPPORTS (SENSE OF COMMUNITY)

1. No community-organized services are in place.
2. Omkazians tend to have few associations with other members of their community.

AIMS OF CHILD REARING

1. Children are taught the importance of success by doing well in school.
2. Children are expected to assume responsibility at an early age.
3. A child who acts irresponsibly is a reflection of unsuccessful parenting.

ALDOO CLIENT INFORMATION

In this scenario, you are Mr. Dant (regardless of your sex), the father of a 15-year-old son, Rhoo. You are approaching your wit's end with Rhoo. For the past 3 or 4 months he has gotten completely out of control. He speaks loudly and disrespectfully to you and your wife and refuses to attend family and community get-togethers. Friends and relatives have commented to you about his behavior and obvious absences and you feel shamed in the eyes of the entire community.

The worst crisis occurred 2 days ago when your brother was visiting. Your brother asked Rhoo how school was going. Rhoo was searching through his CD collection and shouted back, "Can't you see I'm busy, you old codger." You were so shocked and appalled at this uncalled for outburst that you dragged Rhoo into his bedroom and began berating him for his rude and inappropriate behavior. When Rhoo attempted to push you, you grabbed a ruler off his desk and hit him twice in the face, blacking his eye and cutting his cheek.

While you regret hitting him so hard, you felt justified in your actions. Young people must learn to be polite and to treat their elders with respect. How else will the precious traditions of the community be carried on?

ALDOO REFERRAL

You are to investigate a call to the child abuse hotline from Mrs. Katz, the mother of a school friend of Rhoo Dant. Mrs. Katz noticed that Rhoo, a 15-year-old boy, had a black eye and a cut on his cheek when he visited the Katz home. A later conversation with her son revealed that Rhoo said he had gotten the black eye and cut during a fight with this father about something Rhoo had said to his uncle. Mrs. Katz was very surprised because the Dants seemed like such nice people when she talked with them at school functions. She also noted that she had been worried about Rhoo lately because he seemed angry a lot of the time and had been having loud arguments with her son, even though they are best friends. Mrs. Katz reports that the Dants are Aldoonian.

The only thing you have ever heard about Aldoonians is that they are attracted to people who are different and they frequently flirt, or “come on” to them.

Note: When you make the home call, only Mr. Dant is at home.

OMKAZ CLIENT INFORMATION

You are Mrs. Jurant (regardless of your sex), the mother of a 4-year-old girl, Stakz Jurant. Last week you found Stakz cutting up a cherished photograph belonging to your husband. The picture was the one of him shaking hands with President Ronald Reagan and had been taken at an award dinner for top engineers in the aerospace industry. The picture had been inscribed, "Congratulations Tak," and was signed by the President. For your husband, Tak, the picture was a symbol of his personal success and achievement. It was kept in a prominent place on a table in the living room and shown to all who visited your home.

Upon finding Stakz, and the picture cut to pieces, you completely lost your temper and hit her several times on the bare buttocks with one of your husband's belts. While you regret hitting her hard enough to break the skin, you feel justified in disciplining her in this way. If children are going to succeed in this world, they must be taught about the importance of symbols of achievement and learn to be responsible and independent without you having to stand over them all the time.

OMKAZ REFERRAL

You are to investigate a call to the child abuse hotline from Ms. Angie Wolfe, a preschool teacher. The referral concerns a 4-year-old girl, Stakz Jurant, who is in Ms. Wolfe's class. While the children were changing for their swimming lesson, Ms. Wolfe noticed red, swollen welts on Stakz's buttocks and upper thighs. The skin was broken in a couple of places. After much discussion and prodding, Stakz finally told her teacher that her mother had hit her with a belt for wrecking a picture of her dad. The teacher reported that Stakz is a very good student who is highly motivated and works well independently.

You are making a home call to the Jurant home. Stakz's mother, Mrs. Jurant, is the only one at home. Mr. Jurant is at work.

The only thing you have ever heard about Omkazians is that they are physically aggressive.