Integrating Caregiver Protective Capacities into Case Plans

Introduction

Case plans are established and implemented to change things. Yeah, everyone knows that, right? Case plans may be called treatment plans or service plans. Whatever you call a case plan, its purpose is remediation—to end up with results that remove the need for CPS intervention. Case plans and safety plans are different, which we explained in our December 2003 article. You can find it in the archived articles. Case plans do not replace the need for a safety plan while children remain unsafe. The purposes of these two plans are different which is important for you to understand. These plans with their different purposes can co-exist as efforts are expended in changing that which makes a child unsafe.

We've noticed that sometimes case plans can be quite broad, attempting to address every ill or unmet need that exists within a family. While we don't take issue with the idea of treating a wide range of needs and concerns, we know that there is no choice about whether to treat—to change—safety related concerns.

ASFA Brings Focus to Ongoing CPS

The Adoption and Safe Families Act requires you to address safety concerns in case plans:

> Excerpt from ASFA
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> SEC.475. [42 U.S.C. 675] as used in this part or part B of this title:
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> (1) The term "case plan" means a written document which includes at least the following:
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> (B) A plan assuring that the child receives safe and proper care and that the services are provided to parents, child and foster parents in order to improve conditions in the parents' home, facilitate return of the child to his own safe home
>
> and

(4) (B) the status of each child is reviewed periodically but no less frequently than once every six months by either a court or by administrative review...in order to determine the safety of the child, the continuing necessity for and appropriateness of the placement, the extent of compliance with the case plan, and the extent of progress which has been made toward alleviating or mitigating the causes necessitating the placement....

Sure, ASFA is not explicit about exactly how safety concerns are to be addressed, but a fair interpretation supports the responsibility to do so. According to this ASFA provision, a case plan must at a minimum provide services that make changes which result in a safe home. The interpretation is that case plans address what has made a home unsafe. We've pitched to you that the definition for "unsafe" is the presence of present or impending danger and insufficient caregiver protective capacities to mitigate the danger. So provision (1) (B) above says that case plans must contain the ways and means for improving conditions that make children unsafe. The cause that necessitates a placement of a child is "the child is unsafe." Reconsider our definition for unsafe: safety threats are present, and caregiver protective capacities are diminished. So case plans must be established and implemented in order that "a child being unsafe" can be resolved. There are only two ways to resolve a child being unsafe: (1) eliminate safety threats or (2) enhance diminished caregiver protective capacities.

If you've been reading our monthly articles, you know that our answer to the ASFA requirement to integrate safety concerns into case plans is to enhance diminished caregiver protective capacities. In some instances, the safety threat that exists within a family exists separate from a caregiver, but the caregiver is unwilling or unable to manage the threat. In some of those same instances, eliminating the safety threat without addressing caregiver protective capacity does little to assure that a similar or new threat won't once again result in a child being unsafe. Sometimes a safety threat actually is the caregiver such as a caregiver that is out of control. By enhancing the protective capacities of such a person, essentially, you eliminate the safety threat since the threat and the diminished protective capacity are inextricably related.

So, enhancing diminished caregiver protective capacities is the most promising approach to meeting the requirements as described in ASFA and, more importantly, achieving the safe home as identified in ASFA as the desirable outcome. In recent months, we've discussed the importance of assessing caregiver protective capacities in order to arrive at what must change in order to determine what will be addressed in a case plan. The Protective Capacity Assessment—more a process than an evaluation—is implemented collaboratively with caregivers in order to arrive at conclusions about what must change. And, in ASFA language, that could be elaborated on as what must change in order to establish a safe home for a child. Since you and a caregiver reach some mutual agreement about what must change, what are some things that help you to do that?

Caregiver Protective Capacities

For starters, let's get back in touch with what we are talking about when referring to caregiver protective capacities. Caregiver protective capacities are personal and parenting behavioral, cognitive and emotional characteristics that specifically and directly can be associated with being protective of one's young. There are a number of things that make a personal characteristic a protective capacity:

- The characteristic prepares the person to be protective.
- The characteristic enables or empowers the person to be protective.
- The characteristic is necessary or fundamental to being protective.
- The characteristic must exist prior to being protective.
- The characteristic can be related to acting or being able to act on behalf of a child.

Behavioral Protective Capacities

The caregiver has a history of protecting.	This refers to a person with many experiences and events in which he or she has demonstrated clear and reportable evidence of having been protective.
The caregiver takes action.	This refers to a person who is action-oriented as a human being, not just a caregiver.
The caregiver demonstrates impulse control.	This refers to a person who is deliberate and careful, who acts in managed and self-controlled ways.
The caregiver is physically able.	This refers to people who are sufficiently healthy, mobile and strong.
The caregiver has/demonstrates adequate skill to fulfill caregiving responsibilities.	This refers to the possession and use of skills that are related to being protective.
The caregiver possesses adequate energy.	This refers to the personal sustenance necessary to be ready and able to perform the job of being protective.
The caregiver sets aside her/his needs in favor of a child.	This refers to people who can delay gratifying their own needs, who accept their children's needs as a priority over their own.
The caregiver is adaptive as a caregiver.	This refers to people who adjust and make the best of whatever caregiving situation occurs.
The caregiver is assertive as a caregiver.	This refers to being positive and persistent.
The caregiver uses resources necessary to meet the child's basic needs.	This refers to knowing what is needed, getting it and using it to keep a child safe.
The caregiver supports the child.	This refers to actual, observable sustaining, encouraging and maintaining a child's psychological, physical and social well-being.

Cognitive Protective Capacities

The caregiver plans and articulates a plan to protect the child.	This refers to the thinking ability that is evidenced in a reasonable, well-thought-out plan.
The caregiver is aligned with the child.	This refers to a mental state or an identity with a child.
The caregiver has adequate knowledge to fulfill caregiving responsibilities and tasks.	This refers to information and personal knowledge that is specific to caregiving that is associated with protection.
The caregiver is reality-oriented, perceives reality accurately.	This refers to mental awareness and accuracy about one's surroundings; correct perceptions of what is happening; and the viability and appropriateness of responses to what is real and factual.
The caregiver has accurate perceptions of the child.	This refers to seeing and understanding a child's capabilities, needs and limitations correctly.
The caregiver understands his/her protective role.	This refers to awareness...knowing there are certain solely owned responsibilities and obligations that are specific to protecting a child.
The caregiver is self-aware as a caregiver.	This refers to sensitivity to one's thinking and actions and their effects on others—on a child.

Emotional Protective Capacities

The caregiver is able to meet own emotional needs.	This refers to satisfying how one feels in reasonable, appropriate ways that are not dependent on or take advantage of others, in particular, children.
The caregiver is emotionally able to intervene to protect the child.	This refers to mental health, emotional energy and emotional stability.
The caregiver is resilient as a caregiver.	This refers to responsiveness and being able and ready to act promptly.
The caregiver is tolerant as a caregiver.	This refers to acceptance, allowing and understanding, and respect.
The caregiver displays concern for the child and the child's experience and is intent on emotionally protecting the child.	This refers to a sensitivity to understand and feel some sense of responsibility for a child and what the child is going through in such a manner to compel one to comfort and reassure.
The caregiver and child have a strong bond, and the caregiver is clear that the number one priority is the well-being of the child.	This refers to a strong attachment that places a child's interest above all else.
The caregiver expresses love, empathy and sensitivity toward the child; experiences specific empathy with the child's perspective and feelings.	This refers to active affection, compassion, warmth and sympathy.

Remember that children are not safe because caregiver protective capacities are diminished. As you consider this list of twenty five protective capacities, you can imagine that in many, if not most, cases involving child safety, several of these protective capacities may be diminished. That produces a serious challenge when collaborating with a caregiver during a Protective Capacity Assessment to figure out where to begin.

Why are caregiver protective capacities diminished?

It can be helpful to you when getting ready to reach a mutual agreement with a caregiver about where to begin to consider why or how protective capacities have become diminished.

Some caregivers don't know.

One reason caregiver protective capacities might be diminished is the person simply doesn't have the knowledge necessary to be a protective parent. The lack of knowledge may be related to limited information or limited experience.

Some caregivers deny the reality of the world around them.

Such denial need not be pathological in a mental disorder sense. Caregivers may deny realities in order to give themselves permission to conduct their lives as they choose.

Some caregivers are unable to fulfill their essential needs.

While the range of unmet needs may be somewhat extensive, fundamentally, you are likely to find among some caregivers that their diminished protective capacities are explained by their preoccupation with a couple of needs: (a) the need to love and be loved and (b) the need to feel worthwhile to themselves and others. Another way of thinking about this is to combine these two needs into one—the need to be connected in satisfying ways to others.

Some caregivers are isolated and lack support.

While this may just as well fit within the last item on needs, it is important enough to get its own attention. All of us fulfill our needs by being involved with other people. So we can conclude that some caregivers' protective capacities are

diminished because they are disconnected or alienated from others, or the people they are involved with are destructive and manipulative.

Some caregivers are irresponsible.

People are responsible when they go about meeting their needs and fulfilling their roles in ways that do not deprive others of the ability to fulfill their needs.

Some caregivers are not motivated.

We'd like to think that every person who has a child of their own is motivated to care for and protect that child. It's not true. Some caregivers are highly motivated in some areas of their lives, perhaps, but are specifically not heavily inspired, influenced or stimulated to be effective parents or to assure their child's safety and well-being.

Some caregivers have developmental and historical damage.

Agreeably, many caregivers CPS encounters are products of highly destructive childhoods and trauma that pervade their lives. Here we have a problem of readiness and preparation in the sense that such people who are damaged goods are simply totally ill-prepared emotionally, intellectually and socially to parent.

Some caregivers are experiencing developmental or life crises.

While maybe not as often as other explanations, sometimes people are experiencing an event or life circumstance that reduces their effectiveness in general as a person and, therefore, as a parent.

These are among the reasons or influences that explain how caregivers' capacities have become diminished. So, when thinking about what to focus on in a case plan, thought must be given to these kinds of things when planning how to

approach change—what the caregiver will do in order to enhance his or her protective capacities. If you think about it, there are two things to keep in mind: the diminished protective capacity and what has contributed to the diminished protective capacity.

Criteria for Selecting Caregiver Protective Capacities for the Case Plan

When commiserating with a caregiver, as the Protective Capacity Assessment comes to a conclusion, bring to mind and introduce into conversations some of the following that may apply and help in deciding where to begin and what diminished protective capacities to include in the case plan.

- *Most Reliable*

  This refers to identifying among all diminished protective capacities, which do you and the caregiver trust is the closest to being the essential capacity in need of change, the most significant capacity that both of you trust is the right one to begin with?

- *Most Compelling*

  This refers to a diminished protective capacity that is vivid and impressive with respect to explaining how it is that a caregiver is not protective. Among diminished protective capacities, this is the one that you both agree undeniably must be addressed.

- *Most Defining*

  This refers to the diminished protective capacity that is definitive of difficulties of being protective. You might think of it as the central explanation for why the person is not protective. Another way of thinking

of “most defining” is that both of you agree that a diminished protective capacity is actually reflective or representative of the person in general.

- *Genesis*

  This refers to a diminished protective capacity that serves as the root or cause of other diminished protective capacities. It is like observing that several protective capacities are diminished, but they all seem initially influenced or flow from a single one.

- *Sum*

  This criterion acknowledges that some caregiver protective capacities are closely related. For instance, you can see that empathy, love and bonding are closely related protective capacities. It is possible that among some caregivers that one diminished protective capacity actually represents a sum of others. In our example, a parent who has difficulties loving a child could have problems with bonding and empathy. But the problems of love represent a sum of all of these.

- *Greatest Interest*

  Collaboration allows you to realize what is of most interest to yourself and the caregiver. If there are more than one diminished protective capacities, it may be simply a choice of where to begin or what to address that is associated by interest.

- *Quickest Payoff*

  This refers to considering among the diminished protective capacities which might have prompt results, be easily addressed, ripple into changing other diminished capacities.

- *Most Crucial*

  This recognizes that diminished protective capacities are not the same; do not have the same value; may not have the same effect when diminished or when enhanced. What is essential or vital is determined by larger things like hardest to change; most likely to return a caregiver to full authority; likely to result in greatest gain or greatest loss; contributes most to being protective.

- *Least Threatening*

  Sometimes the place to begin is where a person feels the least challenged, threatened or feels less personal risk or commitment.

- *Least Resistive*

  This refers to diminished protective capacities for which a person feels the least concern about addressing or defending. This includes higher likelihood of openness and willingness to approach change because of no felt need for maintaining status quo.

There is a ruling principle in all of this that should be applied as you talk through with a caregiver what diminished protective capacity or capacities to select for the case plan: *Mutual Agreement.* We emphasized that mutuality is the cornerstone in this approach to ongoing CPS. Mutuality demands equal standing between you and the caregiver and caregiver self-determination. When employing these ideas expressed in this criteria, as part of the conversation, keep in the mind the importance of arriving together at what must change.