BEST PRACTICE GUIDANCE FOR SOCIAL WORKER WELL-BEING CHANGE

I. FAMILY-CENTERED PRACTICE – MULTIPLE RESPONSE SYSTEM AND SYSTEM OF CARE

Perhaps the greatest ability for social workers to protect their own well-being is for them to feel successful at the numerous and challenging tasks for which they are charged. One of the strategies for feeling successful at their jobs is to feel connected to the families and children that social workers serve daily.

Both families and social workers report that the foundation of Family-Centered Practice (hereafter, FCP) – the guiding tenet of both Multiple Response System (hereafter, MRS) and System of Care (hereafter, SOC) make them feel more successful and ultimately, more valued.

Legislation enacted by the General Assembly serves to heighten the capacity of agencies to provide family centered protective services to children and their caretakers. None of the legislative revisions changes the practice of family centered child protective services. Legislation supports social workers as they conduct necessary interviews and contacts with children and families during the course of an assessment of valid allegations of child abuse, neglect, or dependency.

A. Six Family-Centered Principles of Partnership

1. Everyone desires respect
2. Everyone needs to be heard
3. Everyone has strengths
4. Judgments can wait
5. Partners share power
6. Partnership is a process

B. Underlying Beliefs of a Family-Centered Approach to Child Welfare

- Safety of the child is the first concern.
- Children have the right to their family.
- The family is the fundamental resource for the nurturing of children.
- Parents should be supported in their efforts to care for their children.
- Families are diverse and have the right to be respected for their special cultural, racial, ethnic, and religious traditions; children can flourish in different types of families.
- A crisis is an opportunity for change.
- Inappropriate intervention can do harm.
- Families who seem hopeless can grow and change.
- Family members are our colleagues.

The application of the six Family-Centered Principles of Partnership…	
…used throughout the implementation of the 7 strategies of MRS…	**…as demonstrated by…**
1. Collaboration between Work First and Child Welfare	Reducing the number of times family members need to repeat the same information. Involving Work First as a preventative effort and reducing the number of children needing CPS and placement services. Preventing recidivism by providing on-going services through Work First.
2. Strengths based Structured Intake	Respectfully allowing reporters to be heard, supported, and encouraged while improving the quality and consistency of information gathered through highly structured intake procedures that focus on family strengths in an effort to ensure the safety of children
3. Choice of two approaches to reports of child abuse, neglect, or dependency	Protecting the safety of children in the most severe cases by not treating all reports in the same way and missing some clear need for immediate action. Engaging some families in services that could enable them to better parent their children. Not overlooking vital information about the strengths of the family, the supports they have, and their motivation to change. Better serving many of the families reported to CPS in ways that focus more on helping rather than “punishing” them.
4. Coordination between law enforcement agencies and CPS for the investigative assessment approach	Achieving joint efforts in interviewing and ensuring safety of families and children. Ensuring an effective working relationship. As a result, perpetrators will be held accountable for harming children; the number of interviews children experience will be reduced, preventing / reducing re-traumatization; and, the evidence process for criminal prosecution will be enhanced.
5. Redesign of CPS In-Home Services (formerly Case Planning / Case Management Services)	Providing the most intensive services and contacts to families with the greatest needs, while those with fewer needs receive less intensive services/contacts. Delivering services within the context of the family’s own community and culture. Social workers better identifying risks in their work with families. Having the option of receiving supportive/voluntary services available for families where there is a low risk of harm. Engaging families in the planning process, and producing better outcomes of safety, permanence, and well-being for children.
6. Child and Family Teams during the provision of CPS In Home Case Planning And Case Management Services	Improving the decision-making process. Encouraging the support and buy-in of the family, extended family, and the community in the planning and assessment process. Developing specific, individualized, and appropriate interventions for children and families. Recognizing the birth family as an expert.
7. Shared Parenting meetings during the first 7 days of placement out of the home	Keeping the family of origin actively involved in their role as parents of their child. Cultivating a nurturing relationship between the birth parents and the foster parents. Foster parents becoming mentors for the birth family regarding appropriate parenting.

C. System of Care Principles:

- Family Involvement
- Community-Based Care
- Individualized Strengths-Based Care
- Cultural Competence
- Interagency Collaboration
- Accountability

Effective family-centered practice is accomplished within a System of Care framework. SOC can make MRS implementation easier for counties because it builds a structure in the community where agencies, workers and families can all be more successful. A SOC framework stresses community collaboration which means that responsibility for outcomes is shared through cross agency Child and Family Team (hereafter, CFT) meetings and community collaboratives are actively working together to eliminate barriers to services and addressing the unique needs of families. "Care review" teams of the local collaboratives work together to keep children in their homes where possible and share responsibility for placements when they are necessary. Families are actively involved in decision making, services are community based and more culturally appropriate. If families are more involved, CFT meetings are taking place, community collaboratives are making more services available in the community, and plans are going to be more individualized. All of these things create an environment for family-centered practice to reach maximum potential. All of these create an environment where MRS can be fully implemented.

II. SOCIAL WORK SAFETY

A. Safety Issues

It is strongly recommended that the county Department of Social Services (hereafter, DSS) have written protocols defining procedures workers are to follow in at-risk situations, including seeking the assistance of law enforcement.

Safety issues have always been a crucial component of social work practice, especially with the recognition that every CPS case has the potential for confrontation. At times social workers unintentionally discount the nature of CPS intervention and the client's view of their role when confronting child protective services issues. Difficulties may occur at any point in the CPS process. Threats and volatile situations, however, are more likely to occur during the CPS assessment process, during crisis situations, and when a significant action is taken; (i.e., removal of a child or the decision to take a case to court).

With a social worker's safety and well-being as a primary goal in the threatening situations which are confronted on a day-to-day basis, each county DSS should take responsibility for assuring safety for all staff. This includes:

- Strengthening the awareness of job-related safety precautions
- Teaching work-related, as well as personal self-protection skills
- Broadening the understanding of law enforcement's role as it relates to CPS
- Familiarizing CPS social workers with the importance of attitude and professionalism as it relates to safety.

The first step in ensuring social worker safety is to assess the risk of the situation before the initial contact. Before social workers conduct the first contact with a client they need to assess the risk to themselves. Questions social workers should consider include the following:

- Is there a previous history of domestic violence or other violent behavior toward others?
- Does the CPS report indicate the possibility of a family member being mentally ill, being physically aggressive, or using drugs (refer to the NC Child Welfare manual's portion about Drug Endangered Children for additional information related to social worker safety in this area)?
- Are there firearms or other weapons noted in the intake report?
- Is the family's geographic location extremely isolated or dangerous?
- Is this a second or multiple CPS report involving the family?
- Is the initial contact scheduled after normal working hours?
- Are there any vicious animals on or near the premises?

All of the preceding questions can be asked during the *Structured Intake* screening process and should be documented on the DSS-1402 (CPS Intake Report). After answering these questions, a decision should be made as to whether or not to call upon law enforcement or another social worker for assistance with initiating the CPS assessment.

A social worker's appearance, verbal and nonverbal statements, and demeanor can impact on the client's response. In confrontational situations, if the social worker appears calm (both verbally and nonverbally), has control of the situation without being intimidating, and uses anger reduction techniques, he or she will probably be able to defuse the situation. The following information should provide some direction in these situations.

B. Approaching the Potentially Irate Client

When a client is hostile or verbally abusive remember to do the following:

- **Maintain a calm disposition** so that feelings of anxiety, fear, anger, etc. do not interfere with the ability to communicate effectively. All statements should be made in a very clear, simple, and direct manner.

- **Be assertive** so that the social worker's involvement in the situation is viewed as clearly professional and not personal. Avoid taking responses personally and responding defensively.

- **Show respect** for clients by speaking to them and not at them. Be directive, not authoritative. Present alternatives in a positive manner.

- **Request help when needed!** If a client or other individual becomes aggressive, make attempts to calm him/her. Otherwise, seek assistance from the nearest allies.

- **Avoid touching** whether it is in a calming or protective manner without first explaining your actions. Try to get the person or yourself to separate or different locations. Remove yourself from the immediacy of the hostile situation.

C. Approaching the Mentally Ill Client

It is very difficult to understand the mentally ill client's reactions when approached, especially when the client has not been previously known to the agency. Mentally ill people seldom become violent, and their mental status is usually characterized by fear and confusion rather than assaultive or aggressive behavior. The following guidelines will enhance the social worker's ability to relate to mentally ill clients in the office or in the field.

1. Try to communicate clearly, at the client's level of understanding, your identity and the purpose of your contact.
2. Be empathetic, nonthreatening, and sincere in your intention to help.
3. Give honest, factual answers. Do not try to appease the client or ignore the clients' questions. If you do not know the answer, say so.
4. Do not belittle any concerns that the client raises. Answer in the most purposeful way.
5. Do not give advice about handling their psychological problems, particularly on initial contact. Refer client-identified issues to the client's therapist or mental health clinic.
6. Do not speak from your own personal feelings in response to client statements. Respond from a professional level only.
7. Be supportive in both comments and gestures.

8. Do not make assumptions about the abilities of mentally ill clients when confronting them regarding issues of child maltreatment. Be specific and concrete in your statements and questions.

9. Know how to access emergency mental health services and use them if the client appears to be a danger to themselves or others.

III. AVOIDING BURN-OUT AND OTHER EMOTIONAL HAZARDS

In addition to having knowledge, skills, specialized techniques, and assistance for confronting the potentially irate and/or mentally ill client, social workers need appropriate training, supervision, consultation, and support. Understanding these components and addressing the issue of "compassion fatigue" will assist social workers in maintaining a balance between protecting their personal well-being while working with less-than adequately functioning families.

Social workers may approach such an array of socio-economic problems through:

- Consultation with supervisor(s) when they are unsure about how to handle a situation;

- Consultation with more experienced social workers who may have dealt with a similar situation; and

- Consultation with professionals who specialize in the problem area who, with some history, may be able to assist with an analysis and interpretation of the current situation and future risks.

Also, group case staffing involving the whole unit are extremely beneficial sources of consultation. In group case staffing, a social worker may present a case and the supervisor and other social workers in the unit share their expertise to determine suggested actions, services, resources, or decisions. This is also an opportunity to discuss policy implications.

IV. BLOODBORNE PATHOGENS IN THE WORKPLACE

The nature of social work often puts social workers in hazardous situations that may impact their health. Social workers are encouraged to have knowledge of the occupational hazards that may affect their lives. This information is provided as guidance to safeguard oneself when faced with these situations. Social workers are encouraged to stay abreast of new information about prevention of the spread of disease.

Bloodborne pathogens are pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV).

A. Hepatitis Viruses: Epidemiology and Transmission[1]

Hepatitis means “inflammation of the liver” and can be caused by a number of agents or conditions including drugs, toxins, autoimmune disease, and infectious agents including viruses. The most common causes of hepatitis are viruses.

There are four types of viral hepatitis which are important in the United States:

1. Hepatitis A, formerly called “Infectious Hepatitis”, which is spread by fecal contamination and is not generally considered to be a significant risk to healthcare workers, although episodes of transmission to healthcare workers have been reported. Effective vaccinations are available to those who are exposed to type A Hepatitis.

2. Hepatitis B, formerly called "Serum Hepatitis”, is a major risk to healthcare workers because it attacks and replicates in liver cells. The Hepatitis B Virus is the major infectious bloodborne occupational hazard to healthcare workers and can easily be contracted and spread to others. HBV has long been recognized as a pathogen capable of causing serious illness and death.

3. Hepatitis C, previously known as “Parenterally (meaning by needle sticks, human bites, cuts, and abrasions) Transmitted (PT) - Hepatitis.” This virus is efficiently transmitted by blood transfusion and needle sharing among intravenous drug users.

4. Hepatitis E, previously known as “Enterically (meaning relating to the intestine) Transmitted (ET) – Hepatitis” has occurred both in epidemic and sporadic forms in parts of Asia, Africa and Central America. It is virtually unheard of in North America. It is a self-limited acute form of viral hepatitis that is typically spread by fecally contaminated water. HEV has an extremely high mortality rate when the infection occurs during pregnancy. No vaccine is currently available.

B. Human Immunodeficiency Virus: Epidemiology and Transmission[1]

The Human Immunodeficiency Virus (HIV) is a member of a group of viruses known as human retroviruses. In June 1981, the first cases were reported in the United States of what was to become known as Acquired Immunodeficiency Syndrome (AIDS). Investigators described an unusual illness characterized by Pneumocystis Carinii Pneumonia (PCP) and Kaposi's Sarcoma (KS) that developed in young, homosexual men without a known underlying disease or cause for immunosuppression. HIV ARC (AIDS Related Complex) is a condition caused by the AIDS virus in which the patient tests positive for AIDS infection and has a specific set of clinical symptoms.

By early 1982, 159 AIDS cases had been identified in 15 states, the District of

[1] Reference Information: Occupational Safety and Health Regulations (Standards - 29 CFR), Blood borne Pathogens Rev. July, 1999

Columbia, and two foreign countries. All but one of them were men and over 92% of them were homosexual or bisexual. By the end of 1982, cases of AIDS were reported among children, intravenous drug users, blood transfusion recipients, hemophilia patients using clotting factor concentrates, and Haitians. In 1983, the disease was also documented among female sexual partners of male intravenous drug users in the U.S. and among Africans. By the end of 1985, all 50 states, the District of Columbia and three U.S. territories had reported AID cases.

Documented modes of HIV transmission include: engaging in anal, vaginal, or perhaps oral intercourse with an HIV-infected person; using needles, including needles used for drug injection, ear piercing or tattooing which are contaminated with the virus; having parenteral, mucous membrane or non-intact skin contact with HIV-infected blood, blood components or blood products; receiving transplants of HIV-infected organs; through semen used for artificial insemination and perinatal transmission (from mother to child around the time of birth).

C. How HIV is NOT spread

You cannot “catch” AIDS or HIV infection like a cold or the flu. It is not spread by coughs or sneezes.

You cannot get HIV through everyday contact with infected people at school, work, home, or anywhere else.

You won't get HIV from clothing, phones, or toilet seats. It cannot be passed on by things like spoons, cups or other objects that someone who is infected with the virus has used.

You won't get AIDS from a mosquito bite. The AIDS virus does not live in a mosquito and is not transmitted through a mosquito's salivary glands like other diseases such as malaria or yellow fever. You won't get it from bed bugs, lice, flies, or other insects. You won't get HIV from sweat, tears, or sneezes.

Although in the past some people became infected with HIV from blood transfusions, this risk has been virtually eliminated. Since 1985 all donated blood has been tested for evidence of HIV, and blood that contains evidence of HIV is discarded.

You cannot get HIV from giving blood at a blood bank or other established blood center. Needles used for blood donations are sterile and are used only once before they are destroyed.

D. Bloodborne Pathogens - Exposure Control Plan

There are certain “universal precautions” that should be practiced regardless of any knowledge that any infectious disease may be present. Universal precautions are an approach to infection control. According to this concept, all human blood and certain body fluids are treated as if known to be infectious for

HIV, HBV, and other bloodborne pathogens. Suspect body fluids include semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, and any body fluid that is visibly contaminated with blood. Social workers assigned CPS responsibilities do not usually perform tasks that involve exposure to blood, body fluids, or tissues. Social workers do, however, work with families and children who may carry the HBV or HIV virus, or who are in high risk situations which make the contraction of the virus more likely.

E. Guidance for Preventing the Spread of Bloodborne Pathogens

1. County DSS are encouraged to have a "safety kit" available to CPS workers at all times. A safety kit should include: medical supplies, such as bandages, peroxide, scissors; latex gloves, etc. This kit should be restocked immediately after use.

2. Know your agency's policy for providing services to clients with infectious diseases. There may be specific protocols to be followed.

3. Assume that **everyone** is a carrier and use universal precautions. Use latex gloves if you will be exposed to blood or other suspect body fluids.

4. Make sure you have a child's medical history as well as that of the family and/or parent if possible. This information should be placed in a client's file where it is easily accessible to review. This information is confidential and should be revealed only on a need-to-know basis. This information, as well as any other client information, should not be discussed casually.

5. Do not engage in any bodily contact with clients that would increase risk of infection for you or the client.

6. If a social worker has the HIV virus or AIDS, conduct yourself in a way that would prevent the disease from being contracted by any others.

7. Thoroughly clean and disinfect spills of body fluids, using a bleach and water disinfectant (one cup of bleach to one gallon of water) or rubbing alcohol. Use gloves to protect yourself and dispose of the gloves inside out. Disposable towels and rags and gloves soiled with body fluids

   should be bagged separately and marked "Biohazard." Rags, towels, and other reusable items used to wipe up spills can be laundered, and machine dried.

8. Stay abreast of new information regarding the prevention of these and other bloodborne pathogens. There are many research studies occurring that are revealing new conclusions around prevention and treatment.