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Supporting Safety Together: Reviewing Child Protective Services Policies, Forms, and Case Records

Rose Thelen, Gender Violence Institute and Denise Eng, Praxis Institutional Analysis

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Please stand by for real time captions.

>> Welcome to the webinar entitled supporting safety together. This webinar is presented by praxis international. My name is Denise Ing I am the senior advisor here at Praxis and I am joined by our presenters. Before we get started with the content of the webinar, I will ask Kue to give us information about the technical aspects .

>> Thank you so much. Everyone my name is Kue and I am the program associate at Praxis. I will go through the technical aspects of the webinar. So on your screen you will see a closed captioning pot. This is live so please excuse any mistakes. To the right of the PowerPoint you have the Q&A box. Feel free to leave any questions in there. Any questions will be answered according to the time that we have and it is private. Presenters will respond. As they come up. And also we have a web link pod which will contain a copy of the PowerPoint and any other materials that may be related to the webinar. Aside from that you can adjust the settings of the closed captioning pods or what you are using by clicking on the icon in the upper rate. In terms of audio, the audio will mainly come from the computer speakers. If you have any issues, you can dial into the phone number listed on the screen. You can use the code on the screen as well. If you have any connection issues you can click on the help button on the upper right corner of the screen. That will allow you to test your connection and download any add-ons. If you have any questions about audio you can message me in the Q&A box. That is about it.

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>> Thank you, Kue. We are talking about how we support safety of battered mothers and their children together who are involved in the child protection services system. We will focus on the reviewing of policies, forms, and case records. And the methodology we will discuss comes from the praxis assessment guide which I will briefly talk about in a moment.

>> This guide was written in response to the reality that advocates and child protection services often find themselves at odds when dealing with cases where domestic violence is present. Both child protection workers and advocates care deeply about protecting children. They often approach the cases from different perspectives. Because of this, there are general gaps I think advocates what identify as those that occur in the institution. For example, advocates often see pressure put on battered mothers to stop the violence. They see a reliance on separation of the adult parent as a primary safety strategy. But that will not accomplish the reduction of violence. They see mandating an extensive list of services and concurrently very few for the batterers. And the lack of ability to control the offender or hold them accountable. We find some time services don't necessarily match the needs of a battered mother or family for example they may order a parenting class. Also there is a notion of failure to protect and placing responsibility on the non-offending mother to protect the children. This dilemma is not the result of the protection workers of course we want to be as effective as they can be in ensuring the safety. The system we have in place is not always effectively organized to account for the violence in these cases. Rose can you add of what you have seen in these cases. As I am saying this I am realizing, Rose I forgot to ask you to introduce yourself.

>> Thank you, Denise. I am Rose Thelen. I am a consultant with Praxis international. We have been involved in domestic violence for a long time and the arena of trial protection as well starting as and - - an advocate when I was alarmed about the potential impact that domestic violence had on kids and I remember rattling cages thinking if everyone got excited about what this was doing to the children, they wouldst stop the abuser. Instead, we saw often the

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mother was deemed co-responsible for the abuse. You see in this list of institutional response gaps that what happens is the victim of domestic violence enters the system because she is battered. Through a series of internal processes, policies and laws and etc. it comes out the other end it leads the other - - leaves the other end of the system identified as a bad parent. Because she is battered it is equated with failure. That is an outcome that is problematic. It is not an outcome that either advocates or child protection workers know is going to actually stop the violence. What we - - my interest has been building over the years and stop - - Praxis was involved for a long time. Relative to this particular topic today, I was involved with the practice for the Praxis child safety assessment in 2016 when I worked with the local county to test this particular tool that was developed. We made recommendations to improve the tool and also made recommendations to improve the criminal - - the child protection system response. There is a quick run through of how I came to the topic. Thank you for having me today, Denise.

>> Thank you for joining us. I am glad you mentioned the tool that we produced here at Praxis and your involvement in the testing. I want to say a brief introduction to what the tool is. I will not describe it in detail today because we have some resources on the website that you can download the tool itself. We have a couple of other webinars where we describe the tool in more detail. Today we will focus on the one aspect. That is the analysis of various tests and documents. As Rose said Praxis led several audits and partnered with juvenile and Family Court judges and the center of social policy doing these projects. We were ready to use the tool to help communities engage in this assessment. In 2010 we applied for and received funding from the office on violence against women. It is available for free on our website as a download. There is a process in it to answer questions about the community's response to violence against women specifically child protective services. If the tool can help you to explore questions like do we know when battering is a factor? Do we know about her strategies to protect children. Will the intervention enhance or diminish the capacity. Will it contribute to harmful desperate outcomes. - -? As Rose mentioned we worked with her and

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the team of practitioners in Wright County Minnesota where they lived to test up materials and the activities. Rose will share her insights. You will find the tool on the website and you can listen to previous webinar recordings. The key steps involved are to begin with mapping and conversation. In the system the experience of relationship building and developing a common purpose and coordinating actions is recent in the child welfare area. It is generally less developed than the criminal legal system's response. There is been a lot of work for the past 40 years. This guide in relation to child protection services includes activities to help establish relationships and develop shared definitions and common language we can go deeper into the assessment activities that will help us identify things. We begin with mapping and conversation. We want to work side-by-side, advocates and child protection officials to understand things on how referrals come in to child protective services. What happens next? Who takes the call? What forms do they fill out? Who screens them? Built into that is a shared discussion village that will help domestic violence workers and child protection workers explore and develop a shared understanding of certain concepts for the system response to child protection. Then by talking with victims and the community we engaged in a process to understand those involved with trial protection. What happens to families when they get swept up in the system? The third point is what we will be spending most of our time on today. Is looking at policies and identify where policies don't exist in looking at case files to see if it's documented. And then finally the tool helps people working together to use the tool to develop a plan for change.

>> As I said they will focus on one end of the tool. We will look at analyzing policies, forms, and case records. We are supporting the process and the teams ability to use these together. The starting point involving conversations on child protection. Help to develop a framework that could support the work of looking at the cases together. The teams will explore common principles and guiding principles for practices. They will include in that various perspectives on strategies and battered mothers and how they keep their children safe. How children can be

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used as a tactic of battering. All of this can help to start conversations and establish releases - - relationships identify ground I can help to work through the analysis of various documents.

>> I want to explore this concept. It is easy for us to think of anything that is a written or spoken word or recorded word that if captured to help guide a workers response or help to understand the experience of people whose lives are affected by this response. It is easy to think of those as passive. We want to train ourselves to think of text as being an active thing. That is that a text can help you to sort or to categorize or prioritize direct monitor and evaluate and more. Texts really help us to see how they tell a worker what it is they are supposed to do. We want to be thinking about that. When we do text analysis we are engaging in close, careful reading of all of the documents. We do them in order to understand how the institutions organize and coordinate workers and carry information and become the official experience. When we do the analysis we want to keep key questions in life. Rose can you add thoughts about how you have come to view the questions as helping to guide an analysis of documents ?

>> Sure. First of all, looking at what's in writing that guides the behavior of the practitioner will be where you find the most fruitful explorations. The text will be used in some way either it will tell them to ask particular questions of the people they are working with or it will have them document what they did or so they can put it into the database that goes to the state that is a requirement of the federal law. It sets off the whole string of behaviors or activities and so the first questions like how is it using created and where does it sit in the sequence that is all about the mechanics. Keeping that in mind as you look at a text can help you. Sometimes it will take you backwards and sometimes forward. It will always help you understand what it is that the worker needs to do as a result of this text. Ellen always used to say you change the form and you change the system. I think that has a lot of truth to it. Sometimes we overemphasize things like we need to train our workers. Training is only as good as the person listening to it or for as long as they stay with your agency. We want to put into the text's what

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it is we want to train them on. If we are talking about principles and dynamics of domestic violence and best practices, and we want people to be utilizing them. Make sure they are in the text. I think the last two as well are very important. Is this really resulting in the safety for both the child and the mother? Or the non-offending parent that we want to happen? We start with that everyone attend - - intent to do well but there can be a gap. How much does that move both child protection workers and domestic violence workers to an outcome that provides for safety for both parties, child and adult victims. Is there any - - is there a difference because of social standing and life circumstances or is it a one-size-fits-all? Will it be do we find there might be classes and racism built right into the text. Those are the things I think about. These are questions we took forward as we look at the text and we will be getting into that.

>> Thank you, - - Rose Thelen. I want to describe about the various kinds of text you might want to take a look at when you do this project. We group them into these areas. There are regulatory texts and what we call administrative texts. There are specific documents and I will tell you about what each of these is. The regulatory text tell workers what they must do. For example state and federal laws. I am involved in a project where we are examining the response to the implementation of the child welfare act. Of course there are state laws and they are are a federal law. That is an example of a federal statute that governs what happens on the local level. Agency policies and guidelines that tell workers what they need to do. Handbooks and flowcharts that show how information goes from one worker or one agency to another. There can be others as well. So can you share some examples of policies you may want to review.

>> One thing we noticed is there really wasn't a policy within the agency that we looked at. Policy with a little [Indiscernible]. The various forms and worksheets but it was [Indiscernible] to the text. It was relative to certain conditions. The state law was fairly vague on a number of things about what is domestic violence and how it impacts the children and when do you know

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it constitutes injury to the child? A lot of it was left up to the discretion of the worker but when we look at administrative texts what we see is that there were a lot of forms and checklists and assessment tools and those sorts of things. It in fact did constitute the directives that told workers what they were supposed to do. So I want to point out a couple of forms I think that were fairly important in the analysis that we did. There is a thing called a structured decision-making tool. You will find this all over the country. It is a copyrighted suite of tools that is supposed to help the people make decisions about how to investigate and how to determine how to response when there is domestic violence. In reality, that particular a structured decision-making tool as it's called is - - it is based on some fairly faulty assumptions. What we saw and found was that it was never clear that they treated the person doing the battering any differently than the victim who was getting battered and the impact. There was no need to identify who did what to whom with what outcome. It was listed as domestic violence. It was defined by fights and violence and threats etc. Domestic violence was also if you had called law enforcement or got a protection order or if you left the home and you came back. That resulted in a negative number against you. What we saw but that there was no place that said there is a difference in who was creating the harm. They are not co-responsible. You could not find that in the form that was a structured decision-making tool that not only did it have to be done but put into the data space that went to the state. Now the county was benefited from some season supervisors who knew there were limitations in this particular tool but in fact what forms do as they train you. The worker who is using the forms wasn't necessarily benefiting from the long history of understanding there is a difference between the victim and the perpetrator. They are not co-responsible. They were not asked to sort this out. That was the one that we really focused on a bit. Again, the outcome of applying this particular decision-making tool was that they were both seen as responsible for the violence. She was also seen as the primary parent and as such, she had primary responsibility for making it stop. It was a very interesting thing. It didn't reveal itself to

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me but I think everyone on the team who wasn't thinking about it in that particular way. That is one that comes to mind for me.

>> One of the thoughts that I have in the project I was involved in is the electronic database is that we were looking at some case files that were included in the electronic case file in a database called SSI. It is interesting because that database was created for the purpose of documenting workers actions because they can build the federal government for reimbursement for time if they document their actions. Workers have to spend a lot of time entering data in this. They have decided to capture case information in this database. And so it was created for one purpose and the use expands to another purpose. It didn't really fit well. What we found was it was cumbersome to use and it is difficult to find information and that statewide mandate to use this tool was really creating some challenges as well for workers. You can really learn a lot by understanding the origin and the use of forms.

>> I was thinking that one of the ways we knew which forms to look at or what forms we were involved with was an outcome of the mapping process. It is also in the guide which helps you to understand how a case goes through a system. Every time the institution ask what are the relevant documents that direct the worker to do particular things? I cannot over emphasize how important looking at the guide is for understanding how it fits together.

>> Exactly. Exactly. Just a quick review of the documents you could look at are you could look at case specific document. By that I mean not an entire case file but really a set of completed documents. Like if there is an intake form or a screening divorce - - device meaning you can look at the form itself or you can look at a set of completed forms. You can look at a set of case plans or petitions filed in court. You could grab a whole bunch of one kind of form. Do you do any of that kind of work in Wright County, Rose ?

>> Yes one of the things we looked at were all of the cases that were sent over by law enforcement were identified as being involved with domestic violence. That constituted a bulk

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of cases that went into that particular system where [Indiscernible] and so we looked at what law enforcement was sending. One thing we saw sometimes law-enforcement sent a report that said the victim was offending. It was a victim who had they hadn't done a good assessment of who was actually a violator in this instant - - instance? Who is using force as opposed to resisting. It's one of the places we bonded and they needed a bunch of stuff and they couldn't be responsible for what happened within these families. You don't have to do all of these are delved deeply into context policy documents. Some of what you are looking at will be quicker to go through. Not to be discouraged by the volume of what you are looking at.

>> I think one of the things about doing child welfare is that there are so many categories of documents that have to be filled out and information that has to be kept. It's in some ways more complex than criminal justice work were you look at police reports were listening to 911 calls. There are many different kinds of forms generated.

>> We looked at over 25 different documents.

>> You don't have to look at all 25 you can pick one or two. And then finally you can look at an entire case file or a set of them which is everything from intake all the way through assessment or investigation and the court process and placement and then the resolution. These will be very lengthy documents sometimes hundreds of patients. Certainly dozens of pages or in the case of the electronic database like in the project I described there's a lot of information. You looked at a number of case files didn't you ?

>> I think we looked at about 12 in all. That was and that was where you saw the rubber hit the road because particularly in the documentation about what the worker entered about the narrative. That stood in for what was the experience and that is where you saw that the structured decision-making tool led to what people said in that particular chart which was generally there was not a lot of information about who was using domestic violence to impose their will or control the other. It was that they were both involved. We looked at that. To let's

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do a little bit of policy analysis. We are looking at this through the lens of what guides the workers. We are looking at the structure of how the worker is organized to respond. We will not look at content yet. We will find that we are looking at case records. We are looking at the structure. We are looking at how workers are organized to respond. The guide includes a lot of information about how to do this and the kinds of principles or strategies you could look for. We are looking for things like how the policy guides the worker to identify and document the existence and what cases are we talking about? How do we know there is a mastic violence? Understanding the nature and the context of the violence and its risks to children and adults. Giving attention to culture, race, and disparity. And then promoting, how does the worker guide advocates and other points of intervention. Rose can you talk about your experience and deciding what it is. You looked at 25 different kinds of documents that you had. How did you make that decision?

>> We decided that we did the mapping and we looked at every form that existed that was in writing. That was - - even though it was 25 of them some of them were very brief. It wasn't like we were diving into a 600 page policy document. We were looking at a one-page checklist that might have one reference to domestic violence on it. What was useful again were the worksheets in the guide. We didn't look at them without a purpose in mind. The guide talks about first you look at and you read them and you go back and you use the worksheet. The worksheets are really where the rubber hits the road. They had different themes. There were four sections and there were different numbers in each of these. You see them on the screen. There was how much did the form and the policy protocol that we were looking at incorporate principles that have been identified as effective for advancing safety for adult and child victims together. And where the procedures - - were the procedures going to promote the idea of the same thing that there will be safety for both parties. Also how do - - are they specific to what is going on in terms of the domestic violence? Do they act as if domestic violence is a general moniker that both parties are responsible? Do they ask them for a separate service plan? How does that work? And then what specifically did the perpetrator do? What was the

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impact on the child? This was missing in a lot of cases. We talked with child protection about some of the frustrations they had when a case went to a custody hearing but they could've helped in regard to influencing that custody hearing if there had been some effort to really document who was the perpetrator not that they are both co-responsible. The other thing was how well does this document incorporate attention to monitoring? So that the worker has to in fact do what is required to be compliant with what the county has as a standard for their practice? Our advocates - - our advocates involved and what about the victims and consumers in terms of what they were doing and how they did it? The big issue is is there any effort and does the policy or the protocol assist the worker in taking a look at what is the cultural issues involved in this? Is there disparity of impact and how are these forms applied? When you look at the worksheet there will be four pages long. You have on the left side it has what you will do and what you are looking for and on the rate where you find it if you do. The extent to which we found these things existing in the county were very slim. That was a big piece of what we were going to be recommending and we will talk about this in terms of outcomes. In the worksheets themselves there is like nine questions or items that direct you to figure out whether there are effective practice principles. There are 14 items that relate to the procedures. You see some of those listed here. 12 items related to monitoring and then there are 15 items related to disparity. Let me say it is a comprehensive tool and it gets at being able to tease apart this complicated institution with so many competing mandates. It was Ellen Penn says last vision. She went to Detroit and met with child protection experts and experts from around the country pick she did that quarterly. They went to the Detroit airport and put this together and figured it all out it is brilliant in the scope and it is another good example of the various practice assessments that were developed. I just want to put a plug in for it. What we can say today will not be half of what you will find in this particular guide. That is what we found and that is my coverage of this particular worksheet. We can go and if you want me to advance and talk about this checklist, there will be some application of this as we take a look at this family assessment response protocol.

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>> Rose, we had a question come in. Someone wants to know if we have found that most states have these kinds of worksheets?

>> I'm not sure. I think they have them but they have a lot of leverage in Minnesota to create their own. They get them from each other as well. This family investment response protocol this is right county. You will find this in many other counties as well. They are not required to have this but people share and they share what they are doing and how they are doing it. I don't know if that answers your question. It depends on your particular state whether you have local child protection or state and that kind of thing. What do you know about that, Denise ?

>> I am not really an expert but child welfare for example in Minnesota it's a state function that is implemented by the county. Of course in the case of [Indiscernible] about what ICWA stands for and that is the Indian Child welfare act. I would expect most agencies whether determined by the local county agency or statewide would have some sort of structure that guide workers on how to assess whether or not they will investigate and - - an allegation and to screen it out without being within their purview. I would guess most states or counties - - I would start with what they used to make a - - in additional screening.

>> This hold structured decision-making tool it is required statewide and required in many other states in the country and that has to go to SSI as well it's an important form. That is across the state and every department uses it. If you look at this response protocol checklist this is where you may find variation. If you look at this form, it is something that was completed by the worker and it had to be done within 45 days. If you see it, if you look at it the only thing that references domestic violence is number nine. It's interesting they complete substance use with screen. Of course when you try to figure out it isn't necessarily that they would have every step that was accomplished in this particular screening on the sheet but generally what you would hope for is that domestic violence was screened per protocol and they look for other forms or policies and procedures. That help the worker to identify what is

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going on and what is the risk and level. Who is doing what to whom? What we found when we looked is it took us back to the structured decision-making tool. That was the most detail we could find anywhere about what was the level of domestic violence. So the case might enter the system and the law enforcement made an arrest. Domestic violence occurred. They applied this assessment tool in decision-making suite of tools and it would ask things about were they both engaged in domestic violence? No sorting out about one of them being the victim and the other one being the offender. Both of them were screened together. It was really limited and you can see where it leads to problematic outcomes. If she's equally responsible always have to do is get her to do the right thing. In the recommendation under the structured decision-making tool it said that they get those back one of the parties is going to have to leave either the primary parent or think it's called the secondary parent. I am not sure if that's right. That was the direction is that one leave. If you look at nothing else I would say ask your child protection agency whether they use the protocol or whether they use structured decision-making and what else do they use? How do they assess for and identify what needs to happen in terms of domestic violence? I will let you take this identification of cultural needs. That is where you are working right now, right?

>> Yes pic you are reading my mind, Rose. It's interesting to note the only information you have here that guides the worker is to check off if they identified culture needs and sent a note to tribes if appropriate. And then for information that don't know too much that is a requirement of the Indian/child welfare act is there it needs to be a determination of whether a child is an Indian child as defined by federal law and whether tribal identification is made. There are many different kinds of cultural needs that a child might have. The culture of a child could be this and it doesn't tell us anything about what the child identified culture is and what the connection is. And what the needs might be and how a worker would appropriately connect the child or a family to meet those needs. Certainly in the work we have been doing we have seen that while some of this is Matt we are seeing a lot of documentation and we aren't necessarily seeing an expiration of what the meaning is for children. Also in other Praxis

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institutional analysis projects for example when they were working with the Center for social policies and looking at racial disparity. We found that there wasn't really a strong identification by child welfare services about child connection to culture or what the meaning of culture is and how the child's group might be organized differently to meet the child's needs and that is usually apparent in the dominant culture. Those are things you may want to look for as we analyze this. It is a protocol. It is built into a checklist and it looks like a form. This is a document that codifies the steps that you are supposed to take. This is an example of how to look at a protocol to see how the ideas we have been talking about are built-in. Rose can you spend a minute talking about the form here for people on the call. It doesn't look like a form but we lifted the information from a form called the family safety plan. That workers are supposed to fill out. On the left side of your screen you see the points on the form and they will be fold - - filled out in a narrative form and on the rate there are question. Can you talk about that ?

>> This was a no-brainer. First of all it was a family safety plan that came out of the structured decision-making. It wasn't a separate safety plan. They were both going to be responsible for ending the violence. It just suggested that the victim had so much more power than she does to be able to stop the abuser. There was a particular form that does not suggest at all that he is capable of coercing her to do whatever he wants including keeping the violence going. I think - - the interesting thing for me wasn't looking at this with the supervisors and the workers themselves they were like because you are in an institution you are in your silo and you do what's required and you don't really put this all together. Looking at these various forms the people first of all said what's going on here? In the guidelines for domestic violence and the occurrences says they will do separate safety plans. No one has to use those guidelines. It was something written and if you wanted it you could get training. We were looking to change the form and change the practice. Is built right in there. What we are able to discuss is how this helps the person who is the batter - - batterer. They believe she is responsible. In general she is the first one that needs to change so he doesn't respond in the

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way he does. It is very loaded and it almost hurts to read it and think about what would happen to that victim who is being reinforced. Yes she has to do something different here too. This is a big place were we made some changes right away.

>> A question came in about how your state were to make a safety plan group decision and I would say in the project I was involved with, one of the things we really are seeing is that there is a lot of discretion that workers have. I am wondering did you do anything or could you close that or maybe open that conversation to include more people ?

>> The workers got guidance from their supervisors throughout. On the safety plan it was something that would grow out of whether what had come up in the structured decision-making tool. To apply that it was that the worker did this with the couple. And so that wasn't a group decision. If the person - - I think that Wright County was very responsive. If there was any need for assistance, but as of the assessment there have been a lot of changes to the safety planning forms. In particular that it is done and there are other changes that don't hold her responsible. I don't know if that answers the question. One of the biggest problems we see that we were working with is how many cases and how much time they have. If you can get your workers trained with a set of texts let's say there is less need. It is the individual ongoing involvement with the team. Depends on the resources.

>> We have another question, in Texas a violation of safety plans have safety consequences. Have you been able to have meetings about them being violated? It's an interesting concept. I don't know if we are thinking of violations in the same way they are in Texas but what did you uncover when you looked at what happened when people put together a safety plan and then if you talked about this already, you are putting together a plan that you don't necessarily have a control over. What did you see when you had your conversations?

>> The safety planning we looked at seemed like fluff. That was one of the things we identified as a big gap in that there was not a lot of ways to hold the offender accountable for whether

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they violated the safety plan. That became an issue or it was an issue and for a couple of reasons. For one thing it led to this whole thing of developing a separate safety plan. It isn't a new thing. And then also to have connections with the system so for example, one of the things we saw was in some cases the guy was violating probation by having contact with her. There is no connection with probation to say we happen to know this happened. Or there was also no way of being able to do that safely. There needed to be parameters around how do we have relationships with the system to hold the sky accountable? I don't know how it would work in other ways to use a safety plan to - - unless there was some sort of court involvement that required the person to do particular things which is what we found the criminal justice system could do and or the protection order system, the civil justice system. Again, there was nothing that existed in Wright County or for that matter that I know exist anywhere. I would be interested in how Texas does it.

>> We have a comment that they had issues with child protection mandating shelters. Of course that puts the shelter in a difficult position because [Indiscernible]. Of course that is not a strategy that we would recommend working with this system to move away from that kind of assumptions that place the money - - mother in this thought - - shelter. I won't ask you to respond because I know we want to talk about case records. We have already seen how there are a lot of - - you can learn a lot by looking at the forms and policies. We also want to capture people's experience. Dorothy Smith who was one of the originators of the work had said that when you look at a case file or record or what is written about someone's life, it almost always is incomplete and it almost always get something wrong. Sometimes dramatically wrong in very important ways. We want to look at case files to see how they capture the experience. I want to say a minute or two about what we did in the project I described to look at case files. They were all electronic. We had to work within our state system and negotiate how they are made available. And to describe the parameters of when we want those cases to be there. We were looking for ones that were not active. They provided a link to the system for us. Everyone

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had to get trained and we spent a week looking at these files. Can you give us a minute on how you prioritize this.

>> We looked into partner violence and screening and the family assessment referred to by police. We gather at the paper documents but I remember Jessica came out to pick up the files and they came out with a bin of sick binders for the 12 cases that we looked at. We look at them all and identified what we thought was a good subset that we thought had the most ongoing coercive control by the batterer involved. And then it only took us a few mornings to read them together and use the worksheets. That is what we did. It was paper documents. It was very fruitful to take a look at those.

>> Were you required to redact the documents and take out all the identifying information or were you looking at unredacted documents?

>> We were looking at unredacted documents. We signed a document that said we would not disclose any of the confidential information. We would not disclose what we found in their. That is how we covered that. It would have been quite a lengthy process to redact them all.

>> I think and child protection files there is so much paper and so many documents it is difficult to do. In our case when we looked at electronic documents we had to watch a video and pass a test and then take a screenshot that we passed the test. That included recognition of the need to hold the information confidential.

>> Moving ahead, in the guide in the Praxis guide, there are case review worksheets that have - - they lay out these kinds of features to look for in the case files. Whether the case file accurately identifies and distinguishes between the able - - adult victim and perpetrator and whether it identifies protective strategies and using culturally relevant practices. I won't talk in detail about these because we want to look at some records. You can see in the guide some further flushing out of each of these features. Let's take a look at the form that was used to look at case files. This is an excerpt from a form in the Praxis guide that you can use to look at

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a case file. On the left there is a question of whether the case file was opened under the offending adult's name. It is pretty common for cases to always be opened in the mother's name. It is our view if the mother is not the offending adult, it is interesting if the case is opened in her name and how does it organize the workers attention? How does it direct the attention toward the mother? And whether each adult has a separate, individual service plan. You see here, to the right some requirements that are commonly put upon parents in child protection cases. So Rose can you describe how you use this very briefly .

>> This was the second part of the worksheet. It was about after you looked at these things we saw what was required of each parent? And the very - - very little was required of the batterer. We didn't see much in terms of what they did. It's a huge gap we knew. I think it's a gap that created some sort of bonding between the protection worker and us. How can we utilize and how can the system shift in order to be able to get a better handle on the batterer? How can it work with others in the legal system? What we saw was the victim should get a protection order. That they should attend the support group and they should get parenting and also that they should - - the woman mentioned they should go to a shelter. We did not see a lot of that. The supervisors knew better. We don't have a shelter so that may have made a difference. If there is any psychological testing it was her. Even though the batterer was the problem, the victim had to do all of these things to prove that in some ways she was cooperative. Being cooperative she made a clear statement to the agency that she was - - she wanted the kids and wanted to protect them. It is a very curious connection between what you see there and what the assumption is. They opened the cases in the victim's name and we didn't see much required of the offender. We didn't see they were getting a handle on it unless the case was open.

>> This is a pretty typical menu of services that child protection will use. Often times this will have a many. It may or may not need it. Sometimes when you look at the case files and you

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can see what is being required and if it seems to be based on the menu or based on what people need.

>> There's more. This is just an excerpt. There are other things as well. Including that she got financial assistance for housing or what were the things she needed. So this is - - this was really constructive in terms of what was going on. For me the other thing that happened was the batterer if there was a subsequent custody evaluation or assessment or proceeding, the batterer would say child protection was involved but that case was closed. Even though they didn't do anything they got credit for the fact that the case was closed because maybe she did all of these things in order to be able to have the case closed.

>> We can't look at an entire case record on a webinar but only a small section. We will look at a little section of the case record. This is from an actual case record. Where there is a police report that says an anonymous complaint stated a female was being hit and was then dragged inside the residence. The victim was very reluctant to speak about it due to the criminal past. The case notes say there was a child present. Can you analyze this quickly using the framework that we talked about for looking at these case records ?

>> It's clear there's no definite identification of what was the violence and who used it and how did it impact the kids. Even with the specifics of the injuries. All we knew was there was a domestic occurring between them. This one jumped out at people. I remember the supervisor was horrified that this was in the case file that it was represented in that way. There were changes right away about how people put stuff into the case notes. There was no accurate identification of who was the batterer and the victim and the violence wasn't concrete. They described all the ways they utilize the form before the worksheet. It was negative under each. From there, one thing we discussed was a possible revision that would make it clear that the father was the one hitting the mother and dragging her inside the house. It wasn't just domestic violence. She was reluctant to speak about anything. Because of the suspects criminal past not because she was complicit in it. And so you can see very clearly that we know

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who had the violence and the parent probably had some reasonable fear and maybe she was keeping her mouth shut in order to protect the child and of course we see clearly again how the child was involved in this particular incident.

>> And looking at every file we didn't have to look at hundreds. This was consistent and it was pretty apparent that even though we had good supervisors and there was some training it was one of the recommendations we made to the state and they include this in the training about how to identify these things. Beyond identifying in the training to be able to identify it in terms of changes to the various forms and protocols and procedures and checklists.

>> Let's look at one more case record quickly. The report says the victim told the subject was being mean and punched me six times. I was seated on the recliner in the living room and it kicked back. My son stood up for me and told the suspect not to hit me and the suspect hit my son. The case notes that it was reported the child was punched in the knee while intervening in the fight between his parents.

>> Can you give us some comments.

>> I think it's fairly obvious that we are just - - it is being reduced into this whole idea that it is about people who are fighting. It is not about someone using violence and other tactics to control the adult victim who will be controlled not just in terms of that incident but also in what they do in child protection and the capacity to comply with what's required of them. And whether it should be required because in fact a person who is doing the damage is the one who is not showing up. They become almost invisible in the case records. The possible revision on that will be getting specific that the mother - - the boyfriend punched her six times, one of the things that the supervisor talk to the worker about was I want to be able to make a picture of this. And so they started to make those changes immediately. As soon as they looked at the case files together. It's interesting to note as well that because of the level of work, the supervisors were not able to look at every case file. They assumed things would be in the case

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file because they had talked about domestic violence. They were very savvy. They knew what they talked about as supervisors. What they required - - were required to do was not - - there was no attention to these things. In addition to the supervisor getting to the workers right away saying we want you to start doing these things differently and here is how, we want to find out where this will be in a form. We want to located in a form or a policy or protocol. As many places as possible that they are asking questions to get at this.

>> That's a quick overview of this case file.

>> In the waning moments of the webinar can you talk a little bit about other applications and a practice assuming you don't want to do a full-blown text analysis. How could you use the forms in the Praxis guide?

>> First of all, every person who is involved with child protection, has a right to see the case file. One of the things you can do is you can review a case file. With the women who is involved in the system who is the victim of violence. Or in the exception there may be a man involved in as the victim. Take a look at that at the case file with her and does it include the ways that she sought help? Does it make clear who is responsible for the violence? Use the checklist to go through it. Every victim has the right to put in stuff to the case file that provides greater detail. May be someone said they were fighting and she could put in there here is what was really going on. The extent to which he used violence to get her to stop or start something or how he used kids to get her to do what he wanted. I found it useful. When Praxis started working on doing something about the child protection system, they got a number of women to go get the case files and started to review these case file. From there they developed the worksheets. That was in conjunction with these experts in the country that were doing it. Taking a look at is the impact clearly documented? One thing that happened in a lawsuit in New York City was that the case law had to determine that would be more adverse for the child to be removed for the home to stay within the home where the batterer was living. It isn't always in the best interest in the child to be removed. It can be very harmful.

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There's a discussion on that. We didn't go into that. The woman who talked about shelters really is problematic because sometimes her leaving can be the most dangerous thing. The other thing is something called [Indiscernible]. I don't know where you can stand - - where used in this but many report this when they know child was. One thing developed a supplement that said how did they protect the children? What was the strategy? Did they get an order? Did they drop the order because they wanted to protect the children? All of the ways that they support the children. Often they think there is a safety plan but in reality they need the community to be doing a bunch of stuff in order to help her and stop the violence. That is a quick run through. I know the mandatory report will be sent out as well as other resources from this webinar.

>> Thank you. We are out of time. And so I don't have time to ask you to talk about the outcomes and the resources but I want to tell folks who are listening on the webinar hopefully you have been able to download the PDF if not we can send it to you. The outcomes here are - - they've already been here and the outcomes are in progress. You can download the entire report. I want to take a moment. I want to talk that OVW will be open up soon and your fear - - if you are interested in applying you can apply and include this and it will be [Indiscernible]. On the Praxis website you will find in addition to the tool itself and the report you will find a variety of resources including grant language and the checklist and templates and a lot of information on focus groups. We have additional reports and tools related to safety audits. All of that is available in the website. Included is a section on resources that reference related to child welfare and domestic violence cases. The New York case that rows referenced and other resources as well. Finally, the alert for upcoming events, the Praxis community assessment Institute will be held in St. Paul Minnesota next year here in St. Paul. Watch for that information. And watch for additional 2019 webinar offerings. With that, we want to thank you very much. Thank you especially to Rose Thelen for being available to us to talk about her important work. We hope everyone has a good day. Thank you, everyone. Goodbye.

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>> [Event Concluded]

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