DEVELOPING PRACTICE PROFILES

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PROGRAMS

In human services, the practitioner is the intervention (Fixsen, Naoom, Blase, Friedman & Wallace, 2005). Practitioners use *programs* to guide their interactions with children, families, adults, and groups. Practitioners who understand the need for the intervention and believe in its benefits, along with those with self-efficacy and skill proficiency are more likely to implement a program at higher levels or dosage or fidelity (Barr et al., 2002; Cooke 2000; Durlak and Dupree, 2008; Kallestad and Olweus 2003; Ringwalt et al., 2003) and therefore, a well-defined program is essential in promoting practitioner confidence and competence. The lack of adequately defined programs is an impediment to implementation with good outcomes in human services. To be useful in practice, any practice, intervention, or innovation should meet the following criteria for a program (Fixsen, Blase, Metz & Van Dyke, in press):

1. Clear description of the program
    a. Clear Philosophy, Values, and Principles
        i. The philosophy, values, and principles that underlie the program provide guidance for all treatment decisions, program decisions, and evaluations (a "lived" set of values); and are used to promote consistency, integrity, and sustainable effort across all practitioners and among all units within a State human service system that are utilizing the program.
    b. Clear inclusion and exclusion criteria that define the population for whom the program is intended
        i. The criteria define who is most likely to benefit when the program is used as intended
2. Clear description of the *essential functions* that define the program
    a. Clear description of the features that must be present to say that a program exists in a given unit ("essential functions" sometimes are called core intervention components, active ingredients, or practice elements)
3. *Operational definitions* of the essential functions
    a. Practice profiles describe the core activities that are associated with each essential function and that allow a program to be teachable, learnable, and doable in typical human service settings; and that promote consistency across practitioners and staff at the level of actual service delivery ("practice profiles" sometimes are called innovation configurations, Hall and Hord, 2006)
4. A practical *assessment of the performance of practitioners and staff* who are using the program
    a. The performance assessment relates to the program philosophy, values, and principles, essential functions, and core activities specified in the practice profiles; assessments are practical and can be done repeatedly in the context of typical human service systems.
    b. Evidence that the program is effective when used as intended.

i. The performance assessment (sometimes referred to as “fidelity” or “adherence” or “dosage”) is highly correlated (0.70 or better) with intended service outcomes.

PURPOSE

The focus of this guide is on the third criterion stated above: practice profiles that provide operational definitions of essential functions. Based on Hall and Hord’s (2006) “Innovation Configurations,” practice profiles operationalize each essential function of a practice or program on a developmental continuum. Six major areas have emerged as critical to successful practice profile development: 1) pre-requisites; 2) resources; 3) teaming; 4) content; 5) process; and 6) alignment. Below we describe these six areas in more detail, providing lessons learned from NIRN work in various human service systems.

I. PRE-REQUISITES/UNDERSTANDING THE PURPOSE OF THE PROFILE

Prior to beginning profile development, other aspects of the program including guiding principles and essential functions need to be defined (criteria 1 and 2 outlined above). These aspects of the program not only set the stage for profile work, they delineate the ***scope for profile development***. It is critical that Implementation Team members understand how practice profiles fit within the broader program. Practice profiles operationalize the essential functions by identifying the core activities related to each essential function. Operationalizing each essential function through the development of practice profiles facilitates the development of a program that is teachable, learnable, and doable in typical human service settings; and promotes consistency across practitioners at the level of actual service delivery. Well-operationalized practice profiles ***define what practitioners will be saying and doing.***

II. RESOURCES

Provide the following materials to Implementation Teams:

- ***Examples of profiles accompanied by written explanations and follow-up support in person or via conference call.*** We have learned that it is critical to review, review, review with the Implementation Team and not assume that one example covers what is needed. Also, be mindful that examples may begin to serve as the basis for a group’s practice profile development. While some of the essential functions or activities of the new profile may be similar to the example, the example should not serve as the basis for a new profile. It is important for the task members to conceptualize and articulate the unique activities that will be carried out to show the essential function in action (what the practitioner will be saying and doing). The discussion and debate that occurs in the process of profile development is just as valuable as the profiles themselves.
- ***Provide the research base for each essential function to ensure that practice indicators are research informed***. It is best to provide synthesized, one-pagers for each essential function. A process for finding and reviewing the related literature should be developed. It is important to identify who will provide the relevant literature synthesis and identify best practices resources. These resources should be shared prior to any profile development. Here are samples of one-pagers provided on two essential functions: 1) engagement and 2) planning. Findings from the literature are emphasized.

ENGAGEMENT: WHAT DOES THE EVIDENCE SHOW?

Engagement is about motivating and empowering families to recognize their own needs, strengths, and resources and to take an active role in changing things for the better. Engagement is what keeps families working in the long and sometimes slow process of positive change" (Steib, 2004).

Engagement is a multilevel phenomenon influenced by and comprised of a number of interwoven factors at the practitioner, client, agency, and larger social environment levels (Yatchmenoff, 2005).

Practitioner Engagement Activities are delineated in four categories:

• Intensive authentic connection with children, youth and families to ensure safety, permanency, and well-being (1)

• Shared planning &decision making with families (2)

• Cross systems partners – including courts, medical and mental health, substance abuse and domestic violence and other key agencies - - are actively involved as key partners in ensuring timely and seamless delivery of services to children and their families.(3)

• Utilizing Formalized partnerships with critical stakeholder and community groups are created to provide ongoing information and insight to improve organizational policy, procedures and practices regarding family engagement (4)

CASE PLANNING: WHAT DOES THE EVIDENCE SHOW?

In the area of case planning, research supports what has been seen as good practice for many years. Research supports case planning that:

- Is based on mutual (i.e., agency—family) agreement about what the child and family needs (Shireman, 1998).
- Matches services to mutually identified needs (Dawson & Berry, 2002; Rooney, 1992).
- Builds on the strengths of the family (Shireman, 1998).
- Includes goals that are clear, specific, and measurable (Dawson & Berry, 2002; Rooney, 1992).
- Lists tasks that are incremental and achievable (Littell & Tajima, 2000).
- Considers immediate needs (like a washing machine or a refrigerator for a mother with an infant) as well as concrete needs, (like day care, housing, transportation) (Gaudin, 1993; Pecora, Whittaker, Maluccio, & Barth, 2000; Dawson & Berry, 2002)
- Recognizes that offering concrete services will produce higher levels of collaboration from the family (Littell & Tajima, 2000).
- Seeks an overt expression of commitment to the plan (like signing the case plan) (Rooney, 1992; Potter & Klein-Rothschild, 2002).
- The case planning process is enhanced, according to the evidence, if practitioners remember that:
- It is important to engage families in the planning process so that they will meet the requirements, especially since "non-compliance" with the plan can lead to removing children from their homes (Dawson & Berry, 2002).
- Families that feel listened to in family meetings and parents who feel their opinions counted 'a lot' are significantly more likely to agree with the plan (Shireman, 1998).
- Agreement with the plan is also linked with the family perception that they had sufficient contact with the practitioner (Shireman, 1998).
- Families that feel 'outnumbered' in family meetings or feel unprepared for the meeting are less likely to agree with the plan (Shireman, 1998).

As well, web-based resources can be helpful to the team working on the practice profiles. Here is an example of an email sent out to task groups in one State working on different practice profile elements.

> Hello all:
> Below and attached are resources for the Assessment and Partnering Practice Profiles. Please know that there are numerous quality hard copy resources on both of these critical areas; I limited my resources to those you could easily access.
> ***Assessing***: Gathering information about reported concerns and family needs, evaluating the relevance of that information as well as identifying family strengths and community and tribal resources that may be applied to address those concerns and needs.
>
> 1. Comprehensive Family Assessment for Child Welfare
> http://www.acf.hhs.gov/programs/cb/pubs/family_assessment/family_assessment.pdf
> 2. Framework for Safety
> http://www.napcwa.org/home/docs/FrameworkforSafety.pdf
> 3. Critical Thinking in Child Welfare Assessment: Safety, Risk and Protective Capacity
> http://bayareaacademy.org/downloads/Critical%20Thinking%20ES%20Final.pdf
> 4. Comprehensive Family Assessment Guide
> http://www.cehd.umn.edu/ssw/cascw/Attributes-CFA/PDF/Model/Guide-Practitioners-FA.pdf
>
> ***Partnering***: Respectful and meaningful collaboration with families and community to achieve shared goals.
>
> 1. Building and Sustaining Effective Partnerships with Parents
> https://www.msu.edu/user/nactpf/initiative_parents.htm
> https://www.msu.edu/user/nactpf/images/initiatives/strategic%20plan%20pdfs/StratPlan-Parents.pdf
> http://www.childwelfare.gov/preventing/promoting/partnering.cfm
> 2. Community Partnerships: Improving the Response to Child Maltreatment
> http://www.childwelfare.gov/pubs/usermanuals/partners/partners.pdf
> 3. Building Successful Collaborations
> http://www.cfc-fcc.ca/link_docs/collaborationReport.pdf

III. TEAMING

WHO will do this work? Depending upon the size of the Implementation Team, we suggest a smaller Task Group to lead the practice profile work, with even smaller groups who work on completing individual rubrics for different essential functions.

Task Group: Multiple perspectives are important here. In one State, we have a mix of State administrators, county supervisors/practitioners, trainers, and consultants. It seems to be the "perfect mix." This Task Group has two co-chairs representing State and county levels.

The role of the Task Group is to complete the entire practice profile for the program. In this role, this group is responsible for reviewing the literature, developing drafts for each essential function, and for participating in group facilitation and decision-making to finalize the products. It also is important for the task group members to have the time available and capacity to do this work. Once the literature is reviewed, and made available to the task group, we have found that it requires about 2 days to complete the practice profiles for each essential function. This includes 6-8 hours for initial draft, 2 hours of group work, and 5-6 hours of revisions.

In terms of capacity, we recommend including members who have the ability to conceptualize and articulate activities in a behaviorally-based manner. While the members will have the ability to practice these skills though the development of the first profile and group processing for feedback, it is more efficient and effective to select members who have experience with and have the skills and abilities to articulate activities in observable, measurable terms.

Pairs: We have found it useful to assign each essential function to a pair of individuals who work to create the first draft, and bring it back to the overall task group for consensus, revisions, and integration with the other practice profiles. We also recommend that this pair have unique perspectives – basically, we intentionally pair folks together that may not always agree.

NIRN – The work of the Task Group initially is facilitated by NIRN. The goal is to transition to internal facilitation after 3 to 4 individual profiles have been completed. However, transition cannot happen too quickly. *Strong facilitation and leadership are important for the work to be done in a political context.* NIRN also can help develop a plan to identify the research-base (one page syntheses of evidence), as well as other resources.

IV. CONTENT

What exactly "makes up" the practice profile? NIRN's current working definition is "identify the core activities that allow a program to be teachable, learnable, and doable in typical human service settings; and promote consistency across practitioners at the level of actual service delivery." This definition is a great starting point, but we have found that critical questions arise in several major areas. These include:

Scope and Purpose: Scope is a major issue when developing practice profiles.
Number of Indicators: We recommend creating some general guidelines on the number of indicators for each essential function. We currently recommend at most 10 indicators per profile section.

Prioritizing Indicators: Prioritizing indicators is a key first step in narrowing the scope. Another scope issue relates back to the purpose of the practice profile. Many times Implementation Team members will suggest the inclusion of general principles or foundational tenets within the practice profile. For example, when developing a profile on "engagement" Implementation Team members may feel compelled to bring in broader issues such as family-centeredness which, while certainly important to the program, should be covered within other areas of the program such as guiding principles. This

allows the Implementation Team to ***narrow the scope*** *of the profile to behaviorally-based, measurable, observable indicators specific to each essential function..*

Inter-relationship among essential functions – in programs, essential functions are typically inter-related. A process needs to be developed to ensure that redundancy is minimized and decisions are made regarding which indicators are associated with which essential function.
Overlap: We currently recommend that a minimal amount of overlap is acceptable, but for the most part, indicators should be developed specifically for each essential function.

Operational definitions for the rubric headings – The middle column of the rubric (developmental) is always a challenge for team members. We recommend ahead of time operationally defining the rubric headings so that there is not confusion regarding which indicators belong in each cell.

Developmental Approach - We have found it useful to describe the profile as a *"developmental, practice-informed reflection of practitioner progression."* In this way, new practitioners competencies (or practitioners who are redeployed to new positions) typically fall in the middle category of Developmental at first as they test out their new skills and learn to generalize skills to a range of contexts and settings. As skills, abilities, and judgment are developed, practitioners will move to the Expected category. Articulating this developmental approach before work begins on the actual practice profiles will save time later and reduce confusion and revisiting issues. Below are operational definitions for the three categories of activities for each essential function.

- **Expected/ Proficient** includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts; use these skills consistently and independently; and sustain these skills over time while continuing to grow and improve in their position. Words used to describe expected/proficient activities may include "consistently, all of the time, and in a broad range of contexts."
- **Developmental** includes activities that exemplify practitioners who are able to implement required skills and abilities, but in a more limited range of contexts and settings; use these skills inconsistently or need supervisor/coach consultation to complete or successfully apply skills; and would benefit from a coaching agenda that targets particular skills for improvement in order to move practitioners into the "expected/proficient" category. Words used to describe developmental activities may include "some of the time, somewhat inconsistently, in a limited range of contexts." This column helps to define the coaching agenda.
- **Unacceptable variation** includes activities that exemplify practitioners who are not yet able to implement required skills or abilities in any context. Often times, if practitioners' work is falling into the unacceptable category, there may be challenges related to the overall implementation infrastructure. For example, there may be issues related to how they are selecting or training staff, managing the new program model, or using data to inform continuous improvement. Activities in the unacceptable variation may include words such has "none of the time, inconsistently." This column may indicate deficiencies in the implementation drivers on a larger scale. The column also should include unacceptable activity that is beyond the absence of or opposite of activity acticulated in the developmental or expected categories.

Examples from the field: Example practice profiles from child welfare are provided in Appendix A. The examples provided are still in development and under review.

V. PROCESS

The process of developing practice profiles involves several steps and cycling between large and small group work. A potential list of steps includes:

1) ***Form Task Group*** – subset of Implementation Team. We suggest selecting approximately 6 members who represent different aspects of the system. We have found trainers are particularly helpful due to their understanding of state guidelines, competencies, etc. It also is useful to identify a leader for the group who will serve as the point person and organizer.
2) ***Ensure strong facilitation and leadership at the outset*** – Presently NIRN plays a strong role in this facilitation but other knowledgeable external consultants may play an active role, depending on their knowledge and comfort level.
3) ***Develop consensus on key issues before beginning profile work*** - Understand the political context and work to attain buy-in for defining programs more specifically. We have found it useful to have some “resistant” folks as key players in the process. Key issues for consensus building include purpose, scope, roles, operational definition of column headers, etc.
4) ***Provide examples, intensive consultation, and protocols***. – We have found that detailed protocols are needed to guide the process for developing profiles. It is critical that everyone understand the purpose from the beginning.
5) ***Develop initial draft of first profile with the larger group*** – We have found that it is instructive to have the entire Task Group develop a draft of the practice profiles for one essential function so everyone can experience the process and see the outcome. This also sets helps to set the standard for use of evidence, behavioral specificity, and scope.
6) ***Conduct intensive group work on first essential function*** – Work together to ensure the “process” and “decision making” works for everyone. We spend a significant amount of time first walking through the “Expected” implementation column with the group and asked the “Key Questions” (see below) for each activity indicator. This allows the group to prioritize the activities and assess the extent to which they are measurable. The draft developer then revises the profile and the group goes through a second round of feedback to refine the indicators across the three activity domains – Expected, Developmental, and Unacceptable.
7) ***Break into smaller groups/pairs to draft the practice profiles for each essential function*** – We recommend pairing folks with different perspectives to complete remaining profiles for each essential function.
8) ***Cycle between small and large group work*** – Profiles for each function are developed by pairs and that report back to the overall Task Group for more group work (live or via web conferences) to build consensus, improve specificity, and delimit or expand scope.
9) ***Key Questions to Ask for Group Work:***

a. Is the indicator a priority for this essential function?
b. If yes, is this indicator measurable? If not, can we state it so that it is measurable?
c. Does the indicator belong somewhere else? Should it be removed?

10) ***Allow enough time –*** The practice profile for each essential function takes approximately 2 days to complete. This includes 6-8 hours for initial draft, 2 hours of group work, and 5-6 hours of revisions. This does not include time to put together initial resources for team members. This **excludes** the time to review the literature and evidence and develop the one-page summaries.

When profiles are completed, they are brought back to the larger Implementation Team for further consensus building and finalization. It is not expected or recommended that the full Implementation Team do a line by line review together. This was the purpose of the Task Group. Rather, we recommend the Implementation Team review the draft profiles on their own and meet to answer the following questions:

a. Do the indicators make sense?
b. Is there anything missing?
c. Is there anything that does not belong?
d. Are there particular indicators you want to discuss with the large group?

VI. ALIGNMENT CHECK

The final step is to ensure that philosophical principles are reflected in the profile, thereby linking principles, functions, and activities.

APPENDIX A

Essential Function: Engagement[1]

Definition:

"The ongoing ability to establish and sustain a genuinely, supportive relationship with family while developing a partnership, establishing healthy boundaries, and maintaining contact as mutually negotiated. Engagement is about motivating and empowering families to recognize their own needs, strengths, and resources and to take an active role in changing things for the better. Engagement is what keeps families working in the long and sometimes slow process of positive change." (Steib, 2004). Engagement is a multilevel phenomenon influenced by and comprised of a number of interwoven factors at the worker, client, agency, and larger social environment levels. (Yatchmenoff, 2005)

Practitioner Engagement Activities are delineated in four categories[2]:

- *Intensive authentic connection with children, youth and families to ensure safety, permanency, and well-being*
- *Shared planning & decision making with families*
- *Actively involving cross systems partners – including courts, medical and mental health, substance abuse and domestic violence and other key agencies - - in ensuring timely and seamless delivery of services to children and their families.*
- *Utilizing formalized partnerships with critical stakeholder and community groups to provide ongoing information and insight to improve organizational policy, procedures and practices regarding family engagement***.**

Expected	Developmental	Unacceptable
• Notifies family in advance of visits. Drop-in visits are used sparingly and only with specific purpose that is clearly documented in the case record. The minimum time of the first visit with a family should be one hour.	• Usually notifies family in advance of visits; will occasionally use drop-in visits to meet timeframe mandates. Usually spends at least an hour with the family for the first visit, but will occasionally spend less than one hour.	• Does not notify families in advance of visits. Drop-in visits are used routinely. Minimum time of first visit with families is frequently less than one hour.

[1] This practice profile is an example and is currently a draft and under review.

[2] Practices that fall within these four categories of "Engagement Activities" are also discussed within the Practice Profiles for other critical components of the Program, including Assessment, Partnering, Planning, Implementing, Evaluating, Advocacy, Communication, and Cultural Competence.

Expected	Developmental	Unacceptable
• Respects family choices when scheduling contacts; incorporates family's preferences for day, time, and location for the assessment visit (unless safety concerns are present); schedules initial contact within OAC requirements. If drop-in visit is necessary because family does not have a phone, worker will ask family about their preference for scheduling the assessment visit.	• Worker determines a time and date for the visit and asks family if this is mutually agreeable. Arrives at appointment on time for scheduled contact; avoids cancellation of appointments.	• Schedules visits primarily according to the worker's convenience for time and location, or fails to ensure that visits occur within OAC guidelines. • Regularly misses appointments with families without notifying the family • Regularly conducts unannounced home visits
• Uses culturally relevant methods for establishing contact and engaging family members in the assessment process and throughout the life of the case.	• Uses culturally relevant methods for cultures that worker is familiar with or conducts research, as appropriate on the family's uniqueness and/or culture.	• Uses the same methods of establishing contact and engaging families regardless of families' preferences or cultural traditions.
• Meets with family members together during home visits to discuss issues, plans, progress, etc. Whenever possible and appropriate per consultation with supervisor.	• Occasionally meets with all family members but speaks with each person individually, even when it is possible and appropriate to meet with all family members together.	• Conducts conversations with the whole family present when inappropriate to do so (e.g., domestic violence), or fails to involve the entire family when it is appropriate.
• Explores and acknowledges the family's uniqueness. Recognizes and reflects back to the family their strengths and skills and documents this in the case record.	• Recognizes and reflects back to the family obvious strengths and skills but does not consistently recognize underlying or less obvious family strengths, skills or resources. • Documents family strengths and skills in the case record but does not consistently to reflect this information back to the family.	• Discusses only family challenges or problems and fails to recognize family strengths or resources that could be leveraged to address areas of concern. • Is dismissive of family's uniqueness.

Expected	Developmental	Unacceptable
• Uses language that reflects respect (i.e., asking each family member how they would like the worker to address them – by first name, by Mr. /Mrs., by nickname, etc.). Avoid labels and jargon. • Engages families in difficult conversations in a straightforward, honest, respectful manner.	• Avoids language that tends to inflame (victim, perpetrator, abusive, neglectful, poor parenting, dirty home, drug addict, etc.) • Is transparent with the family about the worker's/agency's concerns.	• Is judgmental, authoritative or pejorative in communication with the family; uses jargon that the family does not understand. • Uses labels or language that reflects stereotypes or denigrates the family's culture, history, current situation, or behaviors. • Uses acronyms, technical language without explaining their meaning. • Avoids conversations about difficult topics; or language and demeanor are judgmental, condescending, disrespectful or overly authoritative.
• Listens actively to each family member and solicits perspectives from all involved (e.g., by summarizing for the family what the worker understood them to say) • Allows and encourages the family to tell "their story" without interruption (i.e., family speaks more than the worker).	• Listens actively and solicits perspectives from family members; • Avoids assumptions; asks open ended follow up questions to clarify information.	• Communication consists mostly of worker informing the family about his/her assessment conclusions, recommendations for services, etc. without soliciting meaningful input from the family. • Interprets the family's statements from the worker's perspective and summarizes inaccurately for the family. • Indifference about and/or disdain for the family voice in their "story". • Primarily uses "why" questions, or interrogation techniques, or threatens family with law enforcement or juvenile court involvement.

Expected	Developmental	Unacceptable
• Focuses conversation and casework activities on encouraging family to make positive changes to reduce risk of maltreatment.	• Revise service plan agreements with family; discusses progress towards case goals and objectives.	• Communication with family is primarily regarding compliance with the service plan.
• Regularly uses engagement activities(e.g., scaling, life circles, genograms, strength and needs exercises, pointing out to the family what is going well) and strategies to actively involve children and parents/caregivers in all aspects of the case (assessment, case planning and decision making, implementing service plans, discussion of progress etc.) and Uses protective authority only when necessary; engages law enforcement authority only when necessary to ensure child or worker safety.	• Uses engagement activities or strategies inconsistently throughout the life of the case. • Overuses protective authority to ensure child or worker safety.	• Primarily uses protective authority; does not balance protective authority with engaging families in a collaborative casework relationship. Demeanor with families is authoritative. • Does not involve family members in assessment, case planning and decision making, service plan implementation. Does not discuss progress or point out family strengths. • Avoids interactions with family; focuses on paper work to the exclusion or detriment of working with families • Regularly uses law enforcement to gain access to the child, even when child safety is not an immediate concern.
• Uses specific strategies to reduce barriers to engagement (such as creating a safe environment; surfacing, acknowledging, exploring resistance, problem solving to resolve interpersonal barriers to engagement) and to re-engage families when necessary.	• Meets with supervisor to consult about families that require re-engagement or that worker has been unable to engage and develop plan.	Does not re-engage the family once family has become disengaged; does not consult with supervisor regarding families that require re-engagement. •

Expected	Developmental	Unacceptable
• Return family phone calls in less than 24 hours	• Inconsistently returns family phone calls within 24 hours (exclusive of weekends or holidays).	• Takes more than 48 hours (exclusive of weekends or holidays) to return family phone calls.
• Informs family about what to expect from the agency, including: 1. Caseworker contact information and who to contact if caseworker is unavailable, including team/supervisor contact information 2. Consumer rights 3. AR and TR options • Asks family how they prefer to be contacted, e.g., phone, email or text.	• Provides written information to the family about what to expect from the agency but inconsistently provides verbal explanation. • Inconsistently provides written information to the family about what to expect from the agency but provides verbal explanation.	• Does not inform family about what to expect; does not provide family with contact information or sufficient information to make informed decisions about the AR vs. TR pathway.

Essential Function: Assessment[3]

Definition:

Assessment is the process of gathering accurate, comprehensive information utilizing relevant and credible sources of information; documenting the information using appropriate assessment tools; and objectively analyzing the information to determine the best course of action.

When the assessment process is done well, the result is a clear, objective, and detailed picture of a family needs, child vulnerabilities related to safety, permanence, and well being, as well as the strengths and protective capacities of the family. The assessment process must inform next steps with the family including service planning, service provision, and/or service termination. Assessment is ongoing. It begins at the time of first contact with the family and continues throughout the life of the case.

Expected	Developmental	Unacceptable
Conducts an assessment of safety with all family members present and plans for any immediate safety needs.	Conducts an assessment of safety with the caregiver and the child and addresses any immediate safety needs.	Conducts the initial assessment with minimal family participation. Lack of or insufficient attention to the child's (children's) safety concerns as identified by all family members and worker.
Gathers, includes, and considers all the family members' perceptions of their strengths and the issues or problems they are facing, even if they are unable to recognize how the issues/problems create risk for children.	Gathers, includes, and considers family's perception of their strengths and issues, but efforts are inconsistent or not as thorough. Inconsistently able to prompt the family to provide additional information.	Does not gather, include, or consider assessment information from the family and/ or does not include their perspective about presenting issues/problems or strengths. Relies primarily or solely on the opinions/information of other informants to inform decision making. Does not prompt the family to provide additional information.
Effectively and regularly uses strategies (for example, family meetings, genograms, scaling, life circles, etc.) which result in in-depth family participation/ involvement in providing detailed assessment information.	Selective use of strategies (for example, family meetings, genograms, scaling, life circles, etc.) that result in adequate sharing of details by the family.	Does not attempt to use strategies to engage the family in information sharing.

[3] This practice profile is a draft example and is currently under review.

Expected	Developmental	Unacceptable
Gathers thorough information from multiple sources (relatives, kin, service providers, etc.) as appropriate and relevant to assess risk, assess strengths, and/or provide supportive services.	Inconsistently gathers information from collateral sources, but not always thorough; may seek information inconsistently from appropriate sources; struggles to identify relevant sources of information regarding risk, family strengths and protective capacities, and provision of supportive services.	Does not gather, include, or consider information from multiple informants as appropriate or is indiscriminant in information gathering from other sources.
Gathers detailed information regarding factors known to create substantial risk to children (for example, domestic violence, mental health, and substance abuse) and underlying causes of behavior and history as relevant to possible child maltreatment.	Gathers information regarding factors known to create substantial risk to children (for example, domestic violence, mental health, and substance abuse) and underlying causes of behavior and history as relevant to possible child maltreatment that sometimes may be lacking sufficient detail.	Lack of or insufficient attention given to factors known to create substantial risk to children (for example, domestic violence, mental health, and substance abuse). Often focuses only on the incident resulting in agency involvement. Does not gather information regarding underlying causes of behavior and history as relevant to possible child maltreatment.
Gathers detailed information about individual, family, and environmental strengths and protective capacities that can mitigate risk and uses this information effectively in safety planning and case planning with the family.	Gathers information about individual, family, and environmental strengths and protective capacities that can mitigate risk that sometimes may be lacking sufficient detail; struggles to integrate the information in safety planning and case planning with the family.	Focuses primarily or solely the problems or issues the family is facing. Does not gather information regarding individual, family, and environmental strengths and protective capacities that can mitigate risk or if gathered, does not use the information in safety planning or case planning with the family.
Shares complete assessment information and analysis with the family.	Shares required assessment information with the family.	Does not share assessment information or analysis with the family.

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Expected	Developmental	Unacceptable
Seeks and reassesses information at each decision point in addition to prescribed intervals throughout the family's involvement with the agency.	Seeks and reassesses information primarily at prescribed intervals and occasionally at decision points during the family's involvement with the agency.	Does not seek and re-assess given new information and/or changes in the family's circumstances during involvement with the agency.
Regularly uses critical thinking during the assessment process. Assesses the validity of information gathered, suspends judgment (as much as possible) until complete information has been gathered; and synthesizes assessment information. Clearly uses assessment data to inform safety planning, case planning, service planning, and/or case closure.	Compiles assessment data, but sometimes struggles with determining the relevance or significance of certain details as they relate to child safety and/or family well being and how to use the data to identify appropriate service and supports and/or to plan for case closure. Does not always collect all relevant information before drawing conclusions.	Does not use assessment process and/or tools for intended purpose; is not able to articulate the relationship between information gathered and decision making including safety planning, case planning, service planning, and/or case closure. Draws conclusions before all relevant information is gathered and analyzed.

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