

Working with Involuntary Clients: *Key Observations for Concurrent Planning*

*This Q & A with Ron Rooney and Esther Wattenberg took place on July 28, 1999.
See Page 1 of CASCW News for an introduction.*

Interview

Question/Wattenberg: *Your work with involuntary clients would appear to be especially useful as we enter a period of implementing a law requiring a swift assessment of parenting capacity. The population likely to be most affected is chronically neglecting families who have drifted in and out of the system in what appears to be repetitive cycles of maltreatment, followed by removal of children, reunification, or long episodes in out-of-home care. Most of the families that we are speaking about are described as involuntary. Can you provide a definition for what is generally understood to be an involuntary client in a public child welfare system?*

Answer/Professor Rooney: An involuntary client is a person who feels pressured to accept outside help. In current child welfare, that includes two categories, at least: those who are under a court order; and an even larger group of parents who are under the threat of a court order, who are technically voluntary. But they are aware that if they choose not to cooperate, the likelihood is that they will be under court order. So, in fact, the presence of truly voluntary clients in child welfare is very unlikely.

Wattenberg: *Is it possible to anticipate the response of involuntary clients, when they are confronted with an investigation, the necessity to make a case plan, the necessity to make life-shaping decisions about the care of their children?*

Rooney: Yes. I can recall from my beginning days in child welfare that David Fanshel's¹ research suggested that parental visiting was crucial.

He also noted that parents who were agitated about the care of their children and who were assertive or aggressive about arranging for visitation were more likely to regain custody than parents who were passive and waited for agency support. Fanshel, in the 70's, suggested that passive compliance was not a predictor of success and that assertiveness and even hostility toward the agency was more of a predictor. Later, it fits with one of the key concepts that I have written about in my book² "reactance theory". The reactance concept comes from social psychology: it is the study of how people respond when something that they value is threatened. So, if we have parents who want to maintain care of their child and they feel that is threatened, then they are very likely to show some sort of "reactance response", which can be hostility, anger. It can also be an attempt to find the loophole to comply technically with requirements, but not with the spirit of the requirements.

So those are normal responses that have been supported in hundreds of lab studies of how people respond when something they value is threatened. An additional factor in child welfare has been that we know that if parents don't have continuing contact with their children and bonding is broken, then this "high valuing" also breaks down. In my early work in child welfare, part of my responsibility was attempting to reconnect parents who had been apart from their children a year and a half or two years, and you would find that they didn't have this "reactance," because they weren't particularly motivated to change their lives again. This group of parents can be identified as the inaccessible involuntary – inaccessible in the sense that much of child welfare is predicated on the assumption that parents will do almost anything to get their children back. If they've come to the point where this bonding is not present, then you can't effectively threaten them with what they are willing to give up.

-Selected References on Involuntary Clients-

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¹ David Fanshel is the author of *Preschoolers Entering Foster Care in New York City: The Need to Stress Plans for Permanency*, 58 *Child Welfare* 67 (1979)

² Rooney, R.H. (1992). Strategies for work with involuntary clients. New York: Columbia University Press

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So practice which says that if you don't visit and if you don't do these things, then your future with the child is going to be limited. (If they're ready to let the child go, so it is not a powerful threat). Hence, hostile response is actually a good sign for the parents because it suggests that they care about the situation, and it is a greater predictor that there is some possibility for working together. A passive, compliant response: "You know best," "Do whatever you think is best" is more of a predictor that they are really not that bonded and their caring is not that deep.

Wattenberg: Let me pose two questions on that issue. First, on the family that appears to be passive: is it possible that passivity, perhaps evidenced by a remarkable silence in the face of an attempt to establish a relationship with the parent, may reflect a cultural or ethnic dimension?

Rooney: Well certainly I have read accounts that Native American responses have often not been hostile but have been a psychological and physical withdrawal and a seeming acceptance that they can't do anything about the circumstance. That particular response is one that doesn't fit this norm.

Wattenberg: Well let me pose another issue, related to the hostile, angry client. There is some work that has been well documented that a characteristic of some families who have little possibility of being able to summon resources to regain their children demonstrate the following: they are hostile, angry, and disruptive with every institution they deal with, whether it is schools, the health system, the social service system, child protection, or mental health services. In fact, in some studies, they are labeled as so highly suspicious of all organized efforts to help them and their children that they resemble a paranoid profile.

Is there some validity to the notion that some parents who persistently view normative, community institutions in a hostile and suspicious way may have a "paranoid" personality?

Rooney: Well, normative to whom? In which community? Whose community? I think that there certainly is a range of clients. There are clients who experience clinical paranoia. On the other hand, is it appropriate for us to use labels like paranoia for members of oppressed groups in low-income areas whose history and perception of their own experience and that of their neighbors has not been that public agencies are the normative community. They have not had the experience that these agencies function to help them. So, lively distrust of these agencies is probably normative in those communities. I don't have an answer other than to say if we come to this conclusion that hostility is likely to be paranoid and that we can't do anything about it, then we are in a paralysis, and we have described a no win situation: we know that if they're passive, they are unlikely to succeed; and if they're active and hostile they are unlikely to succeed. So how are they likely to succeed? What I suggest is the worker not personalize this hostility, and that in fact, one of the critical issues with families is this: do they think there is a chance that services offered will succeed? Can their efforts lead to something, or are we going through the motions? ... This is the danger of our current situation. The new time lines are not individualized; they are not developed around individual conditions or problems. It's not easy for workers, under many circumstances, to predict whether clients are capable of doing what's necessary within the time frame in order to show that they are capable parents. Currently, we have a dilemma.

That's certainly not true in all situations, but it certainly seems to be the case with chemical dependency that workers are pessimistic from their knowledge of the treatment process and likelihood of relapse that treatment can succeed with no relapses and little prospect of future relapse within the time frames available.

Wattenberg: Well, it seems to me, then, that the key to having a somewhat accurate assessment of whether or not this family is capable or has the interest — the willingness to work toward reunification with their children — depends a great deal on this process we call "engagement." Let me then ask this question: define engagement and then give us a brief summary of the techniques which you have developed and worked on over the past years on implementing this very crucial part of a process for parents.

Rooney: Well, "engagement" is a multiple-level process. It's one where to the degree possible, the worker wants to promote a sense that the client can experience that they are being heard and communicated to honestly about their circumstance - that they're being respected. Also that their own perceptions of the causes and solutions in the situation are listened to and put in some context in relation to the evidence of abuse and neglect that there may be. But "engagement" is an ongoing process. With parents in involuntary circumstances, there is no way, in a single session, to reduce their distrust and increase their trust to a very high level. I suggest that involuntary clients are much more likely to trust the actions of the worker than their words.

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It's useful for the practitioner, in addition to developing a plan in which the clients will take some actions between one session and another, also to make a commitment to do some things to forward the case – for example, to gather information about possible resources. Clients tend to judge the completion of these actions as a collaborative commitment to the plan. So that in fact, you can't determine "engagement" for some time, and similarly, "willingness" and "interest." I recommend that you don't put so much stock in the words as you do in the behavior. And that, in fact, if involuntary clients are initially feeling overwhelmed or pessimistic, that you not put a great deal of stock in that, either. Rather that it is more important to see, as the plan gets going and if they have some successes, at that point, then we may have a better sense of their actual willingness and potential and capability. I don't believe that it is possible to look into the heart of the client in the first session and determine, "do you have what it takes to safely care for your child." But rather, it is more useful to say: "This is the task of both of us to discover over the time we have together, whether you have it within you, augmented by other resources, to provide safe care for your child. You don't know at this point; nor do I, but we will try to find out together, through your work and that of other resources whether safe care can be provided." I think one of the values of "concurrent planning" is that it puts a time limit on this process, so that it makes it a priority. We know that some clients are under pressure from other agencies with other timelines. So, the child welfare timeline is competing with others. One of the values of the time limit is that it can summon a sense of crisis and motivation to act, whereas if the time is indefinite, there is a greater potential

for not starting immediately and procrastinating until the time limit is getting closer.

Wattenberg: If we assume that it is possible to present time limits as an opportunity for an alliance, in order to achieve the case plan, which I presume must be mutually agreed upon, do we have any experience in research or in "practice wisdom" that tells us what families appear to be capable to mobilize themselves to respond to this severely limited time phase? What families will be indifferent to time limits, given their long, crisis-ridden history with an agency, a characteristic of chronically neglecting families?

Rooney: I don't think we know. We do have quite a history, over the last 20 years, of the efforts of family preservation services. Their guidelines for who they would work with were extensive. But if they had one family member who was interested in working toward making some changes, and the child could be maintained safely, they would work with them. Study after study would indicate that there were not external attributes and characteristics that would predict what families would succeed in those kinds of services. One program after another comes up with the same conclusion that you do what you can to make the top priority the safety of the child, and simultaneously you give the opportunity and support and observe which families can do it and which cannot. Great harm is done by making judgments about capacity that are more subjective. It could be that this particular event, a crisis at this point in this person's life in which they may be able to make use of resources in contrast to the past. Past failure is not necessarily predictive of current failure, nor is past success a predictor of future success.

People can be in the circumstance where things that worked before do not now work for them in their situation.

Wattenberg: It occurs to me, however, that our almost 20 years' experience with family preservation work did come to a consensus: that there were certain families for whom a family-centered approach, in providing services, was not likely to create enough change to keep children safe. They were typically families who were involved in multiple stressors, such as serious substance abuse, sometimes combined with mental illness, and certainly where there was often an abusive and violent partner. These overlapping conditions created an unsafe environment for children. Very often research would conclude that these were the families who were less likely to respond to the family preservation techniques.

Rooney: Did they conclude that they should not make those services available to them, or that if you had those conditions, you would be less likely to succeed than if you did not?

Wattenberg: I think the latter. This exchange leads us to policy considerations. With dwindling resources, what families, in a priority sense, can make use of services, and when should we shift attention to the safety and well-being of the children?

Rooney: This question suggests a pendulum swing of a choice between family ability to use services and child safety. I think that these goals are not mutually exclusive.

Wattenberg: Well then, let's return to the techniques of engagement. Even with these reluctant clients, are there ways in which one can move into a collaborative understanding in which there will be a mutual attempt to make some changes?

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In your work you sometimes allude to something called "congruence," as a technique for helping to maintain a relationship that has integrity in the engagement process. Can you explain that?

Rooney: "Motivational congruence" suggests that outcomes are more likely to be successful if there is some overlap between the client's own perception of the situation and concerns, and that of the agency. The form that "motivational congruence" can take doesn't mean that there has to be an exact fit between the agency's or the court's view and the client's view. In my own early work with my dissertation, I found that a critical issue was the parents' concern with their children being out of their home. Did they want them returned? If they did, then there was congruence, with the high priority of the child welfare system: to have children returned to a safe home. So it is possible to contract, with some congruence, with parents where there is an agreement on a goal, and the parents are moderately willing to go through the steps necessary to demonstrate their capacity, because they are agreeing with the goal. Hence, parents agree to jump through many hoops; to go through parenting classes; to change their living circumstances; to get chemical dependency treatment — when they don't, in some cases, accept the seriousness of the problem. But they do it, because there is some congruence around the goal. The hope is that if those services are effective, and the client experiences some success in them, then there begins to be some congruence about those needs as well. For example, with parenting classes, the proof is whether they feel that they learned something that's helpful.

They don't have to volunteer to be in such groups, but they do have to come to a point where they feel they're learning something that will put this into use, and use it not just when they think they're likely to be observed, but to use it at other times. I think a critical issue with child welfare involuntary clients is to accept that they're frequently going to be carrying out many tasks that are what I've called "disagreeable tasks," in the sense that isn't what they want to do. They are agreeing to do it in order to get something else. We shouldn't anticipate that while they're carrying out "disagreeable tasks," they will act as if they enjoy it. The critical factor is to give those services some time, and if they are successful, then many parents will change their views, over time, as a result of being in chemical dependency treatment, or as a result of being in a parenting group. It is not necessary or expected that they embrace the value before they begin. I think that another guideline for practitioners is you have to seek some congruence, but don't expect full congruence. You should not expect that they need to embrace the plan and fully accept, from the beginning, their responsibility for each problem and their resolution, that is very unlikely to happen. It has rarely happened in the past with any population of involuntary clients, and it is not likely to happen here. It is important that by the end of services any condition that poses a danger to children is gotten under sufficient control, that it is not likely to endanger these children in the future.

Wattenberg: It seems to me, then, you've outlined a very daunting task for a practitioner. Let me ask you if I'm saying it in a way that clarifies the task that is involved in trying to assess the extent to which parents are willing, able, have a capacity to change, in order to have their children returned, with some assurance of safety. I would say, the chief task for the practitioner is to try to distinguish superficial compliance from a genuine response to a case plan. Compliance may only prolong behaviors that will not allow the children to be safe or provide assurance for their well-being — the kind of response that says, "I'll do it to get it over with," but with very little intent to create an improvement for their child's safety.

Rooney: "Do not diminish the importance of compliance." As I read the guidelines for concurrent planning, there is heavy emphasis on behavioral responses. It is not sufficient to say the words. That is also my experience with involuntary clients. Too frequently, clients have been rewarded for making the appearance of having had insight, and if they make that appearance, they don't have to do anything. In this case, we are very concerned about actual behaviors and stability for children, so it is important to start with, "Are they actually doing things" that are likely to increase the safety of their children? To be able to observe that, have they learned it and are they doing it? And then over time, monitor, "Is there any reason to believe that they seem to be doing it on their own and not doing it only under circumstances where they're likely to be scrutinized?"

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That would increase the chances that this has “taken” in some way – that it is not just a behavior that’s learned in order to get through. With regard to external crises [shelter, income] ... people live in circumstances where some crisis management and assistance in getting resources and figuring out what to do is likely to be part of their lives, whether they are part of child welfare or not. They tend to live in communities and are in circumstances where crises occur. In the research for my dissertation of families who received task-centered services in foster care, we found that the successful cases were likely to have two or three crises in three months. The unsuccessful cases had three or more. I am defining a crisis as something of such a major proportion that efforts to complete case plans are blocked. Part of the life condition of our clientele. The fact that you have crises doesn’t mean that you won’t succeed.

Wattenberg: Can one, in the engagement process, in attempting to arrive at a mutually acceptable case plan, set out what are “negotiable” or “non-negotiable” items? I understand these are your techniques for establishing an effective case plan. Does that glimpse into how parents respond to “negotiable” and “non-negotiable” items give us any clues about how our families are likely to proceed?

Rooney: I’m much more interested in compliance. If you develop agreements for tasks from the first session and you set them up in such a way that they appear to be feasible, and you pay much more attention to what people do, then it is quite possible, on the one hand, for clients to comply, initially, and still have somewhat unpleasant attitudes.

And in other cases, there are parents who are quite verbally willing to accept their own responsibility for their circumstances, but aren’t able to act or don’t act on them. So, to pay most attention to compliance, to pay attention to “do they do it,” would help. If they don’t then that is a danger signal that unless you fix the plan, it’s not going to work. Most of this method has some original roots in the task-centered approach that suggests that clients frequently have failure histories in trying to improve their life situations. When they try something to improve their situation, and if it doesn’t work, they don’t have a systematic way of considering “how could we improve that?” They tend to abandon the problem. So the problem-solving process, with the clients, may be learning a new way to not give up after the first task is not entirely successful – to keep fixing, for a while, and then pay attention to how their capacity to stick with the problem and carry things out improves. If it doesn’t, or if it doesn’t improve to a level where it looks safe for the child, then we have very credible, solid evidence that while their own circumstance might have improved, it is not at a level where the children are likely to be safe.

Wattenberg: That brings us to a final and perhaps crucial question and that is the issue of shortened time limits. What are your comments about time limits which might create an urgent circumstance for genuine engagement?

Rooney: Well, the general principle of time limits is well supported. It does stimulate motivation on the part of clients who, if they’re concerned about circumstance, bring a level of anxiety and motivation that can be useful. That’s also true of workers. There are somewhat similar timelines [for both practitioner and families.] The difficulty is that the timelines are arbitrary, and they don’t take into consideration particular conditions or the experiences of particular individuals. It’s understandable, from a legal standpoint, why that is, but it means that we have a very uneven playing field. The six-month timelines are likely to be most successful with families who have not been in the system before and don’t have any of those conditions that we described earlier. But with particular conditions such as substance abuse, there is reason to believe that it will be a small minority who will be able to improve, drastically, in substance abuse treatment and have a much better experience than others in overcoming the problem. So my response is guarded. It is supportive of the idea of time limits and supportive of some flexibility. At our most recent conference, I was hearing people predicting flexibility; a time limit means that we have to have a very solid assessment, at the end of that point, and the capacity for the system to take immediate action is there. But the system may not take action. Now that makes some sense to me, creating that time limit and creating the motivation, both in the practitioner and the client to show the level of capacity. I think that if at the end of that time we have a circumstance where there were five goals for stability of a child and there has been substantial improvement on four or three and a half, and the remaining

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one and a half are not crucial to their safety, but are desirable, then there is a real question about “Is now the time to stop this?” Or is there reason to believe that, with some extension, in the long run, the best interest of the child is served? So, I think that the time limits will be very useful for discovering, with families, that if there are five goals and one of them improves, or one and half, then it’s very useful, that we had this early time limit and we can move quickly to another plan. And it’s useful for those where there is nearly 100% compliance, but it is more difficult for the families who get close, but don’t get there. In the task-centered approach, that would have called for a re-contract, usually not as long as the previous limit – a shorter re-contract to finish some things up and focus on maintenance after services are over.

Wattenberg: What is your experience with those parents who are genuinely conflicted, ambivalent, uncertain about whether they really want to care for their children, and over a very long history, move in and out of the system in very uncertain ways?

Rooney: “Ambivalence” may involve many things: uncertainty about capacity to care, lack of confidence and knowledge about whether the plan would work. This kind of “ambivalence” as uncertainty is not a bad sign – most of us would come to the same conclusion. So, whether a parent is ambivalent is less important than whether they resolve the ambivalence. An early task that I recommend is “let’s explore it. ... Your task is to make a list of all the reasons that make you think you would be a good, safe parent for this child. Now, make another list of all of the reasons that cause you or other people to suspect that you would not be the best parent for this child.”

And looking at those two lists over a period of time, they become an agenda for tasks. “If we are to come to a greater consensus that your child is maybe better off with you, then we’ll have to find the positive things on your list – are they based on something that is substantive, other than just a hope? And the fears that you and others have, we have to assess them as well.” Rather than expect that this ambivalence will be resolved in a single session, such work becomes the backdrop for many weeks. It’s important to see that resolving the ambivalence, one way or the other, is a success, no matter what. If the negative ambivalence is reduced by increased courage and capacity and a sense of ability to work, that is a positive outcome. Similarly, if the balance goes to “I’m less and less sure, and the others are less and less sure whether I can provide competent care,” that is also a good outcome. So moving away from being immobilized is a goal.

Wattenberg: A final question which really deals with some ethical considerations. In concurrent planning work, there is a guideline known as “full disclosure.” Are there any ethical considerations about disclosing to the parent what others have provided as an assessment of their substance abuse past; their mental illness history; their criminal background? Further, if one comes to the conclusion that the parent is not likely to improve, is there an ethical obligation to inform them, as soon as possible, that you are going to proceed to recommend termination, and then provide them information on their right to legal counsel?

Rooney: Well, ethical questions are replete. Among them, I think that misinforming clients is as big an ethical issue as harmful disclosure.

And I think one of the potential benefits of concurrent planning is that you don’t have the luxury of waiting for a comfortable moment to share unpleasant realities. You really have to get into them quickly. The issue becomes “what is the skill of the practitioner in translating.” Frequently these outside assessments are not written in language that clients are likely to understand. So what is the capacity of the practitioner to translate into simple, understandable English, that is not highly pejorative, but is descriptive of, “what is it that people have observed that causes them to have reservations about your capacity to parent.” That’s one of the things I work on with my students is this ability to translate — to give a clear indication of what the dangers are, so that a person is fully informed, but perhaps not always using the exact language that the referral source used. I think that a bigger ethical concern is to misinform. They need to be informed what the views are, and I think the question that workers are asking now is that if they have done a good job of this, and have shared it, and the parent says, “so are you telling me that this is worth a try or not?” what do you say then? What is your response? Yes, there are formidable obstacles. There are people who have been able to work through such obstacles. We don’t have a lot of experience in these time frames about what will work. However, truthful speeches are a useful goal: conveying hope without false assurance.

Wattenberg: I want to thank you for sharing some of your expert knowledge with practitioners as they move forward on the initiative known as “concurrent planning”.