

# CORE II:

case planning & family-  
centered casework in  
child welfare

## **Handouts**

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## Core II Training Agenda

### Day 1

8:30 – 10:45 Introductions & Opening Activities and pretest

#### **Section I: Integrating Casework and Protective Authority in Family-Centered Child Welfare**

10:45 – 12:00 Family-Centered Practice

12:00-1:15 LUNCH

#### **Section II: Collaborating with the Community in Child Welfare**

1:15 – 2:30 Collaborative Decision Making Models

#### **Section III: Development of Relationship: The Foundation of Family Centered Casework**

2:30 – 3:30 Roles and responsibility of the caseworker  
Reducing resistance and increasing involvement  
Cultural Factors

3:30-4:30 Ethnographic Interviewing

### Day 2

#### **Section IV: Engaging the Family**

8:30 – 12:00 Motivational Interviewing  
Solution Focused interviewing

12:00 – 1:15 LUNCH

1:15 – 2:15 Solution focused interviewing continued

2:15 – 3:00 Caseworker Jeopardy

#### **Section V: Comprehensive Family Assessment**

3:00 – 4:30 Assessment-NCFAS

### **Day 3**

8:30 – 10:00      Assessment-NCFAS (continued)

10:00 – 11:00      Out-of-Home Placement

#### **Section VI: Developing the Case Plan**

11:00-112:00      Case Plan and Permanency goals

12:00 – 1:15      LUNCH

1:15 – 4:30      Case Planning (objectives, action steps, measure of success)  
Visitation

### **Day 4**

8:30 – 9:30      Case planning continued

9:30-10:30      FSP documentation in TRAILS

#### **Section VII: Case Recording**

10:30-11:30      Purposes of Documentation  
Characteristics of Good Case Recording

11:30 – 12:00      Meeting the Demands of the Job  
Use of Supervision

12:00 – 1:00      LUNCH

#### **Section VIII: Ongoing Assessment, Evaluation, & Case Closure**

1:00 – 1:30      Ongoing Assessment and Evaluation

1:30-4:30      Case Closure and Training Evaluation (includes Lab)

## **Core II Competencies**

### **Section I: Integrating Casework and Protective Authority in Family-Centered Child Welfare**

The participant who masters the content of this training module will:

- ❖ Know how social work values and principles apply to child welfare practice, including respecting the family's dignity, individuality, culture, and right to self-determination.
- ❖ Know the philosophy, values, and characteristics of family-centered child welfare.

### **Section II: Collaborating with the Community in Child Welfare**

The participant who masters the content of this training module will:

- ❖ Know the proper roles and responsibilities of other community agencies in the child protective service process and know how to collaborate with these agencies and practitioners to develop case plans and provide services that assure a safe and permanent family environment for children.

### **Section III: Development of Relationship: The Foundation of Family-Centered Casework**

The participant who masters the content of this training module will:

- ❖ Know strategies to engage family members into constructive and collaborative casework relationships that engage and empower families, and that promote joint case assessment, planning, and service provision.
- ❖ Understand the dynamics of resistance and know caseworker strategies to defuse family members' hostility and anger.
- ❖ Know how to integrate casework methods with authority, when necessary, to simultaneously engage and empower families and assure protection of the children.
- ❖ Understand the potential effects of cultural differences on the development of the casework relationship, and know strategies to establish relationships with families from cultural backgrounds different from one's own.

### **Section IV: Engaging the Family**

The participant who masters the content of this training module will:

- ❖ Be able to effectively engage the family in the casework process.

## **Section V: Comprehensive Family Assessment**

The participant who masters the content of this training module will:

- ❖ Understand the importance of effective case assessment and planning as the foundation of casework and family-centered interventions and know the proper sequence of steps in the case planning process.
- ❖ Be able to demonstrate the ability to apply the NCFAS to practice.
- ❖ Be able to correctly use the NCFAS to assess family functioning for case planning and other case activities.
- ❖ Be able to identify the sources of information, the tools necessary to complete the assessment, the conclusions to be drawn, and/or decisions to be made based on the comprehensive family assessment.
- ❖ Be able to describe the criteria for out-of-home placement.

## **Section VI: Developing the Case Plan**

The participant who masters the content of this training module will:

- ❖ Be able to involve families in the development of an appropriate, time-limited Family Services Plan; know how to formulate measurable behavioral objectives; and be able to identify the most appropriate services and activities to achieve case objectives.

## **Section VII: Case Recording**

The participant who masters the content of this training module will:

- ❖ Be able to write concise, summarized case assessment, case plan, and other supporting documentation into the family case record in a timely manner.

## **Section VIII: Ongoing Assessment, Evaluation, & Case Closure**

The participant who masters the content of this training module will:

- ❖ Understand the importance of conducting routine and timely case staffings with families, know how to reassess the outcomes of all case plans and service interventions, and make appropriate modifications in the case plan.
- ❖ Be able to effectively utilize the Colorado Assessment Continuum to guide decision making for case closure.
- ❖ Be able to explain strategies for closing a case that involve the family and utilize community resources.

## **Good Casework Involves...**

### **Accurate Role Clarification**

### **Modeling Pro-Social Values**

### **Collaborative Problem Solving**

Other things involved in good casework:

- ❖ Show concern for client.
- ❖ Accept client as a person (separate from their actions).
- ❖ Have the belief that people can change.
- ❖ Attempt to understand the clients' feelings as well as their point of view.
- ❖ Use empathy that is genuine.
- ❖ Use authority only when appropriate.



## Parent's Expectations of Caseworkers

- ❖ My caseworker encourages me to discuss when things were better in my family.
- ❖ When my caseworker makes a mistake, she/he admits it and tries to correct the situation.
- ❖ My caseworker tells me what she/he plans to say in court about my family and me—both negative and positive.
- ❖ My caseworker explains to me what will happen in court.
- ❖ My caseworker tells me whom I can contact for help when she/he is gone for more than a day or two.
- ❖ My caseworker informs me about the help that is available to complete my case.
- ❖ My caseworker devotes enough time to my case.
- ❖ My caseworker gets me necessary services in a timely manner.
- ❖ My right to make decisions about my children has been respected during the time they have been in care.
- ❖ My caseworker helps me talk to my child often.
- ❖ My caseworker speaks up for me with other professionals involved in my case.
- ❖ My caseworker's expectations of me are reasonable.
- ❖ My caseworker is clear about what she/he expects from me.
- ❖ When my caseworker says she/he will do something, she/he does it.
- ❖ My caseworker respects my right to privacy.
- ❖ My caseworker returns my calls.
- ❖ I am involved in decisions made about my case.

(Children and Family Research Center: John Poertner, DSW, Dennette Derezzotes, LCSW, Cassandra Woolfolk, MSW, Ellyce Roitman, LCSW, and Jo Anne Smith, LCSW)



## **Seven Essential Elements of Collaborative Decision Making**

- ❖ Teamwork
  
- ❖ Active Family Involvement
  
- ❖ Facilitators
  
- ❖ Safety Plans
  
- ❖ Strengths-Based Assessment
  
- ❖ Needs-Driven Services
  
- ❖ Long-Term Support Network

## Engagement Methods Chart

<b>Strategy</b>	<b>Purpose</b>	<b>Benefits</b>	<b>Liabilities</b>
Closed-ended Questions	<ul style="list-style-type: none"> <li>• To gather factual information regarding a specific content area</li> <li>• To obtain answers to specific questions</li> </ul>	<ul style="list-style-type: none"> <li>• Can obtain a considerable amount of information in a short period of time</li> </ul>	<ul style="list-style-type: none"> <li>• Limits potential responses of family members to those directed by the interviewer</li> <li>• May be threatening to family members; may encourage evasiveness, lying</li> </ul>
Open-ended Questions	<ul style="list-style-type: none"> <li>• To gather a lot of information about a wide range of topic areas</li> <li>• To gain insight regarding a client's feelings and perceptions about the situation</li> </ul>	<ul style="list-style-type: none"> <li>• Caseworker may discover information that s/he may not have thought to ask about</li> <li>• Provides information to be used in the assessment; helps identify "process" level issues</li> </ul>	<ul style="list-style-type: none"> <li>• Takes considerable time</li> <li>• Caseworker may need to sort through extraneous information to identify pertinent issues</li> <li>• Person may use open format to digress and avoid discussing important topics</li> </ul>
Supportive Responses Active Listening	<ul style="list-style-type: none"> <li>• To communicate and demonstrate the case manager's interest and concern</li> <li>• To establish a positive casework relationship</li> </ul>	<ul style="list-style-type: none"> <li>• Builds trust, communicates caseworker's interest and willingness to listen and help</li> <li>• May have an enabling effect on the client</li> <li>• Client may feel better for having talked</li> </ul>	<ul style="list-style-type: none"> <li>• Client has considerable control of the direction of the interview</li> <li>• Little change may be generated; few goals set</li> <li>• Does not always promote action</li> </ul>

<b>Strategy</b>	<b>Purpose</b>	<b>Benefits</b>	<b>Liabilities</b>
Clarification	<ul style="list-style-type: none"> <li>• To point out inconsistencies or otherwise confusing messages in a client's statements</li> <li>• To promote accuracy of information</li> <li>• To promote insight into one's own behaviors and actions so as to enable change</li> <li>• To enable the caseworker to better understand the family's dynamics, needs, and problems</li> </ul>	<ul style="list-style-type: none"> <li>• Helps move to the process level in interview</li> <li>• Allows caseworker to make accurate assessment of causal and contributing factors to family problems and family strengths</li> <li>• Helps family gain insight into own situation</li> </ul>	<ul style="list-style-type: none"> <li>• May be threatening to family members who may be unaware of or not want to discuss issues raised by the caseworker</li> <li>• May increase family members' resistance</li> </ul>
Summarization	<ul style="list-style-type: none"> <li>• To keep the interview focused, on track</li> <li>• To help the person organize information</li> <li>• To shift responsibility for talking to the client</li> </ul>	<ul style="list-style-type: none"> <li>• Makes efficient use of time by keeping the discussion focused on pertinent topics</li> <li>• Helps family members organize thinking</li> <li>• Prevents family being overwhelmed by details</li> </ul>	<ul style="list-style-type: none"> <li>• People who are redirected may feel cut off, as if the caseworker is not listening</li> <li>• Over direction by caseworker may lead to moving too quickly off a topic, thus missing important information</li> </ul>
Confrontation	<ul style="list-style-type: none"> <li>• To encourage family members to acknowledge problems, feelings, or behaviors when other, less directive interventions have failed</li> </ul>	<ul style="list-style-type: none"> <li>• Can precipitate movement quickly</li> <li>• Can cut manipulations and digressions and focus on the critical issues</li> <li>• Can help family members become aware of their own resistance</li> </ul>	<ul style="list-style-type: none"> <li>• Cannot be used without a well-established and supportive relationship</li> <li>• May greatly increase resistance if not successful</li> <li>• May require considerable follow-up support from caseworker</li> <li>• Takes time and commitment</li> </ul>

<b>Strategy</b>	<b>Purpose</b>	<b>Benefits</b>	<b>Liabilities</b>
Silence	<ul style="list-style-type: none"> <li>• To allow client to gather thoughts</li> <li>• To shift responsibility for talking to the client</li> </ul>	<ul style="list-style-type: none"> <li>• Can reflect on thought process</li> <li>• Establish that interview is joint responsibility</li> </ul>	<ul style="list-style-type: none"> <li>• Discomfort</li> </ul>
Options, Suggestions, Alternatives	<ul style="list-style-type: none"> <li>• To expand range of options for client</li> <li>• To allow client to focus on solutions</li> <li>• To allow client to recognize there is more than one solution</li> </ul>	<ul style="list-style-type: none"> <li>• Can empower client to make choices</li> <li>• Can assist in reducing power struggles</li> <li>• Can help client “invest” in their choice vs. if client is directed to one choice</li> </ul>	<ul style="list-style-type: none"> <li>• Client can become overwhelmed with too many choices</li> <li>• Client may not be ready to move to action</li> <li>• Client may feel that choices are not real</li> <li>• Client may feel they have no choice</li> </ul>
“Bridge” Response	<ul style="list-style-type: none"> <li>• To move client beyond “content” (words used) to “process” (meta communication)</li> <li>• To facilitate client’s self-awareness and awareness of others</li> </ul>	<ul style="list-style-type: none"> <li>• Positive relations between client and caseworker</li> <li>• Can demonstrate caseworker’s understanding of client feelings/situation</li> <li>• Can de-escalate client</li> </ul>	<ul style="list-style-type: none"> <li>• Client may not want to be vulnerable</li> <li>• Can escalate client’s feelings to the point of discomfort</li> </ul>

## Ethnographic Interviewing

Interviewing people about their cultures helps us to understand a significant part of what influences their goals, values, problem-solving approaches, and child-rearing behaviors.<sup>1</sup> In cultural interviewing, you may hear terms that aren't really familiar to you. Be sure to ask about them.

*You said that many people in your group would turn to a curandero if their child were sick in that way. I think it means healer, but I don't know much more. Can you tell me about curanderos?*

**Probe:** *So the curandero has a special way of seeing problems. How would you describe that?*

*You said that many people in your culture use "cupping" to help children who have bad colds breathe better. Can you describe that to me?*

**Probe:** *How long does the welt tend to last?*

Essentially, ethnographic interviewing<sup>2</sup> takes the stance that: "I am a stranger. I don't know what I don't know, and I am willing to learn." Ethnographic interviewing "assumes that language and words, in particular, are windows to the world of the ethnic minority person."

### Some Considerations When Exploring Differences Between Cultural/Ethnic/Racial Groups

- ❖ Work settings (supportive, not supportive)
- ❖ Time (perceptions of, references to)
- ❖ Space (closeness, distance)
- ❖ Language
- ❖ Roles (gender, family, community, etc.)
- ❖ Group/Individualism
- ❖ Ritual and Superstition (uses for, negative & positive connotations)
- ❖ Class and Status
- ❖ Values

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<sup>1</sup> Adapted from a curriculum (2003): *We to me: A training on cultural considerations in working with youth*. Denver, CO: University of Denver, Graduate School of Social Work, Institute for Families.

<sup>2</sup> Leigh, J. W. (1998). *Communicating for cultural competence*. Prospect Heights, IL: Waveland Press. Further adapted by Zeitler, L. (2005) in the curriculum: *Assessment challenges and creative solutions*, Head Start Summer Institutes.

## Suggested Process for Ethnographic Interviews (After Friendly Conversation)

1. Self-disclosure through an admission that I know nothing (or know very little) about the lives of persons whose cultural, racial, and ethnic backgrounds are radically different from my own.
2. Openly request for the person to become the cultural guide in the opening phase of the ethnographic interview—and seek open agreement to this suggestion.  
**Example:** “I need your help in understanding your culture and how it plays a part in who you are and decisions you make. You are the expert, and I need for you to teach me more about it.”
3. Develop “global” questions (some before the interview, some may be developed as the interview proceeds). Global questions address the person’s perception of how the community works along any dimension, such as definition of problems, group role norms, important rituals and rites, how people get help and from whom, and accepted ways of problem resolution. Global questions also address how the person relates to community cultural values, norms of behavior, and worldviews.

### Sample Global Questions

#### Community Related

- How do people in your church think such problems occur?
- How would others in your church treat the problem?

#### Space-Related

- I have never been to your neighborhood, so explain it to me in detail.

#### Time-Related

- What were the daily activities of the people in your village?
- What do they do for recreation?
- Do people keep schedules, or is time pretty free flowing?

#### Actor-Related

- Who are the people in your circle of people?
- Who is in charge?
- Who makes the decisions?

4. Listen for “cover” terms. Cover terms are “a ...guide to the cultural meanings that give structure to [the person’s] experience.”

*You said that many people in your group would turn to a curandero if their child were sick in that way. I think it means healer, but I don’t know much more. Can you tell me about curanderos?*

*You said that many people in your culture use “cupping” to help children who have bad colds breathe better. Can you describe that to me?*

5. Ask for descriptive information. Examples include:
  - “So, the curandero has a ‘special’ way of seeing problems. How would you describe that special way?”
  - “You said that your people believe in spanking to teach children right from wrong. Explain to me what you mean by spanking.”
6. Write an ethnographic summary. It is a summary that reflects directly the words of the cultural guide. It does not involve interpretation. What the person says it what is written.

### **Some Examples of Ethnographic Interview Questions**

1. “Can you tell me about how people from your country view physical punishment of children?”  
**Examples of probes:** “Is physical punishment viewed as good for the child? In what way? At what age might that type of punishment be used?”  
**Follow-up:** “Would you say you share the same views, or are your views different? In what ways?”
2. “Different communities have different ideas about what responsibilities children should have at different ages. Can you tell me what people in your community or town think about what responsibilities it is okay for an 8-year-old to have? What about a 12-year-old?”  
**Examples of probes:** “Is it the same for boys and girls? How about in the area of obeying parents?”  
**Follow-up:** “Would you say you share the same views, or are your views different? In what ways?”

## Cultural Considerations

### Part 1: Family Structure and Child-Rearing Practices

#### Family Structure

##### *Family Composition*

- Who are the members of the family system?
- Who are the key decision-makers?
- Is decision-making related to specific situations?
- Is decision-making individual- or group-oriented?
- Do all family members live in the same household?
- What is the relationship of friends to the family system?
- What is the hierarchy within the family? Is status related to gender or age?

##### *Primary Caregiver(s)*

- Who is the primary caregiver?
- Who else participates in the care giving?
- What is the amount of care given by mother versus others?
- How much time does the infant spend away from the primary caregiver?
- Is there conflict between caregivers regarding appropriate practices?
- What ecological/environmental issues impinge upon general care giving (e.g., housing, jobs)?

#### Child-Rearing Practices

##### *Family Feeding Practices*

- What are the family feeding practices?
- What are the mealtime rules?
- What types of foods are eaten?
- What are the beliefs regarding breastfeeding and weaning?
- What are the beliefs regarding bottle-feeding?
- What are the family practices regarding transitioning to solid food?
- Which family members prepare food?
- Is food purchased or homemade?
- Are there any taboos related to food preparation or handling?
- Which family members feed the child?
- What is the configuration of the family mealtime?
- What are the family's views on independent feeding?
- Is there a discrepancy among family members regarding the beliefs and practices related to feeding an infant/toddler?



### **Family Sleeping Patterns**

- Does the infant sleep in the same room/bed as the parents?
- At what age is the infant moved away from close proximity to the mother?
- Is there an established bedtime?
- What is the family response to an infant when he or she awakes at night?
- What practices surround daytime napping?
- What is the family's response to disobedience and aggression?
- What are the parameters of acceptable child behavior?
- What form does discipline take?
- Who metes out the disciplinary action?
- What is the family's response to a crying infant?
- How long before the caregiver picks up a crying infant? (Temporal Qualities)
- How does the caregiver calm an upset infant?

## **Part II: Family Perceptions and Attitudes**

### **Family's Perception of Child's Disability**

- Are there cultural or religious factors that would shape family perceptions?
- To what/where/whom does the family assign responsibility for their child's disability?
- How does the family view the role of fate in their lives?
- How does the family view their role in intervening with their child? Do they feel they can make a difference, or do they consider it hopeless?

### **Family's Perception of Health and Healing**

- What is the family's approach to medical needs?
- Do they rely solely on Western medical services?
- Do they rely solely on holistic approaches?
- Do they utilize a combination of these approaches?
- Who is the primary medical provider or conveyer of medical information? Family members? Elders? Friends? Folk healers? Family doctors? Medical specialists?
- Do all members of the family agree on approaches to medical needs?

### **Family's Perception of Help-Seeking and Intervention**

- From whom does the family seek help—family members or outside agencies/individuals?
- Does the family seek help directly or indirectly?
- What are the general feelings of the family when seeking assistance (ashamed, angry, demand as a right, view as unnecessary)?
- With which community systems does the family interact (educational, medical, social)?
- How are these interactions completed (face-to-face, telephone, letter)?
- Which family member interacts with other systems?
- Does that family member feel comfortable when interacting with other systems?

## Part III: Language and Communication Styles

### Language

- To what degree:
  - Is the home visitor proficient in the family's native language?
  - Is the family proficient in English?
- If an interpreter is used:
  - With which culture is the interpreter primarily affiliated?
  - Is the interpreter familiar with the colloquialisms of the family members' country or region of origin?
  - Is the family member comfortable with the interpreter? Would the family member feel more comfortable with an interpreter of the same sex?
- If written materials are used, are they in the family's native language?

### Interaction Styles

- Does the family communicate with each other in a direct or indirect style?
- Does the family tend to interact in a quiet manner or a loud manner?
- Do family members share feelings when discussing emotional issues?
- Does the family ask you direct questions?
- Does the family value a lengthy social time at each home visit unrelated to the program's goals?

Originally adapted from: Wayman, K. I., Lynch, E. W., & Hanson, M. J. (1990). Home-based early childhood services: Cultural sensitivity in a family systems approach. *Topics in Early Childhood Special Education*, 10, 65–66.



## Motivational Interviewing

### The Spirit of Motivational Interviewing

It is important to distinguish between the *spirit* of motivational interviewing and *techniques*. Too much focus on technique can result in losing sight of the spirit and style that are central to the approach. There are as many variations in technique as there are clinical encounters. Key points regarding the *spirit* of this approach are:

1. Motivation to change is elicited from the client, and not imposed from without.
  - Coercion and threats are not used.
2. It is the client's task, not the worker's, to articulate and resolve his or her ambivalence.
  - The worker's task is to facilitate expression of both sides of the ambivalence impasse and guide the client toward an acceptable resolution that triggers change.
3. Direct persuasion is not an effective method for resolving ambivalence.
  - It is tempting to try to be "helpful" by persuading the client of the urgency of the problem and the benefits of change.
  - Direct persuasion generally increases client resistance and diminishes the probability of change.
4. The interaction style is generally a quiet and eliciting one.
  - To a worker accustomed to confronting and giving advice, motivational interviewing can appear to be a hopelessly slow and passive process.
  - More aggressive strategies, sometimes guided by a desire to "confront client denial," easily slip into pushing clients to make changes for which they are not ready.
5. The worker is directive in helping the client to examine and resolve ambivalence.
  - The operational assumption in motivational interviewing is that ambivalence or lack of resolve is the principal obstacle to be overcome in triggering change.
  - The specific strategies of motivational interviewing are designed to elicit, clarify, and resolve ambivalence in a client-centered and respectful counseling atmosphere.
6. Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction.
  - The worker is therefore highly attentive and responsive to the client's motivational signs. Resistance and "denial" are seen not as client traits, but as feedback regarding worker behavior.
  - Client resistance is often a signal that the worker is assuming greater readiness to change than is the case, and it is a cue that the worker needs to modify motivational strategies.

Motivational interviewing is not a technique to be "used on" people; rather, it is an interpersonal style. It is a subtle balance of directive and client-centered components shaped by a guiding philosophy and understanding of what triggers change. If it becomes a trick or a manipulative technique, its essence has been lost.

When a motivational interviewing approach is employed, the worker is:

- Seeking to understand the person's frame of reference, particularly via reflective listening.
- Expressing acceptance and affirmation.
- Eliciting and selectively reinforcing the client's own self-motivational statements, expressions of problem recognition, concern, desire and intention to change, and ability to change.
- Monitoring the client's degree of readiness to change and ensuring that resistance is not generated by jumping ahead of the client.
- Affirming the client's freedom of choice and self-direction.

## **Four General Principles Behind Motivational Interviewing**

### **Express Empathy**

- Expression of empathy is a critical component.
- Look at things from the client's perspective.
- Clients are more apt to share their experiences when they feel understood.
- Understanding the client improves our capacity to do an accurate assessment.
- When a client feels understood, they are less defensive and more open to change.
- An empathetic style:
  - Communicates respect for and acceptance of clients and their feelings.
  - Encourages a nonjudgmental, collaborative relationship.
  - Listens rather than tells.
  - Gently persuades, with the understanding that change is up to the client.
  - Provides support throughout the change process.
  - Allows the worker to be supportive and a knowledgeable consultant.

### **Support Self-Efficacy**

- A client's belief that change is possible is an important motivator to succeeding in making a change.
- Helping clients to stay motivated and supporting clients' sense of self-efficacy is a great way to empower clients to believe they are capable of change.
- One source of hope for clients using the motivational interviewing approach is that there is no "right way" to change, and if a given plan for change does not work, clients are only limited by their own creativity as to the number of other plans that might be tried.

### **Roll with Resistance**

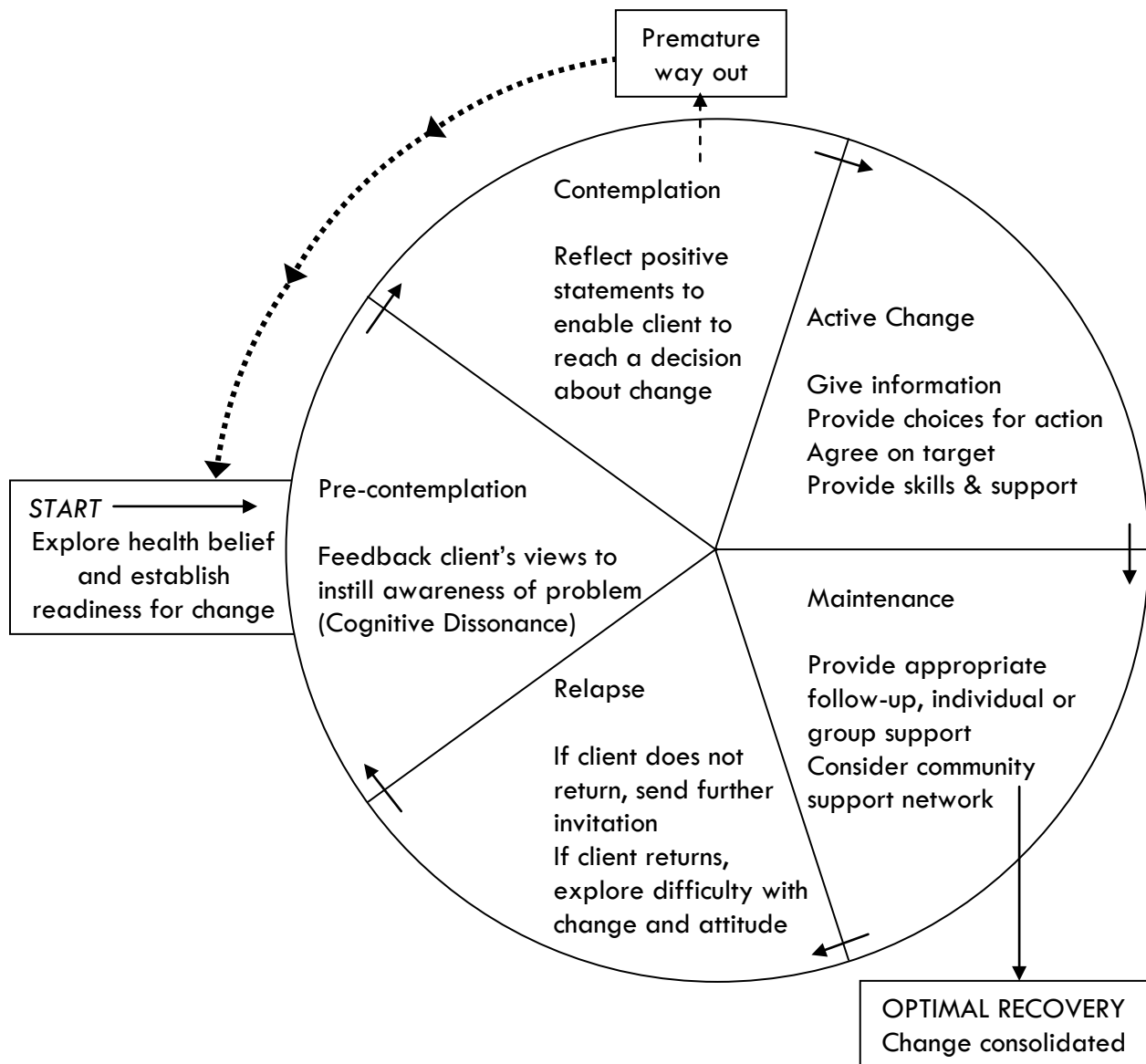
- The worker does not fight client resistance, but "rolls with it." Statements demonstrating resistance are not challenged.
- The worker uses the client's "momentum" to further explore the client's views.
- Resistance is decreased, as clients are not reinforced for becoming argumentative and playing "devil's advocate" to the worker's suggestions.
- Clients are encouraged to develop their own solutions to the problems that they themselves have defined.

### **Develop Discrepancy**

- “Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be” (Miller, Zweben, DiClemente, & Rychtarik, 1992).
- Workers help clients examine the discrepancies between their current behavior and future goals.
- When clients perceive that their current behaviors are not leading toward some important future goal, they become more motivated to make important life changes.

Adapted from: Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1992).

## Stages of Change Wheel



## Stages of Change Descriptions

<b>Stages</b>	<b>Descriptors</b>
<u>Pre-contemplation</u>	Person is not thinking about or does not want to change a particular behavior
<u>Contemplation</u>	Person is thinking about changing a behavior
<u>Preparation/Determination</u>	Person is seriously considering and planning to change a behavior and has taken steps toward change
<u>Action</u>	Person is actively doing things to change or modify behavior
<u>Maintenance</u>	Person continues to maintain behavioral changes until they become permanent
<u>Relapse</u>	Person returns to pattern of behavior that she/he has begun to change (returns to one of the first three stages)

From Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (1994). *Changing for good: The revolutionary program that explains the six stages of change and teaches you how to free yourself from bad habits*. New York: William Morrow Comp.



## Stages of Change Worksheet

Take a couple of minutes to think about a behavior change you have made in your life in the last few years, or that you are currently attempting to make. Try the “fit” of the stages of change model by trying to identify:

1. What behaviors you can identify from the various stages of change.
2. What you remember being the events or developments that tipped the balance related to your movement from stage to stage.
3. If you aren't at the stage of change you'd like to be in, what you think might be necessary to move yourself there.

### Behavior That Did Change or is in the Process of Change

<i>Stage of Change</i>	<i>Related Behaviors</i>
Pre-contemplation	
Contemplation	
Preparation/Determination	
Action	
Maintenance	
Relapse	

## Motivational Interviewing Exercise

While watching the video clip assess these various areas and jot down examples for further discussion.

1. Where in the change wheel is Jim at the beginning of this session? How do you know?

Does he make any movement? How do you know?

2. How does the therapist role with his resistance? What benefit does she gain by applying this technique?

3. How does the therapist use reflection to begin the process of examining discrepancies?

4. How does she move him toward taking action?

5. How can you use this in your role as a caseworker?

## Appropriate Motivational Strategies for Each Stage of Change

<i>Client's Stage of Change</i>	<i>Appropriate Motivational Strategies for the Clinician</i>
<p><u>Pre-contemplation</u> The client is not yet considering change or is unwilling or unable to change.</p>	<ul style="list-style-type: none"> <li>• Establish rapport, ask permission, and build trust</li> <li>• Raise doubts or concerns in the client about substance-using patterns by:               <ul style="list-style-type: none"> <li>– Exploring the meaning of events that brought the client to treatment or the results of previous treatments</li> <li>– Eliciting the client's perceptions of the problem</li> <li>– Offering factual information about the risks of substance use</li> <li>– Providing personalized feedback about assessment findings</li> <li>– Exploring the pros and cons of substance use</li> <li>– Helping a significant other intervene</li> <li>– Examining discrepancies between the client's and others' perceptions of the problem behavior</li> </ul> </li> <li>• Express concern and keep the door open</li> </ul>
<p><u>Contemplation</u> The client acknowledges concerns and is considering the possibility of change, but is ambivalent and uncertain.</p>	<ul style="list-style-type: none"> <li>• Normalize ambivalence</li> <li>• Help the client "tip the decisional balance scales" toward change by:               <ul style="list-style-type: none"> <li>– Eliciting and weighing pros and cons of substance use and change</li> <li>– Changing extrinsic to intrinsic motivation</li> <li>– Examining the client's personal values in relation to change</li> <li>– Emphasizing the client's free choice, responsibility, and self-efficacy for change</li> </ul> </li> <li>• Elicit self-motivational statements of intent and commitment from the client</li> <li>• Elicit ideas regarding the client's perceived self-efficacy and expectations regarding treatment</li> <li>• Summarize self-motivational statements</li> </ul>
<p><u>Preparation/Determination</u> The client is committed to and planning to make a change in the near future, but is still considering what to do.</p>	<ul style="list-style-type: none"> <li>• Clarify the client's own goals and strategies for change</li> <li>• Offer a menu of options for change or treatment</li> <li>• With permission, offer expertise and advice</li> <li>• Negotiate a change (or treatment) plan and behavior contract</li> <li>• Consider and lower barriers to change</li> </ul>

<b><i>Client's Stage of Change</i></b>	<b><i>Appropriate Motivational Strategies for the Clinician</i></b>
<p><u>Preparation/Determination</u> (continued)</p>	<ul style="list-style-type: none"> <li>• Help the client enlist social support</li> <li>• Explore treatment expectancies and the client's role</li> <li>• Elicit from the client what has worked in the past, either for him or others whom he knows</li> <li>• Assist the client to negotiate finances, childcare, work, transportation, or other potential barriers</li> <li>• Have the client publicly announce plans to change</li> </ul>
<p><u>Action</u> The client is actively taking steps to change, but has not yet reached a stable state.</p>	<ul style="list-style-type: none"> <li>• Engage the client in treatment and reinforce the importance of remaining in recovery</li> <li>• Support a realistic view of change through small steps</li> <li>• Acknowledge difficulties for the client in early stages of change</li> <li>• Help the client identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these</li> <li>• Assist the client in finding new reinforcers of positive change</li> <li>• Help the client assess whether s/he has strong family and social support</li> </ul>
<p><u>Maintenance</u> The client has achieved initial goals, such as abstinence, and is now working to maintain gains.</p>	<ul style="list-style-type: none"> <li>• Help the client identify and sample drug-free sources of pleasure (i.e., new reinforcers)</li> <li>• Support lifestyle changes</li> <li>• Affirm the client's resolve and self-efficacy</li> <li>• Help the client practice and use new coping strategies to avoid a return to use</li> <li>• Maintain supportive contact (e.g., explain to the client that you are available to talk between sessions)</li> <li>• Develop a "fire escape" plan if the client resumes substance use</li> <li>• Review long-term goals with the client</li> </ul>
<p><u>Recurrence</u> The client has experienced a recurrence of symptoms and must now cope with consequences and decide what to do next.</p>	<ul style="list-style-type: none"> <li>• Help the client reenter the change cycle and commend any willingness to reconsider positive change</li> <li>• Explore the meaning and reality of the recurrence as a learning opportunity</li> <li>• Assist the client in finding alternative coping strategies</li> <li>• Maintain supportive contact</li> </ul>

U.S. Department of Health and Human Services. (2000). *Enhancing motivation for change in substance abuse treatment*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

## **Solution-Focused Interviewing**

Solution-Focused Therapy (developed by Steve deShazer and Insoo Kim Berg) has the following characteristics:

1. Focus on the family's strengths and abilities.
2. Find out what is working and do more of it.
3. Families have the resources for change.
4. Families generate workable solutions.
5. Change starts small and has a ripple effect.
6. Focus on the future when the problem has been solved.
7. Focus on when the problem is not a problem.

Basic stages of solution-building interviews (DeJong & Berg, 1998):

1. Describe the problem: Ask clients how you, the worker can be useful.
2. Develop well-formed goals: Clients describe how their lives will be different when their problems are solved.
3. Explore for exceptions: Find out from clients when in their lives the problems were not happening or were not as severe, and what exactly was happening and who was involved.
4. Provide end of session feedback: Construct messages to clients that offer compliments and perhaps suggestions.
5. Evaluate client progress: Evaluate how clients are doing, typically using scaling questions (0-10, How are things going?).

When solution-focused interviewing is used, clients are the experts about their own lives.

## **Solution-Focused Interviewing Worksheet**

### **Clip 1: Role Clarification/Acknowledge what's Important to the Client**

1. Think back to the beginning of the interaction between the worker and Tim. How does the worker from the beginning allow the Tim to take ownership of the case?
2. How does the worker begin the joining process with Tim?
3. How does the worker put responsibility on Tim without being accusatory?
4. How does the worker use reframing?

### **Clip 2: Getting the Client's Understanding**

1. The worker immediately addresses what Tim wants. How does this help you in the current interview? In future interviews?
2. What are the advantages of asking Tim what he thinks the assessment worker would say?
3. Tim does not agree with the allegations. What does the worker gain by accepting his perceptions? How does he lay the groundwork to challenge this in the future?

### **Clip 4: Getting the Client's Perception of Agency Expectations**

1. How does the worker use relationship questions to empower Tim to comply with nonnegotiable expectations?
2. How does the worker lose an opportunity for more role clarification and to deepen their relationship? How would you have handled it?

## **End-of-Session Feedback**

The worker excuses himself to review his notes and reflect on what has been accomplished. Jot some notes as to what you think are the key points you would want to make with Tim.

## Language Techniques That Promote Solution-Focused Interviewing

- ❖ Suppose, (pause)...  
This is a good way to help families begin to imagine an alternative future without implying that their preferred future will occur. It is good practice to use pauses to help families make the transition to thinking about alternatives to problems. **For example:** “Suppose you were able to find ways to have your children do what you want them to do, (pause)... What would they notice you doing differently with them?”
- ❖ Instead  
It is quite normal for families to not know what they want when they first meet with the caseworker. Sorting this out usually begins by talking about what they do not want. Be prepared to help families define what they want by building on what they find troublesome. The word “instead” is very useful. **For example:** “Instead of ‘screaming at the kids,’ what would you do?”
- ❖ “When,” not “If”  
“When” encourages a future focus and creates more hope that a different way could happen. “If” retains the future focus, but introduces more doubt. **For example:** “When you are able to talk to your kids in a normal tone of voice, what will be different at your home?”
- ❖ “How come?”  
This question is less confrontational and accusatory than “why” and asks, “What were you thinking?” **For example:** “How come you decided to respond to your children’s misbehavior differently from how your mother responded to you as a child?”
- ❖ Using silence and responding to “I don’t know”  
Because the questions we ask families are difficult and require thought, they often fall silent or say, “I don’t know.” When that happens, try:
  - (First) sitting back, looking expectantly, and waiting for an answer.
  - Saying, “I am asking some tough questions,” and wait some more.
  - Saying, “If you were to guess, what would you say?”
  - Using relationship questions like, “What would your husband say that he sees that tells him that you no longer have this problem?”
  - Reviewing how the agency became involved with the family; that is, looking at who is the “real client” in this case, the person who wants something different, and then proceed to relationship questions that build around the “real client.” **For example:** “When social services got involved with your family, you told me that you wanted to find a way to have your children behave that didn’t involve hitting or yelling at them. You said you wanted to raise your children differently from the way your mother raised you. What do you suppose the judge wants to see different as the result of our talking?”



❖ Difference questions

Families make changes when they notice something is different in their lives; the difference gives them ideas about what they do to bring on further changes. Therefore, expect to use the word “different” frequently in your questions. **For example:** “What will you notice different about your children that will let you know that a miracle has happened and their problems in following your instructions are solved? How will you know that is really different this time? What difference would that make in your relationship with your children?”

❖ Tentative language

Tentative language is consensus-building language; it invites and allows space for the listener to offer thoughts and ideas on a topic. **For example:** “I wonder what will happen when.... Could it be that...? Perhaps.... Is it possible that...?”

❖ So...

A very useful word to use in order to break in on families who are “non-stop, problem talkers,” who “control” the situation with such talk. Once families have some time to express their difficulties and reactions, use “so” (not “but,” see below) followed by a paraphrase or empathic statement, and then move on to solution-focused questions. The use of “so” signals to the family that a topic change is coming and gives the interviewer a device to redirect the conversation in a more useful direction. **For example:** “So, I can see that having social services in your life has created lots of problems for your family, (pause).... When things start to go better, what will be different?”

❖ Words or phrases to avoid

- “You want to \_\_\_\_\_, don’t you?”  
Such questions reflect the worker or Agency’s frame of reference and minimize the importance of what the client wants different.
- “Yes, but...”  
If you are using this phrase, it is a good indication that you are about to engage in a debate with the family. We can often influence a family’s way of thinking, but we cannot win a debate or argument. If you find yourself saying “but...,” it’s a pretty good clue that you want to do something different. Get in the habit of catching yourself in time and experiment with other phrases. Start by asking, “So what has to be different as the result of our meeting today for you to say our time together was worthwhile?”

❖ Exception finding questions

When exploring for exceptions, be aware that such questions can be phrased to ask for the family’s perceptions of exceptions (individual questions) and the family’s perception of what significant others might notice (relationship questions). These ideas also incorporate the miracle scenario in which the family is told that when they awoke this morning a miracle had occurred and the problem was completely resolved. Families are then asked to describe what the miracle would “look like.” These questions also incorporate the use of scaling in which the family is told that 1 represents no chance and 10 means every chance of something occurring, and then asks the family to choose a number to identify the likelihood of the target behavior happening.

- Exceptions related to the miracle:
  - “So when the miracle happens, you are able to have someone watch your children while you are away from the home, and they are well cared for. Are there times already which are like the miracle—even a little bit?”
  - “If your kids were here and I was to ask them that same question, what do you think they would say?”
  - “When was the last time someone took good care of your children when you had to go away? Tell me more about that time. What was that like? What did the kids say about it? When they said that, what did you do? How was that for you? What else was different?”
  - “Was that new for you and the kids? Did it surprise you that having that person take care of your kids went so well?”
  - “Seems like that might have been difficult for you to do, given that finding someone responsible and not being able to pay someone. How were you able to overcome barriers?”
- Explore how the exception happened:
  - “What specifically did you do to make that happen?”
  - “If your kids were here and I asked them, what do you suppose they would say that you did to make that such a successful experience for both them and the babysitter?”
  - **Use compliments:** “Where did you get the idea to do it that way? That seems to make a lot of sense. Have you always been able to come up with ideas about what to do in difficult situations like this?”
- Project exceptions into the future:
  - “On a scale of 1 to 10, what is the likelihood of you being able to get someone that you are comfortable with to take care of your children this week (month, sometime in the future), with 1 being no chance and 10 being every chance?”
  - “What will it take for that to happen more often in the future? Who has to do what to make it happen again?”
  - “What is the most important thing for you to remember to do to make sure that you children having adequate care has the best chance of happening again? What is the next most important thing to remember?”

❖ Coping questions

- In some cases, the family cannot identify any exceptions and seems overwhelmed. You can ask coping questions to uncover what the family is doing to make it in such difficult circumstances. **For example:** “I’m amazed. With all that’s been happening, I don’t know how you make it. How do you do it? How do you get from one day to the next? I’m wondering how you manage to keep going.”
- If the family indicates that they have to keep going for the kids, you might say: “Is that how you do it? You think about your kids and how much they need you? You care a lot about them. Tell me more about what you do to take care of them.”

Adapted from DeJong, P. & Berg, I. (1998). *Interviewing for solutions*, 2<sup>nd</sup> Ed. Pacific Grove, CA: Brooks/Cole Publishing Co.



## Family Services Plan

### Part 1: Family Information

Court Case:                      Hearing Type:                      Date/Time:                      Division#:  
  
County:                              HH#:

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#### Family Members

Name:  
DOB:  
Employer/School:  
Address:  
Phone:

Attorney/GAL:

Name:  
DOB:  
Employer/School:  
Address:  
Phone:

Attorney/GAL:

Name:  
DOB:  
Employer/School:  
Address:  
Phone:

Attorney/GAL:

Name:  
DOB:  
Employer/School:  
Address:  
Phone:

Attorney/GAL:

Others Involved

Provider:

Provider:

Collateral:

Some or all of the above information has changed since the last court appearance:  Yes  No

Caseworker: \_\_\_\_\_ Date: \_\_\_\_\_

## Family Services Plan

### Part 2: Family Social History & Assessment Summary

Family Name: \_\_\_\_\_ Court Case #(s): \_\_\_\_\_

Date Case Accepted for Ongoing Services: \_\_\_\_\_ Risk Level: \_\_\_\_\_

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Reason for Intervention: Include the reason for intervention and/or conditions giving rise to the abuse/neglect or the parent/child conflict; how does this affect the child(ren)/youth, family, and/or community?

Safety: Record the safety needs of the child/youth, family, and/or community.

Family Perceptions: How does the family perceive the problem(s); include previous efforts to meet needs and solve problems; what needs to change?

Family Strengths: Describe the family's strengths.

Family/Social Support: Include reasonable efforts and current support/future support.

Child History: Include child(ren)'s roles, ages, emotional/physical/social/developmental history and milestones.

**Family Environment:** Describe environment and overall functioning, including physical environment of housing/neighborhood, family composition, stability, stresses, parenting skills, discipline methods, and relationships.

**Education & Employment:** Include the child/youth, parent, and/or other relevant family members.

**Culture/Religion/Ethnicity:** Include language; include how these affect the needs of the child(ren).

**History of Abuse/Neglect:** Include children and parents; include history and domestic violence.

**Medical/Mental Health:** Record needs/history of parents and children, including medications.

**Substance Abuse History:** Include child/youth, parent, and any other relevant family member.

**Legal History:** Include child/youth/family member(s).

**Additional Information:** If necessary, elaborate on your responses to the previous subjects, or write a Family Social History/Assessment that includes your responses to all of the subject areas.

## Family Services Plan

### Part 3A: Treatment Plan

Court Case #:

Date Approved by Court:

Family Name:

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Parent Name:

Objective:

Start Date:

Est. Comp. Date:

Action Steps:

Measurement of Success:

Service Type:

Service Provider:

Responsibility for Fees:

---



Child Name:

Permanency Goal:

Date Set:

Target Date:

Alternative Permanency Goal:

Objective:

Start Date:

Est. Comp. Date:

Action Steps:

Measurement for Success:

Service Type:

Service Provider:

Responsibility for Fees:

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Provider Name:

Objective:

Start Date:

Est. Comp. Date:

Action Steps:

Measurement of Success:

Service Type:

Service Provider:

Responsibility for Fees:

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Collateral:

Objective:

Start Date:

Est. Comp. Date:

Action Steps:

Measurement of Success:

Service Type:

Service Provider:

Responsibility for Fees:

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## Family Services Plan

### Part 3B: Visitation Plan for Child or Youth in Placement

Court Case #(s):

Child's Name:

Date Developed:

Start Date:

End Date:

Visitor:

Relationship:

Purpose:

Frequency:

Duration:

Location:

Method:

Special Considerations or Restrictions:

Phone Contact:

Notification of Changes to Plan (include date and method of notification):

---

Visitation Plan may be modified through the agreement of the following parties or by the Department in emergency situations for child safety reasons:

## Family Services Plan

### Part 3C: Summary & Recommendations

Family Name:

Dispositional Summary:

Agency Recommendations:

## Family Services Plan

### Part 3D: Signature Page

Initial Treatment Plan

Changes in Current Treatment Plan

The following persons indicate by the presence of their signatures below that they have read or have been made aware of the contents of this plan and, by initialing in the appropriate spaces, do acknowledge that they participated in, agree with, disagree with, reviewed, and/or received a copy of the plan.

	Signature	Date	Reviewed	Participated in Development	Agree	Disagree	Received Copy
Parent/ Step Parent:	_____	_____	_____	_____	_____	_____	_____
Parent/ Step Parent:	_____	_____	_____	_____	_____	_____	_____
Parent/ Step Parent:	_____	_____	_____	_____	_____	_____	_____
Parent/ Step Parent:	_____	_____	_____	_____	_____	_____	_____
Child/Youth:	_____	_____	_____	_____	_____	_____	_____
Child/Youth:	_____	_____	_____	_____	_____	_____	_____
Child/Youth:	_____	_____	_____	_____	_____	_____	_____
Child/Youth:	_____	_____	_____	_____	_____	_____	_____
Provider(s):	_____	_____	_____	_____	_____	_____	_____
Provider(s):	_____	_____	_____	_____	_____	_____	_____
Provider(s):	_____	_____	_____	_____	_____	_____	_____
Others:	_____	_____	_____	_____	_____	_____	_____
Others:	_____	_____	_____	_____	_____	_____	_____
Caseworker:	_____	_____					
Caseworker:	_____	_____					
Supervisor:	_____	_____					
Supervisor:	_____	_____					

Comments:

## Family Services Plan

### Part 4A: Imminent Risk of Out-of-Home Placement Criteria Checklist

#### For Child/Youth Entering Core Service or Kinship Placement

\*Complete this form every 6 months while Core Services are provided, or as long as the child/youth remains in a Kinship Placement.

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**Child/Youth:**

**Completed Date:**

**Worker Name:**

This child is eligible for a Core Service and/or Kinship Placement on the basis of the child's need for services because the child has met the criteria for out-of-home placement (Refer to Volume VII Section 7.304.3). Absent Core Services or Kinship Placement, the plan for the child would be out-of-home placement with non-kin.

**Criterion # 1:** The child/youth is at imminent risk of out-of-home placement [CRS 26-5.3-103(2)] because none or more of the following conditions exist (CHECK ALL THAT APPLY):

- |  |   |
|--|---|
| <input type="checkbox"/> Abandonment by or incarceration of parents/caretaker  | <input type="checkbox"/> Domestic Violence                                |
| <input type="checkbox"/> Death of Parent   | <input type="checkbox"/> Mental Illness (child/caretaker)                 |
| <input type="checkbox"/> Abuse/Neglect-as defined in the Children's Code   | <input type="checkbox"/> Disability (child/caretaker)                     |
| <input type="checkbox"/> Substance abuse (child/caretaker); drug exposed infants   | <input type="checkbox"/> Physical Illness (child/caretaker)               |
| <input type="checkbox"/> Homelessness/Inadequate Housing (child/caretaker)   | <input type="checkbox"/> Relinquishment or termination of parental rights |
| <input type="checkbox"/> Infant or young child of teen parent in placement   | <input type="checkbox"/> Beyond control of parents                        |
| <input type="checkbox"/> Delinquency-(adjudicated in compliance with CRS 19-2-1602)  | <input type="checkbox"/> Danger to self, others, or community             |
| <input type="checkbox"/> Child/youth returning home from out-of-home placement or moving to less restrictive level-of-care | <input type="checkbox"/> Other  |

**Describe how these conditions result in "imminent risk":**

**Criterion #2: Assessment**

The above conditions are to be addressed through Core Services and/or Kinship Placement because all other resources, services, and/or funding sources considered were:

- not immediately available without DHS funding
- absent
- unsuccessful
- exhausted
- other

**Comments:**

**Criterion #3: Determination of Core Services and/or Kinship Placement**

- Core Services       Kinship Placement with Core Services       Kinship Placement with No Core Services

**Comments:**



Name/Addresses of child's doctor and dentist at time of removal:

Does the child have any medical needs/problems?

Are the child's immunizations up-to-date?

Is the child taking any medications?

Name and address of current physician/dentist:

A medical and dental examination are required following placement:

Date medical exam completed:

Date dental exam completed:

Indian Child Welfare Act requirements have been completed for eligible children:

Summary of Parental Fee Status:

**Recommendations:**

Date of most recent approved court ordered treatment plan:

Are any changes recommended?

**Signatures:**

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Caseworker	Date	Supervisor	Date
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## Family Services Plan

### Part 4C: Subsequent Placement Information

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Subsequent Placement Name:            Type:            Date Entered:    /   /            Date Left:    /   /

Any Rule Exception?

Did this move result in permanent placement?

Describe efforts to place with relatives:

Describe what factors have been assessed that indicate this placement will provide a safe environment for this child:

Describe how the placement is in close proximity to the child's school/home consistent with the child's best interest and special needs, or give reasons why child placed a substantial distance from home or out-of-state:

Describe how the placement is in the least restrictive (most family-like) and most appropriate setting:

If siblings are not placed together, explain:

Date the child's health passport reviewed, updated, and supplied to the new placement provider:

Initials of Caseworker: \_\_\_\_\_

Current Grade Level: \_\_\_\_\_            Functioning Grade Level: \_\_\_\_\_

Name/Address of current school:

Physician:

Dentist:

## Family Services Plan

### Part 4D: Plan for Transition to Independent Living

#### *For Youth in Placement Age 16 or Older*

Factors/Barriers affecting the successful completion of the Plan:

Youth's involvement with biological family or extended family:

Plan for continued education/training:

I will have \$\_\_\_\_\_ in savings by:

Assessment of daily living skills:

Planned living arrangement after leaving foster care:

Support system available to youth:

Specific services agreed upon with the youth:

Signature indicates youth's involvement in development of the plan:

Youth: \_\_\_\_\_ Caseworker: \_\_\_\_\_ Date: \_\_\_\_\_

Other: \_\_\_\_\_

## Family Services Plan

### Part 5A: Review

**Reason for Review:**

90 day supervisor/caseworker

Court Review

**Review Date:**

Change in Treatment Plan

**Court Case #(s):**

**Family Name:**

Family Assessment Update:

Services:

Are court ordered/agreed upon services being provided?

Are services/placement appropriate and do they continue to meet the needs of the child, the family, the foster parents?

Were abuse/neglect allegations investigated in this setting during this review period?

Are the number of children and the presenting problems of the children in the home limited sufficiently to meet the safety needs of this child?

Describe any safety concerns regarding this child's placement. If safety concerns are identified, what is the plan? Explain "NO" responses. Additional comments optional:

**Progress:**

Objective:

Start Date:

Est. Comp. Date

Progress:

Status:

Outcome:

**Permanency Goal:**

Child Name:

Permanency Goal:

Date Set:

Target Date:

Permanency Goal Comments:

Time Frames: Are the existing time frames still appropriate?

Summary of Foster Care Review Results:

## Family Services Plan

### Part 5A Attachment: Termination of Parental Rights Review

Name of Child: \_\_\_\_\_

#### Section A

In the case of a child who has been in foster care under the responsibility of the County for fifteen of the last twenty-two months, the County Department shall file a petition to terminate the parental rights of the child's parents (or if such a petition has been filed by another party, seek to be joined as a party to the above petition), and, concurrently, to identify, recruit, process and approve a qualified family for adoption, unless:

1. \_\_\_\_ The County deems the child is being cared for by a relative in a permanent placement.
2. \_\_\_\_ The County has not provided to the family of the child, consistent with the time period in the Family Services Plan, such services as the County deems necessary for the safe return of the child to the child's home.
3. \_\_\_\_ The County has determined that there is a compelling reason for determining that filing a petition for Termination of Parental Rights would not be in the best interest of the child such as:
  - a. \_\_\_\_ The family is involved, cooperative, and achieving some success on an approved plan, and it is likely that the reunification will occur as specified in the Family Services Plan within six months.
  - b. \_\_\_\_ Permanent custody action or a Probate Court guardianship action, which the Department supports, is already pending.
  - c. \_\_\_\_ A County appointed review team agrees that adoption would not be in the child's best interest because the child's mental and/or physical needs or conditions or behaviors deem it improbable that such child would have a successful adoption.
  - d. \_\_\_\_ A child who is twelve years of age or older has declined adoption after being counseled by staff who are trained in adoption or relinquishments. The decision that adoption was not in the best interest of the youth was made with the involvement of the caseworker and Guardian Ad Litem.
  - e. \_\_\_\_ The child has been in foster care under the responsibility of the County Department for fifteen of the last twenty-two months due to circumstances beyond the control of the parent, such as incarceration of the parent, AND the parent has otherwise followed the plan supported by the County Department.
  - f. \_\_\_\_ The County Department has determined another compelling reason that they wish to present for judicial determination. Please document: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_ None of the above conditions have been met and a petition for termination of parental rights will be prepared for the Court.

**Section B**

**A child/youth for whom no Dependency and Neglect petition has been filed and who has been in foster care under the responsibility of the State/County for fifteen of the last twenty-two months:**

1. \_\_\_\_ Has been reviewed for the need to file a Dependency and Neglect Petition.

**The findings are:**

A. \_\_\_\_ There are no conditions warranting the filing of a Dependency and Neglect Petition.

B. \_\_\_\_ A Dependency and Neglect Petition will be filed.

Caseworker Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Family Services Plan

### Part 5B: CWSA Requirements/Special Reviews

Child's Name:

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INITIAL CASE PLAN EXCEPTION

Review Date:

If the initial permanency goal is not to return home, indicate reason:

- Both parents are deceased or plan to or have voluntarily relinquished parental rights (circle which applies);
- Parents cannot be located after a diligent search (which must begin no later than three working days following placement and won't exceed three months to completion);
- Parents have been guilty of repeated and/or severe abuse or neglect of the child or the child's siblings such that termination of parental rights is appropriate; or,
- Safe return home appears impossible even with the provision of reasonable services.

Caseworker Initial & Date:

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CHILD IN PLACEMENT 12 MONTHS

Review Date:

For any child who has a permanency goal of returning home for more than twelve months, explain your justification for continuing this goal:

Caseworker Initial & Date:

Supervisor Initial & Date:

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CHILD IN PLACEMENT 18 MONTHS

Review Date:

If permanency goal continues to be return home for more than eighteen months, explain what extraordinary circumstances and strong reasons(s) there are to believe that the child can still be returned home within a specified and reasonable time period.

Signatures indicate Approval:

Date Signed:

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Caseworker

Supervisor

Administrator

---

WHEN LEGAL GUARDIANSHIP OR OTHER PLANNED PERMANENT LIVING ARRANGEMENT ARE BEING CONSIDERED

Review Date:

- A plan for return home, adoption, or independent living are not viable alternatives.  
Explain:
- Significant relationships and how visitation/communication to maintain these relationships are described in the treatment plan.
- The county-designated permanency planning team has reviewed and approved this plan.

Review Team Representative Initials & Date:

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SPECIAL COUNTY REVIEW

- 1. This child has been placed in four or more different placements (excluding a return home).
- 2. This child has current plan for return home for more than twenty-four months since most recent removal.
- 3. This child has a goal of Adoption for more than one year and has not been placed in an adoptive home.
- 4. This child has been returned home and re-entered foster care more than twice, and the current plan is for return home.

If any of the above applies, this case must be referred for “further county review.”

Date Referred:

Results of Special Review:

Date of Special Review:

Review Team Representative Initials & Date:

# Family Services Plan Instructions

Revised 05/2006

## General

Intervention with abused and neglected children and their families must be planned, purposeful, and directed toward the achievement of safety, permanency, and well-being. One of the essential elements of planned and purposeful intervention is a complete understanding of the factors contributing to maltreatment. The case plan identifies risks and problematic behaviors, as well as specific strategies and interventions to facilitate the changes needed. Safety plans and concurrent permanency plans are often incorporated into the case planning process, as needed.

Flexibility also is critical in developing and implementing case plans. The use of creativity helps in developing new approaches to tackle difficult problems. The children and family's needs and resources may change, and flexibility allows the plan to follow suit. Planning is a dynamic process; no plan should be static.

## Involving the Family

Families who believe that their feelings and concerns are heard are more likely to engage in the case-planning process. Therefore, decisions regarding outcomes, goals, and tasks should be a collaborative process between the caseworker, family, family network, and other providers. Caseworkers should help the family maintain a realistic perspective on what can be accomplished and how long it will take to do so. Involving the family accomplishes the following:

The FSP is to be used for an entire family, even if there is more than one child. Each child in out-of-home placement must have specific parts of the FSP completed separately as described below.

## How to Use These Instructions

Each caseworker should have a copy of the instructions. The instructions are divided into parts to coincide with the FSP parts. Each part has an "Overview," which is a general description of the use of that part. After the overview is "Court Use," which gives specific instructions about whether the particular part of the FSP is used for court. Then each part is broken down into the separate items under the heading "Specific Sections," where you will find specific instructions and other information you need to complete each item. Not every part has a "specific sections" heading, as those specific items were felt to be self-explanatory. The instructions will give you a "quick reference" guide to use while you are getting familiar with the FSP.

## Part 1: Family Information

### Overview

This section will show all participants (not just children) involved in the FSP Part 1. Information will include participant name, start date, end date, permanency goal, alternate permanency goal, date set, and target date.

This part is to be used for the court report face sheet. You can use the form to initially gather the information. Once it is entered and submitted to court, this copy becomes the official one. You can add another handwritten form to address changes between court hearings or make changes on entered copy. You only need to update the entered copy when the next court report is submitted.

### Court Use

This part is submitted to court with the initial treatment plan and for court progress reviews. Since it is distributed to all the parties along with your court reports and treatment plan, use your judgment about any information on this part that you do not want other parties to have. Caseworkers should also check with foster parents about any concerns they may have about their information being included in the court copy.

### Specific Sections

#### **Court Case #/Hearing Type/Date & Time/Division**

List all case numbers of current court cases that are pertinent to DSS involvement. Indicate the type of hearing, i.e., review, dispositional, etc., the date and the time of the hearing, and the court division number if applicable.



### **Family Members**

This section is to be used for all members of the household (list household members first), special respondents and other family members. List all parents' names even if whereabouts are unknown and so indicate.

#### **Attorney/GAL Name**

Indicate the name of this person's attorney of record for the court case or "none."

#### **Address/Phone #/DOB**

Write in the address, phone, and DOB for each person. For persons who reside at the same address, you may group them together and indicate "same as above" after listing the address once. If the person listed is a child in placement, list the facility/foster home name and, where appropriate, indicate the relationship to the child. In cases where the name and/or address of the placement or other parties should not be disclosed to the parent(s) or others, use your judgment as to what information is written on this form. Use initials for the foster family if they do not want their identity disclosed.

#### **Employment/School**

Note the person's employer's name or school they attend.

#### **Other Involved Persons/Agencies**

Use this section for information on any other persons significant to the case.

#### **Information Has Changed**

When you resubmit this to court at the next hearing/review, indicate if the information has changed. This is to alert the court and others to look for changes.

## **Part 2: Family Social History & Assessment Summary**

### **Overview**

Family assessments, in order to be most effective, should be culturally sensitive, strengths-based, and developed with the family. They should be designed to help parents or caretakers recognize and remedy conditions so children can safely remain or return to their own home. Given the emphasis on timeliness built into the Adoption and Safe Families Act (ASFA), the assessment of the family's strengths and needs should be considered in the context of the length of time it will take for the family to provide a safe, stable home environment.

A culturally sensitive assessment recognizes that parenting practices and family structures vary as a result of ethnic, community, and familial differences, and that this wide range can result in different but safe and adequate care for children within the parameters of the law. Each family has its own structure, roles, values, beliefs, and coping styles. Respect for and acceptance of this diversity is a cornerstone of family-centered assessments. The assessment process must acknowledge, respect, and honor the diversity of families.

A strengths-based assessment "recognizes that people, regardless of their difficulties, can change and grow, that healing occurs when a family's strengths, not its weaknesses, are engaged, and that the family is the agent of its own change." While an outline for the family assessment process increases the likelihood that all assessment areas are covered, family assessments must be individualized and tailored to the unique strengths and needs of each family. An individualized assessment is undertaken in conjunction with other service providers to form a comprehensive picture of the individual, interpersonal, and societal pressures on the family members—individually and as a group. This holistic approach takes both client competencies and environment into consideration and views the environment as both a source of and solution to families' problems. When possible, the assessment process also should be conducted in conjunction with the families' extended family and support network through the use of family decision-making meetings and other formats.

The assessment is to be completed in all program areas. It is completed only once, at the time the family is accepted for ongoing service. Only one assessment is completed per family, whether the children reside at home or in out-of-home placement. Updating information on Part 2 will be done every 90 days by completing the "Family Assessment Update" section of Part 5A (see instructions for 5A).

Part 2 meets all of the requirements reflected in Volume 7 for family assessment (Section 7.301C.) and the requirements agreed upon by the state judicial for a social history. The NCFAS, however, must also be completed for PA 5 cases.

The case planning process must begin no later than 7 days after a case is "accepted for ongoing services" according to Volume 7. Any assessment open for more than 30 days is deemed an "ongoing" case. The case plan as well as the NCFAS must be completed within 60 days of the referral being opened. Since the case plan (Family Services Plan) must be based upon a thorough assessment of the entire home situation, work on Part 2 and the NCFAS should begin as early as

possible in the case. Counties with separate “assessment” and “ongoing” units may need to have assessment caseworkers complete some or all of Part 2, so that it can be completed by the time the case plan is due.

### Specific Sections

Complete Part 2 by writing narrative responses regarding the information for each of the identified assessment areas. The narrative should include information about the whole family and/or for specifically identified individuals, depending upon the family’s composition and case situation. Remember that each child in the household open in TRAILS is to be assessed and information about each child is to be recorded. All of the numbered items must be addressed for all cases. When addressing sections such as education and employment, health, substance abuse, the children and the parents should both be addressed in the section.

## Part 3

### Overview

With the passage of the Adoption and Safe Families Act (ASFA) in 1997, child welfare agencies have been directed to design their intervention systems to measure the achievement of outcomes. There has been consensus that child welfare outcomes, at the program level, can be organized around four domains: child safety, child permanence, child well-being, and family well-being (functioning). Although all four are important, Federal and State laws emphasize child safety and permanence, so these two outcomes are often used to evaluate agency performance. The agency outcomes are defined as:

- **Child safety:** The safety of children is the paramount concern that guides CPS practice. The evaluation of child safety is equivalent to the determination that the child is at imminent risk of serious harm.
- **Child permanence:** Although maintaining a constant focus on child safety is critical, casework interventions also must be aimed at maintaining or creating permanent living arrangements and emotional attachments for children. This is based on the belief that stable, caring relationships in a family setting are essential for the healthy growth and development of the child. This stresses providing reasonable efforts to prevent removal and to reunify families, when safe and appropriate to do so and as specified under ASFA. This also promotes the timely adoption or other permanent placement of children who cannot return safely to their own homes.
- **Child well-being:** The general well-being of children who come in contact with the CPS system also must be addressed, especially for children placed in substitute care. This requires that children’s physical and mental health, educational, and other needs will be assessed, and that preventive or treatment services are provided when warranted.
- **Family well-being:** Families must be able to function at a basic level in order to provide a safe and permanent environment for raising their children. Caseworkers are not expected to create optimal family functioning, but rather facilitate change so that the family can meet the basic needs of its members and assure their protection.

The FSP Part 3 serves both as the case plan (Federal requirements) and the treatment plan (court requirements) to be submitted to court. This part of the FSP is the focal point of the treatment planning process. The treatment plan must be completed within 60 days of the referral being opened.

Parents, other appropriate family members, and providers are required to participate in the development of the treatment plan. Caseworkers can use the printed form to develop the treatment plan with the family, and then get the needed signatures. For voluntary (non-court) cases, it may be left handwritten. For court cases, it will need to be “typed” or printed from TRAILS.

How family involvement will be obtained in the assessment and case planning process will vary depending on the situation, but it is expected that the family will be involved in developing the treatment plan.

## Part 3A: Treatment Plan

### Overview

The case plan that a caseworker develops with a family is their road map to successful intervention. The outcomes identify the destination, the goals provide the direction, and the tasks outline the specific steps necessary to reach the final destination. The purposes of case planning are to:

- Identify strategies with the family that address the effects of maltreatment and change the behaviors or conditions contributing to its risk;

- Provide a clear and specific guide for the caseworker and the family for changing the behaviors and conditions that influence risk;
- Establish a benchmark to measure client progress for achieving outcomes; and
- Develop an essential framework for case decision-making.

The primary decisions during this stage are guided by the following questions:

- What are the outcomes that, when achieved, will indicate that risk is reduced and that the effects of maltreatment have been successfully addressed?
- What goals and tasks must be accomplished to achieve these outcomes?
- What are the priorities among the outcomes, goals, and tasks?
- What interventions or services will best facilitate successful outcomes? Are the appropriate services available?
- How and when will progress be evaluated?

Caseworkers should work with families to develop goals that indicate the specific changes needed to accomplish the outcomes. The objective is not to create a perfect family or a family that matches a caseworker's own values and beliefs. Rather, the goal is to reduce or eliminate the risk of maltreatment so that children are safe and have their developmental needs met. Goals should be **SMART**; in others words, they should be:

- **Specific:** The family should know exactly what has to be done and why.
- **Measurable:** Everyone should know when the goals have been achieved. Goals will be measurable to the extent that they are behaviorally based and written in clear and understandable language.
- **Achievable:** The family should be able to accomplish the goals in a designated time period, given the resources that are accessible and available to support change.
- **Realistic:** The family should have input and agreement in developing feasible goals.
- **Time limited:** Time frames for goal accomplishment should be determined based on an understanding of the family's risks, strengths, and ability and motivation to change. Availability and level of services also may affect time frames.

Goals should indicate the positive behaviors or conditions that will result from the change and not highlight the negative behaviors.

Goals should then be broken down into small, meaningful, and incremental tasks. These tasks incorporate the specific services and interventions needed to help the family achieve the goals and outcomes. They describe what the children, family, caseworker, and other service providers will do and identify time frames for accomplishing each task. Families should understand what is expected of them, and what they can expect from the caseworker and other service providers.

In developing tasks, caseworkers should also be aware of services provided by community agencies and professionals, target populations served specializations, eligibility criteria, availability, waiting lists, and fees for services. With this knowledge, caseworkers can determine the most appropriate services to help the family achieve its tasks.

You may address more than one child in placement on the same page as long as each child has his/her own section. To meet the federal requirements, each section for a child in placement must include his/her name, individual goal, objectives, action steps, etc. (see below).

Children who are residing in their own home and are open in TRAILS must be identified in the treatment plan and have their needs addressed individually, but may be addressed together in the same section.

### **Court Use**

Part 3A is submitted to court as the dispositional treatment plan. The sections that address the providers and the agency should also be submitted to court with the rest of the treatment plan. The court is clear about who it has jurisdiction over. In order to show "reasonable efforts" by the county department, it is important to provide the court with this information. The providers need to know that they are not subject to court orders in the case, but their involvement in the treatment plan is essential to the agency's management of the case.

### **Specific Sections**

#### **For Child/Youth/Parent/Provider/Agency**

Write in the name of the person/agency whose needs will be addressed in this section.

**Date of Most Recent Approved Court Ordered Treatment Plan**

After the court has approved the treatment plan, write in the date for the most recent approval. If the plan is changed and the changes approved, add the changes and write in the new date. (See instructions for Part 5A, “When Used as a Court Review.”)

**Permanency Goal**

Identify one of the permanency goals: remain home, return home, permanent placement through adoption (relative or non-relative), permanent placement through guardianship/permanent custody (relative or non-relative), other planned living arrangement through emancipation, or other planned living arrangement (relative or non-relative). NOTE: The permanency goal and associated dates are only required if you are addressing the objectives/action steps for a child.

**Date Set**

The date the current goal was established.

**Target Date**

The specific date upon which you expect the goal to be achieved. This is your best estimate given the progress and situation in the case.

**Alternative Permanency Goal**

This is also known as the concurrent plan goal—the goal that will be pursued on a concurrent basis when there is no significant progress toward the approved goal. This is recognizing that reasonable efforts must continue on the approved goal until the court adopts an alternative permanent plan. The alternative goal is optional at this time.

**Objectives/Action Steps**

The specific layout of the treatment plan (Part 3A) may be altered to fit the particular needs of your county and judicial district. HOWEVER, the following must be specifically included:

- **Objectives:** Describe, in measurable terms, what change is desired. This should describe the outcome you hope to achieve based on the needs identified in the assessment. Objectives must address the areas that necessitated the agency’s involvement.
- **Action Steps:** The specific actions that must be taken by the person/agency to achieve the objective. Each action step must include:
  - **Persons Involved:** Who is responsible for completing or has a role in completing the action step.
  - **Time Frames:** Specific dates for when the action is to begin and end.
  - **Service Provider:** If the action step involves the provision of any service, name the provider.
  - **Responsibility for Fees/Costs for Services:** If a service is involved, who will actually pay for the service.
- **Measurement of Success:** Describe how the person/agency will demonstrate they have completed the action steps and accomplished the objective. Should include both quantifiable as well as qualitative measurement.

**Part 3B: Visitation Plan for Child or Youth in Placement**

**Overview**

The visitation plan is required for all children in placement. It is to be completed when visitation is to occur between a child in placement and any other significant person or family member on a regular basis. One or more children may be included in the same plan. Label any child specific sections or information with the child’s name if you include more than one child in the plan. It is the county’s decision as to when it may be appropriate to have more than one visitation plan in the same case. Examples: if children are in different placements; if the visitors (parents, etc.) have different visitation plans; if different age children have different visitation needs/plans; etc.

**Court Use**

The visitation plan is to be submitted to the court as part of the treatment plan (Part 3A).

**Specific Sections (Row Headings)**

**Name and Relation**

Write in the appropriate name of the person visiting and that person’s relationship to the child(ren) listed at the top of visitation plan. Each column is completed for the person(s) you list in the first row. Each column specifies a separate

visitation plan for the person listed at the top of the column. You may list more than one person in one column if appropriate, i.e., possibly both parents, siblings, grandparents. The column for "Other Visitors" is there to allow you to add any other visitors as needed.

**Purpose**

Describe the purpose of the visitation, i.e., what are the desired outcomes of the visitation?

**Frequency**

Specify how often the visits are to occur between the person(s) listed in each column and the child(ren) listed at the top of the plan. Be specific. Include specific schedule if there is one.

**Duration**

The length of the visit.

**Location**

Where the visits will take place, where the visitor will pick up the child(ren), etc.

**Method**

Describe details of how the visit is to occur, i.e., who will provide transportation; who will pick kids up; who initiates contact to set up visit if it is being left up to older children, etc.

**Special Considerations or Restrictions**

Note such things as restraining orders, are visits to be supervised and by whom, persons not allowed to have contact, who is responsible to give child their medication if applicable, etc.

**Phone Contact**

Include any details of how phone contact will occur, frequency, who initiates the call, how it will be supervised if needed, etc.

**Notification of Changes to Plan**

Each time you notify any of the involved parties of changes in visitation plan, indicate date and method of contact.

**Visitation Plan may be modified...**

This is very important in order to get the court's permission to change the plan by agreement of the designated parties without going back to court. Complete this block prior to submitting plan to the court.

**Part 3C: Summary & Recommendations**

**Overview**

Part 3C provides a format for caseworkers to summarize any important family assessment or other information when the treatment plan is submitted to court, and to make recommendations to court. As part of the summary, the caseworker should include the reasonable efforts that have been made to prevent placement, to reunify the child(ren) with the parents, and/or to achieve permanency.

Federal rule requires that if the permanency goal is not return home, adoption, or legal guardianship, then the agency must document to the court the compelling reason for determining that it would not be in the best interests of the child to return home, be referred for termination of parental rights, or be placed for adoption with a fit and willing relative or with a legal guardian. This information must be included in your court report and could be included in Part 3C.

This section could also contain an explanation to the court of the compelling reason not to file for termination of parental rights to meet the Federal requirements for 15 of 22 months. Also, if the 4D is not submitted to the court as part of the Treatment Plan, you need to address independent living needs/skills for all children age 16 or older as part of the Permanency Plan recommendations to the court and ask the court to find that services for transition to independent living are being provided.

**Court Use**

Part 3C is submitted to court with the treatment and visitation plan. It is optional for cases that are voluntary (non-court involved) cases.

### **Part 3D: Signature Page**

#### **Overview**

The signature page is to be signed by all persons involved in the treatment plan. Each person should initial the appropriate box to the right of his or her signature. Under the comments section, the caseworker may write in any comments or objections by any party signing the plan. Use this space to explain why any of the required signatures were not obtained and the efforts to do so. The involvement of both parents, child (signatures required for children age 12 or older), and foster care provider in the development of the treatment plan is most important. Therefore, their signatures are also most important. Mailing the copy to these parties after the plan is completed is not involving them in the planning process. For absent parents, this involvement may be obtained by phone contact and documented in "comments," and then the copy mailed and a request made for signature.

Parties may sign and indicate that they "received a copy," "participated in the development," and "reviewed" it without necessarily agreeing or disagreeing. Hopefully, this may encourage parents to be more willing to sign it without having to have their attorney see it first.

This page may need to be periodically updated to add the signatures of the current caseworker, supervisor, and/or provider. This part can also be used for the Review (Part 5) when recommendations for changes to the treatment plan are made. Indicate by placing an "X" in the appropriate space whether the signature page is being used for the "Initial Treatment Plan" or for "Changes in Current Treatment Plan."

#### **Court Use**

This part may be submitted to court to show who was involved in developing the treatment plan and who received copies, etc.; however, it is NOT REQUIRED that it be submitted to court.

### **Part 4**

#### **Overview**

This part is to be used by the caseworker for all children/youth who are placed out of home (Parts 4B, 4C, and 4D for youth 16 and older). Part 4 is for documentation purposes only and does not need to be discussed with or shown to the family, with the exception of Part 4D, the Plan for Transition to Independent Living (see Part 4D instructions). If there are no children in Core Services or out-of-home placement, these pages do not need to be completed, nor do they need to be left blank in the file. Part 4 must be kept in the file with rest of the FSP.

#### **Court Use**

It is not required to submit any of Part 4 to court.

### **Part 4A: Imminent Risk of Out-of-Home Placement Criteria Checklist**

#### **Overview**

This document is required for all children receiving Core Services, Kinship Care, or both Kinship Care and Core Services. This document must be completed when Core Services and/or Kinship Care is initiated (within 30 days) and every 6 months thereafter if services remain open. The report will display an error for all children receiving Core and/or Kinship services who do not have an Imminent Risk document completed within the last 6 months. Volume VII, 7.301.24, A and 7.303.13 and 7.304.3.

### **Part 4B: Placement Information**

#### **Overview**

This section is filled out only for children in out-of-home placement. A separate page is required for each child. The "**GUIDE**" gives you an abbreviation for the "type of placement" to be used in the Placement Information Blocks and also references CWSA Rule Exceptions which, if apply, need to be addressed in the Blocks. Completing the information in the Blocks will meet all federal requirements for children in placement. **DO NOT LEAVE ANY ITEM IN A BLOCK BLANK UNLESS THE ITEM SPECIFICALLY GIVES DIRECTIONS FOR DOING SO. IF "NOT APPLICABLE," WRITE "N/A"!!**

All explanations/descriptions are to be brief, concise, and answer specifically what the item calls for.

### **Specific Sections**

#### **Placement Information Blocks: Initial Placement**

The information block in Part 4B is to be completed for the first foster care placement after each removal from the home. This only applies to foster care (including independent living, foster homes, group homes, residential treatment facilities). It does not include hospitals or detention.

#### **Placement Name**

Enter the specific name of the facility. Use the abbreviation of the type from the "GUIDE" and enter the actual date child entered the facility. When child leaves, enter actual date left.

#### **Rule Exceptions**

Refer to the "GUIDE" to see if any exceptions apply and, if so, explain why an exception was made and how it met the needs of the child.

#### **Diligent Search**

This documents when you initiated the search for missing parents. If all parents' whereabouts are known, indicate "N/A."

#### **Efforts to Place With Relatives**

This asks for your "efforts." "No relatives available" does not describe efforts.

#### **Factors That Indicate This Placement Will Provide a Safe Environment**

This asks for the worker's assessment of safety in the placement environment. Examples of factors to address are: 1) child's challenging behaviors; 2) child's vulnerability; 3) child's viewpoint of safety and acceptance; 4) match between child's needs, capacities, and behaviors and the foster parent's preferences, expectations, and adaptive capacities; 5) physical environment of the home; 6) provider's child care responsibilities; 7) stressors present in the foster home; 8) provider's willingness to seek help; and 9) other children's behaviors and presenting problems.

#### **Close Proximity**

This section outlines the degree to which the placement has changed the child's life, i.e., distance from home, contact with important people including family and friends, school change, cultural needs. Comment on how placement meets the child's needs. If placement is a "substantial distance" or out-of-state, reasons for making this placement must be documented.

#### **Obtain More Specialized Evaluations**

During the first 30 days of a child's placement, an evaluation of the child's needs is required. If any further evaluations need to be obtained as a follow up to this 30-day evaluation, indicate how they will be obtained. If none are needed, indicate N/A.

#### **Least Restrictive, Most Family Like**

This section refers to the child's level of care. The continuum starts with family home (least restrictive) and progresses to Residential Treatment setting (most restrictive). Workers must make every effort to place the child in the least restrictive setting WHICH IS APPROPRIATE TO MEET THE CHILD'S NEEDS. An explanation is required when the child is placed out of parent's home.

#### **Siblings**

Describe how it is in one or more of the sibling's best interests to not be placed together. "N/A" if no other siblings are in placement.

#### **Health Passport**

If you have an up-to-date copy of the health passport in the case file, which includes the information regarding school, medical/dental providers, medical needs, etc., you do not have to complete this part of the information block.

#### **Medical/Dental Exam & Indian Child Welfare Act**

These items are to serve as prompts to the caseworker to remind you of these requirements and give you a place to document their completion.

## **Part 4C: Subsequent Placement Information**

### **Overview**

Each child in placement must have a separate Part 4C. This part is used to document subsequent placements for each child (including independent living). You may add as many Part 4Cs as needed per child to keep track of their placements.

Short-term temporary placements of less than 30 days when a child returns to the same placement he/she was in previously do not need another placement block completed. However, enter all temporary placements in TRAILS as you would any change in placement. These placements might include detention, hospitalization, respites, etc.

### **Specific Sections**

#### ***Placement Information Block***

These items are the same as in Part 4B with the exceptions noted below. Refer to instructions on Part 4B.

#### ***Move Result in Permanent Placement***

If the current placement is considered a permanent placement for this child, answer “yes” only. If not, explain why move was made and how it is in child’s best interests. “Permanent placement” is to be considered in relationship to the goal, i.e., for a goal of return home, the permanent placement would be the placement in which the child can stay until that occurs; for long-term foster care, the permanent placement is the placement in which the child will stay until possibly emancipation, etc.

#### ***Update of Health Passport***

It is a Federal requirement that at the time a child moves from one placement to the other, the health and educational record of the child must be updated and given to the new provider. It is the responsibility of the agency to assure that this has been done. It is also a good time for the agency to get an up-to-date copy for your files. The caseworker dates and initials that the health passport was updated, reviewed, and supplied to the new provider.

## **Part 4D: Plan for Transition to Independent Living**

### **Overview**

This plan is to be completed for all youth in placement who are age 16 or older. If youth enters placement before his/her 16th birthday and turns 16 while in placement, the plan must be completed within 60 days after his/her 16th birthday.

The plan must be completed with the youth with his/her signature at the bottom. If you refer the child to Chaffee and the Chaffee worker completes the independent living plan, it will substitute for this Part 4D if attached to the case plan.

### **Court Use**

This part may be submitted to court at the time of the permanency planning hearing to meet the Federal requirement that the court at this and subsequent permanency planning reviews determine “whether needed services are provided for a child age 16 or older to transition from foster care to independent living.” If it is not submitted, you need to address independent living needs/skills in your permanent plan recommendations to the court and ask the court to find that services for transition to independent living are being provided.

## **Part 5A: Review**

### **Overview**

This section is a multi-purpose document that meets the requirements of the 90-day caseworker/supervisor review conference. It is also designed to serve as a progress report to the court and/or to document changes in treatment plan. If substantive changes are made, or the permanency goal changes, a new 3A needs to be completed with the family. The 5A is family-based and can be used to address the entire family. To meet Volume VII (7.301.3, E) requirements for the 90-day reviews, the case plan must be “reviewed in conference” between the caseworker and the supervisor. It is not enough to have the caseworker write the review (Part 5A) and the supervisor to read and sign the review. An administrative review can substitute for one of these conferences. The first review should take place 90 days after the referral was accepted and subsequent review held every 90 days thereafter.



## **Court Use**

This Part 5A is required to be used for the Progress Report to the Court.

## **Specific Sections**

### ***Reason for Review***

Check the type or types of reviews that apply. Depending on the use chosen, only certain parts of the form will be completed as explained below. It is required that it be used as your court progress report when a progress report is due. It is acceptable to add other information that your particular court may require.

### ***When Used as a 90-day Supervisor/Caseworker Review***

Use Part 5A as a form and take brief notes based on the discussion of the caseworker/supervisor conference.

### Family Assessment Update

Refer back to Part 2 (Family Social History & Assessment Summary) and update any significant changes that have occurred. This meets the requirement for updating the family assessment every 6 months. Include an update of new safety concerns either in the biological home or in placement.

### Services

Answer “yes” or “no” to both questions and explain “no” responses.

### Progress

Address progress of parent(s) and child(ren); what still needs to be accomplished to achieve the permanency goal; identify any barriers to progress or non-compliance in following plan, etc. This is a good time to get a report or refer to a report from service providers regarding parent'(s) and/or child(ren)'s progress.

### Permanency Goal

Note the current goal with the appropriate target date. If the existing goal for the child(ren) is still appropriate, answer “yes” and you are done with this section. If the goal for one or more child(ren) is not appropriate, indicate which child(ren) and explain why it is no longer appropriate and give the new goal and target date.

If the goal changes at this review, by the next 90-day review, the treatment plan needs to be changed to address the change in direction.

### Time Frames

Time frames refer to the date for achieving the permanency goal and/or to the time frames for accomplishing specific action steps. If still appropriate, indicate “yes.” If “no,” specifically indicate which time frames are not appropriate and give new time frames.

### Summary of Administrative Review/Parental Fee Status

These are not required for the 90-day supervisor/caseworker conference review.

### Recommendations

Indicate any significant changes in the direction of the case, updates of the FSP that are needed, new services needed, etc. These should then be followed up on by the caseworker. NOTE: if you are recommending changes in the treatment plan (Part 3A) for non-court cases, make those recommendations here, change Part 3A, and get appropriate signatures.

### Signatures

Both caseworker and supervisor should sign the form at the time of the review—on the same date!

### ***When Used as a Court Review***

### Family Assessment Update

This is an update for the court since the last court review of any changes in current situation, new information, etc. Since this serves as the update of the assessment, refer back to Part 2 (Family Social History & Assessment Summary) and update any significant changes that have occurred in any of the areas.

### Services

Answer “yes” or “no” to all questions and explain “no” responses or a “yes” response to the question regarding abuse/neglect allegations in this setting. This is where you describe the Department’s “reasonable efforts,” services that have been provided, and your continuing efforts to address the safety needs of the child in placement.

### Progress

Use this section to specifically address progress on the court ordered treatment plan. Include behavior changes as well as compliance or non-compliance with the plan. List each “need area” of the treatment plan and indicate what progress must still be made to achieve the goal. For children in placement where the goal is to return home, specifically address what must still be done in order for children to be returned home. Also, address any barriers to progress, etc.

### Permanency Goal

Note the current goal with the appropriate target date. If the existing goal for the child(ren) is still appropriate, answer “yes” and you are done with this section. If the goal for one or more child(ren) is not appropriate, indicate which child(ren) and explain why it is no longer appropriate and give the new goal and target date.

If the goal changes, you also need to review and update the treatment plan, Part 3A, and submit the entire updated treatment plan to the court. In this way, the current treatment plan, once it is approved, will only reflect what is needed in the plan to achieve the current goal.

### Time Frames

Time frames refer to the date for achieving the permanency goal and/or to the time frames for accomplishing specific action steps. If still appropriate, indicate “yes”. If “no,” specifically indicate which time frames are not appropriate and give new time frames. Time frames do not necessarily need to correspond with court reviews or be indicated in 6-month intervals. Use time frames that you feel are realistic to complete a given action step given the goal and the date by which the goal needs to be accomplished.

### Summary of Administrative Review

Report Administrative Review findings. It is suggested that the date of the review, what level of care was approved, who attended, and any recommendations that were made by the reviewer be included in the summary.

### Parental Fee Status

Report on the fees and status of fee collection as per CRS 19-1-107 & 19-3-701(5).

### Recommendations

This is where you make all the usual recommendations to the court about placement in the best interests of the child, reasonable efforts were made, legal custody, placement, etc.

NOTE: If you are recommending changes in the court ordered treatment plan, make those recommendations in this section; you then have two options. You may attach a complete copy of the treatment plan with those changes incorporated in it. Or, once the court has approved the changes, you may update the changes on the original copy of the treatment plan and indicate the date of approval on each change.

### Signatures

If the court review is also serving as the 90-day case plan review, both caseworker and supervisor should sign, indicating there was discussion in “conference” of the progress review.

## **5-A Attachment: Termination of Parental Rights Review**

### **Instructions**

This form is to be completed if a child/youth has been in foster care under the responsibility of the County for fifteen of the last twenty-two months. Please check the appropriate reasons if filing for termination of parental rights is not in the best interest of the child.

- If item 3 is checked, indicating that there is a compelling reason for not filing a petition for the termination of parental rights, check the compelling reason that best describes the situation.
- When a Petition for the Review of Need for Placement has been filed and the County Department believes that it is in the best interest of the child to maintain the current status, the situation may be documented in Section B on the checklist.
- A situation with a juvenile offender, whose parents are involved appropriately in the case plan, and who is not to return home because of lack of safety for other children in the home, can be documented in 3f.
- If items 1, 2, and 3 are not checked, then item 4 will be checked indicating that a motion for termination of parental rights will be filed as soon as possible.

- Section B is to be completed when a child/youth is in placement because of a delinquency petition or a petition for the review of the need for placement. If the review indicates the need to file a dependency and neglect petition, the petition should be filed as soon as possible, not to exceed 60 days.
- The completed checklist must be presented at the next court review/hearing for judicial approval regarding the exception to termination of parental rights. This checklist should be filed in Section 2 of the case file with the FSP.

## **Part 5B: CWSA Requirements/Special Reviews**

### **Overview**

This page is to be completed on each child in placement. It is to be used for documenting special circumstances and exceptions as required by Volume VII (7.301.3, F). Each "block" addresses a separate review requirement. Each time the supervisor and caseworker have a 90-day review conference on a case of a child in placement, this page must be reviewed and completed for any blocks that apply at the time of the review. Always indicate the date of the review in the appropriate space given.

Some blocks (special circumstances) require further county action, such as administrative review, county permanency planning team review, or special county review. The space on this page is to be used to document that those reviews have been done. If you have a separate form that your county uses for any of these special reviews, instead of completing the block, you may attach that form and indicate "see attached" in the appropriate block.

### **Court Use**

This Part 5B is not to be submitted to court, nor is it discussed with or shared with the parent.

### **Specific Sections**

#### ***Initial Case Plan Exception***

If the INITIAL (meaning the goal immediately following a child being removed from their home) goal is NOT "return home," check the reason, date, and initial.

#### ***Child in Placement 12 Months***

This only applies if permanency goal continues to be "return home." At the 90-day review that would occur on or immediately after the child has been in placement for 12 months, give written explanation for why goal continues to be "return home." Supervisor and caseworker need to date and initial.

#### ***Child in Placement 18 months***

This also only applies if the permanency goal continues to be "return home." At the 90-day review on or immediately after the child has been in placement for 18 months, give written explanation, including the extraordinary circumstances which warrant a continuation of efforts to return child home and the strong reason(s) why you think child can still be returned home within a reasonable time period and give the ADMINISTRATIVE approval.

#### ***When Legal Guardianship or Other Planned Permanent Living Arrangement Are Being Considered***

Consider all three check-offs in this block, check them, give explanation where asked for, and indicate when your county designated permanency planning team (Volume VII: 7.504.23 & 7.504.24) reviewed and approved this plan. The caseworker and supervisor need to date and initial.

#### ***Special County Review***

Each of the four items listed in this block are separate items to be considered each time a 90-day review is done. Since they are separate items, one or more could apply at any time. They are "trigger" events that require "further county review." This review is an administrative review. Record the date and results of each review as required by each of the "trigger" events occurring. Use the backside if more space is needed. NOTE: For Special County Review 1, only count placements since October 1995.

## **Bibliography**

Office on Child Abuse and Neglect (DHHS), DePanfilis, & Salus. (2003). *Child Protective Services: A Guide for Caseworkers*.

## Child Welfare Deadlines

### Assessment

Safety Assessment	Documented in TRAILS no later than 30 calendar days from the date the investigation/assessment was received (PA 5 cases only)
Risk Assessment	Documentation in TRAILS within 30 calendar days from the date the referral was received (PA 5 cases only)
Assessment Completed	Within 30 calendar days of the date the referral was received

### Case

Complete FSP	Within 60 calendar days of opening an assessment in TRAILS
Complete NCFAS	Within 60 calendar days of the date the investigation/assessment was assigned
Supervisory Review of Case	Every 90 days beginning 90 days after the referral is opened
Risk Reassessment	Prior to case closure

### Child in Out-of-Home Placement

Visitation Plan	ASAP, but within 60 of opening an assessment in TRAILS
Full Medical Exam Scheduled	Within 2 weeks of placement
Full Dental Exam Scheduled	Within 8 weeks of placement
Educational Assessments	For children placed on an emergency basis: In emergency placements, the caseworker shall make a verbal notification within 5 working days and a written notification within 10 working days after the placement (if children are not placed on an emergency basis, notification should be made prior to placement)
Independent Living Plan	Within 60 calendar days of the child's 16 <sup>th</sup> birthday or of case opening
Caseworker Contact: Child	In-home cases require monthly face-to-face contact with the child  Out-of-home placement cases require monthly face-to-face contact; at least every other month, contact must take place at the child's out-of-home residence
Caseworker Contact: Parent	For PA 5 cases, contact must be monthly; at least every other month, contact must be face-to-face

## NCFAS-R – North Carolina Family Assessment Scale for Reunification: Introduction

for Intensive Family Preservation Services (IFPS) Programs Serving Reunification Cases  
Version: R 2.0

IFPS System ID#:	Date Intake Assessment Completed / /
IFPS Worker:	Date Case Closure Assessment Completed / /
Other Agency ID#:	Family Name:

This instrument comprises 7 domains relating to family functioning. Each of the domains includes sub-scales to use to assess how a family is functioning. The results of the assessment may be important to determining the risk of out-of-home placement or successful reunification for the assessed family. For each sub-scale, rate its influence as a strength or problem for the family along a 6-point continuum, using the following schema: +2 = Clear Strength, +1 = Mild Strength, 0 = Baseline/Adequate, -1 = Mild Problem, -2 = Moderate Problem, and -3 = Serious Problem. To rate each scale, circle the appropriate number. “I” represents the rating given at intake or at the beginning of the case, and “C” represents the rating at service or case closure. The “overall” ratings (the ones in the shaded areas) should indicate your overall, composite rating in each of the seven domains. The subscales represent areas of interest relating to the domain under which they appear (e.g., Housing Stability appears under domain A. Environment). The overall domain ratings should not be the arithmetic average of the sub-scales, but rather should be your informed, subjective rating of the family-based on information gathered to make the sub-scale ratings. The reliability and validity studies have shown that it is essential to rate each of the subscales before making the overall domain rating. Use the definitions in the Definitions Manual to the NCFAS-R (Version 2.0 or higher) to assist you when making your ratings.

Complete the intake (I) ratings as soon as sufficient information is available to make thorough and accurate ratings (suggested within 2 to 3 weeks of beginning case activities), and make the closure (C) ratings within 1-2 weeks of completion of intensive reunification services.

**A. Environment**

		<b>Clear S.</b>	<b>Mild S.</b>	<b>Baseline A.</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious P.</b>
1. Overall environment	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
2. Housing stability	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
3. Safety in the community	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
4. Habitability of housing	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
5. Income/employment	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
6. Financial management	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
7. Food and nutrition	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
8. Personal hygiene	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
9. Transportation	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
10. Learning environment	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3

**B. Parental Capabilities\***

Note: This section refers to biological parent(s), if present, or current caregiver(s).

		<b>Clear S.</b>	<b>Mild S.</b>	<b>Baseline A.</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious P.</b>
1. Overall parental capabilities	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
2. Supervision of child(ren)	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
3. Disciplinary practices	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
4. Provision of developmental/enrichment opportunities	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
5. Parent(s)/caregiver(s) mental health	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
6. Parent(s)/caregiver(s) physical health	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
7. Parent(s)/caregiver(s) use of drugs/alcohol	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3

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**C. Family Interactions**

Note: This section refers to family members living in the same or different households.

		<b>Clear S.</b>	<b>Mild S.</b>	<b>Baseline A.</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious P.</b>	
1. Overall family interactions	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
2. Bonding with child(ren)	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
3. Expectations of the child(ren)	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
4. Mutual support within the family	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
5. Relationship between parents/caregivers*	(I)	+2	+1	0	-1	-2	-3	NA
	(C)	+2	+1	0	-1	-2	-3	NA

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**D. Family Safety**

Note: This section refers to family members living in the same or different households.

		<b>Clear S.</b>	<b>Mild S.</b>	<b>Baseline A.</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious P.</b>	
1. Overall family safety	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
2. Absence/ presence of physical abuse of child(ren)*	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
3. Absence/ presence of sexual abuse of child(ren)	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
4. Absence/ presence of emotional abuse of child(ren)	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
5. Absence/ presence of neglect of child(ren)*	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
6. Absence/ presence of domestic violence between parents/ caregivers	(I)	+2	+1	0	-1	-2	-3	NA
	(C)	+2	+1	0	-1	-2	-3	NA

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**E. Child Well-Being**

Note: This section pertains to the **imminent risk child(ren)**.

		<b>Clear S.</b>	<b>Mild S.</b>	<b>Baseline A.</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious P.</b>	
1. Overall child well-being	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
2. Child(ren's) mental health	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
3. Child(ren's) behavior	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
4. School performance	(I)	+2	+1	0	-1	-2	-3	NA
	(C)	+2	+1	0	-1	-2	-3	NA
5. Relationship with parent(s)/ caregiver(s)	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	
6. Relationship with sibling(s)	(I)	+2	+1	0	-1	-2	-3	NA
	(C)	+2	+1	0	-1	-2	-3	NA
7. Relationship with peers	(I)	+2	+1	0	-1	-2	-3	NA
	(C)	+2	+1	0	-1	-2	-3	NA
8. Cooperation/ motivation to maintain the family	(I)	+2	+1	0	-1	-2	-3	
	(C)	+2	+1	0	-1	-2	-3	

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**F. Caregiver/Child Ambivalence**

		<b>Clear S.</b>	<b>Mild S.</b>	<b>Baseline A.</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious P.</b>
1. Overall Caregiver/ Child Ambivalence	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
2. Parent/Caregiver Ambivalence Towards Child	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
3. Child Ambivalence Towards Parent/Caregiver	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
4. Ambivalence Exhibited By Substitute Care Provider	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
5. Disrupted Attachment	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
6. Pre-Reunification Home Visitations	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3

Note: Although "Intake" ratings are always important on this subscale, "Closure" ratings may not be appropriate in all cases, depending largely on the reunification model employed and the timing of the assessment.

**G. Readiness for Reunification**

		<b>Clear S.</b>	<b>Mild S.</b>	<b>Baseline A.</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious P.</b>
1. Overall Readiness for Reunification	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
		<b>Clear S.</b>	<b>Mild S.</b>	<b>Baseline A.</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious P.</b>
2. Resolution of Significant CPS Risk Factors	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
3. Completion of Case Service Plans	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
4. Resolution of Legal Issues	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
5. Parent/Caregiver Understanding of Child Treatment Needs	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3
6. Established Back-Up Supports and/or Service Plans	(I)	+2	+1	0	-1	-2	-3
	(C)	+2	+1	0	-1	-2	-3

## NCFAS-R – North Carolina Family Assessment Scale for Reunification: Definitions

for Intensive Family Preservation Services Programs Serving Reunification Cases  
Version: R 2.0

### A. Environment

<b>1. Overall Environment</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to family receiving very high ratings in the following areas: housing stability, safety in the community, housing habitability, income/employment, financial management, food and nutrition, personal hygiene, transportation, and learning environment.		Refers to family experiencing minimal problems in the following areas: housing stability, safety in the community, housing habitability, income/employment, financial management, food and nutrition, personal hygiene, transportation, and learning environment. However, problems do not interfere in family's ability to function, and problems do not need to be addressed.			Refers to family receiving very low ratings in the following areas: housing stability, safety in the community, housing habitability, income/employment, financial management, food and nutrition, personal hygiene, transportation, and learning environment.

<b>2. Housing Stability</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to family occupying the same, adequate residence for more than three years. If less than three years, move is prompted by a job change or move to better housing, etc. Rent/mortgage are paid on time. There are no problems meeting financial obligations of rent or mortgage.		Refers to family experiencing or previously experiencing minor problems in remaining in the same residence, but family is relatively capable of meeting financial obligations, present housing is not threatened, and family members are not inhibited in pursuing other obligations due to these problems.			Refers to family being threatened with eviction. Unable to meet rent or mortgage obligations on time, or at all. Or, family does not have housing, is living with different relatives or friends, or living in a homeless shelter. Family is not satisfied with living situation.

<b>3. Safety in Community</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to a safe and secure neighborhood for the children. Caregivers can allow children to play outside without fear. Neighbors look out for each other (i.e., neighborhood “watch.”)		Refers to minor disturbances in the neighborhood, but disturbances do not prevent family members and children from spending time outside in the community.			Refers to many disturbances such as fights and/or outbursts in the neighborhood. The neighborhood is not safe for children to play outdoors or walk to the bus or to school. Evidence of violence, “boarded up” or barred windows, gunfire, the use of alcohol or drugs, and/or drug “trafficking” in the neighborhood. Neighbors fearful of “getting involved.”

<b>4. Habitability of Housing</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to family and neighbors experiencing home as “warm.” Home is very clean and neat. Plenty of space and privacy for children. Plenty of furnishings in good repair. Safety precautions are considered and taken, such as the use of smoke alarms and dead bolts on outside doors. Poisonous items are kept locked and out of children’s reach. Plumbing is in good condition.		Refers to minimal problems in the home, such as slight overcrowding, or some clutter. However, most safety precautions are taken (e.g., poisons are out of sight but not locked). Minor house repairs (e.g., crumbling plaster) may be evident, but do not require immediate attention.			Refers to unsanitary situations, including roaches, litter, clutter, and/or unpleasant odors present in the home. Food particles and/or rotting food on the counters and tables. Urine-soaked or stained furniture, dirty diapers, dirty dishes, overflowing garbage, and/or animal or human feces on the floor. Hesitance to sit down or enter the home. Nonfunctioning plumbing, and/or no electricity. Many hazards within the reach of children, such as guns, knives, street drugs, or open medication and poisons.

<b>5. Income/Employment</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to family having stable employment and income over the past 12 months. More than enough income to pay for food, housing, and/or clothing. Money is not an issue. Family has money to meet responsibilities and spend on leisure activities.		Refers to family having relatively stable employment in the past 12 months. Income is sufficient in meeting basic needs, such as food, rent, and clothing. There are some money pressures, such as credit card debt, but they do not significantly inhibit family activities or present purchase of necessities.			Refers to family losing employment for "negative" reasons 2 or more times in the past 12 months and inability to pay for food, housing, and/or clothing. Family receives public assistance and/or primary caregivers are unemployed. Money is a major issue. Child support is not paid. Public assistance has been canceled. Family does not have money to meet basic needs.

<b>6. Financial Management</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to family using money in a way that provides benefits financially, and family has clear spending plans or priorities. Debts are small and manageable. There is a planned use of money, and no back bills. Family is good at bargain hunting.		Refers to family having debts, but debts are under control. Some problems with budgeting, but problems do not prevent family from meeting basic needs for food, rent, etc.			Refers to family being severely in debt. Family has a history within the past year of being evicted from their home due to bills. Great difficulty paying bills, and/or bills are paid late. Chaotic budgeting, and family is constantly in crisis over money. Frequently broke, due to betting or gambling. No budget plan. Luxuries are bought before necessities.

<b>7. Food/Nutrition</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to caregivers' awareness of nutritional needs of children, including any special needs. Meets those needs. Prepares balanced, nutritious meals. Ample food available. Children eat on a regular schedule. Food/nutrition actively "monitored" by caregivers.		Family meets basic nutritional needs. Children have access to sufficient and varied food, though individual meals may not always be "balanced."			Refers to caregivers' lack of awareness of nutritional needs of children, including any special needs. Does not attempt to meet nutritional needs. Does not consider food preparation important. Inadequate supply of food, and/or inappropriate food. Lots of "junk" food consumed. Children often go hungry.

<b>8. Personal Hygiene</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to children looking clean and well groomed. Children have plenty of clothing, appropriate to the season. Adults look clean and well-groomed. Adults have plenty of clothing appropriate to the season. Awareness of personal hygiene and grooming. Take pride in themselves.		Refers to children occasionally wearing inappropriate clothing or appearing unkempt. However, appearance or inappropriate clothing is not causing problems for the family or children.			Refers to constant appearance of children as unkempt or dirty. Appearance of adults as unkempt. Noticeable poor personal hygiene, obviously poor dental hygiene, and/or body odor. Lack of awareness of children or adults of personal hygiene and grooming. Dress is inappropriate to the season.

<b>9. Transportation</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to family having a car, or regular access to a car or public transportation. Reliable transportation allows family to meet obligations such as doctors' visits, school, or regular work attendance.		Refers to family having fairly regular access to reliable transportation. Occasionally, transportation difficulties will cause a problem for family (e.g., arriving late to work because of difficulties).			Refers to family not having transportation available which in turn, inhibits work, increases social isolation, and/or limits access to services, and/or prevents regular school attendance.



<b>10. Learning Environment</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to caregivers' enthusiasm in teaching children. Family has routine for play and study. Time is planned for reading, attending outings, structured activities. Caregivers' actively involved with school, and assist children with developmental tasks. Age appropriate games and toys are provided, and evident in the home (e.g. school work is displayed). Caregivers are supportive of school personnel.		Refers to caregivers' occasionally planning time for learning activities. Caregivers do not actively seek out constant involvement with child's school, but make time available as requested.			Refers to caregivers' lack of attention or hindrance to developmental tasks of children, and low involvement with children's school. Caregivers do not value education, and are frustrated and angered with children's learning needs. No opportunities for learning at home. Games and toys absent, and/or are not age appropriate. Caregivers are not supportive of school personnel, or are disdainful of public schools/teachers.

**B. Parental Capabilities\***

Note: This section refers to biological parent(s) if present, or current caregiver(s).

<b>1. Overall Parental Capabilities</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to family receiving very high ratings in the following areas: supervision of children, disciplinary practices, provision of developmental/enrichment opportunities, parent(s)/caregiver(s) mental health, parent(s)/caregiver(s) physical health, and parent(s)/caregiver(s) use of drugs/alcohol.		Refers to family experiencing some problems in the following areas: supervision of children, disciplinary practices, provision of developmental/enrichment opportunities, parent(s)/caregiver(s) mental health, parent(s)/caregiver(s) physical health, and parent(s)/caregiver(s) use of drugs/alcohol. However, problems do not pose major difficulties for family members.			Refers to family receiving very low ratings in the following areas: supervision of children, disciplinary practices, provision of developmental/enrichment opportunities, parent(s)/caregiver(s) mental health, parent(s)/caregiver(s) physical health, and parent(s)/caregiver(s) use of drugs/alcohol.

<b>2. Supervision of Children</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to caregivers' provision of age appropriate supervision, such as setting limits for activities based on the child's age. Caregiver is careful and attentive to child's needs in selecting substitute caregivers (baby-sitter, neighbor). Makes sure children feel comfortable and safe with substitute caregiver, keeps track of children, and knows children's friends.		Refers to caregiver providing satisfactory supervision of children. Some limits are set on activities based on the child's age. Some consideration given to selecting substitute caregivers, and some concern with children's comfort with the substitute caregiver. Has a basic knowledge of location of children, and has a basic knowledge of children's friends.			Refers to caregivers' lack of age appropriate supervision, or any supervision. Limits on activities of children are not set or set inconsistently. Little or no consideration given to selecting substitute caregivers (strangers, known abusers, persons under the influence of drugs, alcohol). No thought about children's comfort and feeling of security with substitute caregiver. Children's friends are not known, and location of children is not regularly known.

<b>3. Disciplinary Practices</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to caregivers' ability to provide age-appropriate, non-punitive, consistent discipline. Uses positive reinforcement, and tries to educate children through appropriate discipline. Presents good role model. Caregivers agree on parenting style and support one another.		Refers to caregivers' adequate provision of discipline and guidance of children. Occasionally discipline is inappropriate to age, too harsh or too lenient, but inconsistencies do not create major problems between child and caregivers.			Refers to caregivers' lack of discipline, or past or current emotional or physical abuse referred to as discipline. Discipline is excessive, punitive, inappropriate to age, inconsistent, and/or absent. Present poor role models. Caregivers disagree on parenting strategies and present mixed messages to child.

<b>4. Provision of Developmental/Enrichment Opportunities</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to caregiver(s)' encouragement of opportunities such as sports, music lessons, and/or visits to museums & parks. Caregivers do not "push" children to be involved. Caregivers are actively involved providing transportation, coaching teams, and/or participating in advisory boards.		Refers to caregiver(s)' support of opportunities for children such as sports, music lessons, and/or field trips, but caregivers are not actively involved or are involved sporadically in supporting these activities.			Refers to caregiver(s)' lack of support or over-involvement in opportunities for children such as sports, music lessons, and/or field trips. Caregivers do not encourage or discourage children's involvement in these activities. Conversely, caregivers "push" children to not only be involved but excel in activities, and are demanding regarding their children's progress.

<b>5. Parent(s)/Caregiver(s') Mental Health</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to caregivers' current (e.g., positive self-esteem) mental health, which positively affects ability to parent and/or successful resolution of past mental health problems (e.g., using success from overcoming issues to bolster parenting).		Refers to caregivers' current or past mental health (e.g., mild depression), which occasionally inhibits caregiver, but does not significantly hinder the caregiver's ability to parent			Refers to caregivers' current and/or past mental health problems (e.g., severe depression, bipolar disorder, active psychosis, etc.) that negatively affect ability to parent children. Caregiver projects personal problems on children or other household members

<b>6. Parent(s)/Caregiver(s') Physical Health</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to caregivers' current (e.g., caregivers' exercise regimen, etc.) or past medical or health history that positively affects ability to parent children.		Refers to caregivers' current or past medical or health history which provides some limits (e.g., overweight caregiver), but does not pose major obstacles in parenting abilities.			Refers to caregivers' current or past medical or health history, which are not under control and greatly impair ability to parent. (Issues can range from severe asthma, diabetes, blindness, heart problems, high blood pressure, cancer, etc.).

<b>7. Parent(s)/Caregiver(s') Use of Drugs/Alcohol</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to caregivers' current or past use of drugs/alcohol. Caregiver does not use drugs/alcohol, or uses alcohol appropriately. Caregiver does not use illegal drugs, and actively discourages children's use of drugs/alcohol. Caregivers' moderate or non-use does not impair ability to parent.		Refers to caregivers' current or past use of drugs/alcohol; mostly uses alcohol appropriately. Use of drugs/alcohol does not significantly hinder the caregivers' ability to supervise or parent children.			Refers to caregivers' current and/or past alcohol/substance abuse problems that negatively affect ability to parent children. Caregivers are frequently unable to care for or supervise children due to use of drugs/alcohol. Caregiver projects personal problems on children or other household members.

### C. Family Interactions

Note: This section refers to family members living in the same or different households;  
an overall assessment.

<b>1. Overall Family Interactions</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to family receiving very high ratings in the following areas: bonding with child, communication with child, marital relationship, expectations of the child, and mutual support.		Refers to family receiving ratings of adequate in the following areas: bonding with child, communication with child, marital relationship, expectations of the child, and mutual support.			Refers to family receiving very low ratings in the following areas: bonding with child, communication with child, marital relationship, expectations of the child, and mutual support.

<b>2. Bonding with Child</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to caregivers' healthy closeness with their child, and their ability to nurture a child. Caregivers encourage appropriate independence for child, and give love and attention freely to child. They respond to child's needs appropriately, and have a sense of attachment to child.		Refers to caregivers' ability to be close to their child. Caregivers do not openly encourage independence for their child, and may not give affection openly to child. However, child's needs appear to be met.			Refers to caregivers' inability to form a close relationship with their child, and inability to nurture their child. Caregivers are resentful, rejecting, or detached from their child. Also refers to caregivers' non-responsiveness, inappropriate responsiveness, or extreme enmeshment with their child.

<b>3. Expectations of the Child</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to caregivers' possessing age appropriate expectations for the child, and clear expectations of the child. Above average understanding of child's development cognitively, physically, socially, and emotionally.		Refers to caregivers' expectations for the child as mostly age-appropriate. Caregivers appear to have an average understanding of child's developmental needs, but this understanding does not warrant intervention.			Refers to caregivers' having unrealistic and unclear expectations for the child. Do not tolerate mistakes in the child. Child is expected to take on adult responsibilities (i.e., "parentified"). Or, child is not allowed to engage in age-appropriate behaviors (e.g. sports, dating). Little or inappropriate understanding of normal child development.

<b>4. Mutual Support within the Family</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to excellent emotional and/or "physical" support within family. "Physical" support is given when needed, such as providing day care, transportation, or financial help. Family members appear to help each other willingly.		Refers to good support within the family. Some physical support is provided when requested by a family member. Most requests for help from family members are met by other family members.			Refers to poor or lack of emotional support or "physical" support among family members. Family does not provide transportation, day care, or financial assistance when needed. Undermining of each other in the family. Family members do not tolerate success by other family members.

<b>5. Relationship between Parents/Caregivers*</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to relationship between caregivers as stable, consistent, affectionate, and loving. Couple is able to communicate clearly and encourage each other. Couple maintains a "separateness" from children.		Refers to relationship between caregivers. Some conflicts are evident, but do not appear to be leading to divorce, separation, or abandonment. Some minor difficulties with communication, but do not significantly impair the relationship.			Refers to relationship between caregivers as unsupportive and unstable. Major communication difficulties with evidence of discord, violence, or indifference. Divorce, separation, or abandonment are prominent issues. Boundaries are not clearly maintained between partners, or between the couple and children.
NOTE: This item may not be applicable in all cases. This would be the case if there were only one caregiver involved, and there is no significant other. If this is the case, circle NA on the form.					

### D. Family Safety

Note: This section refers to family members living in the same or different households

<b>1. Overall Family Safety*</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to families receiving very high marks in the following areas: absence/presence of physical abuse of children, absence/presence of sexual abuse of children, absence/presence of neglect of children, and absence/presence of domestic violence between parents/caregivers.		Refers to families receiving baseline ratings in the following areas: absence/presence of physical abuse of children, absence/presence of sexual abuse of children, absence/presence of neglect of children, and absence/presence of domestic violence between parents/caregivers.			Refers to families receiving very negative marks in the following areas: absence/presence of physical abuse of children, absence/presence of sexual abuse of children, absence/presence of neglect of children, and absence/presence of domestic violence between parents/caregivers.

<b>2. Absence/Presence of Physical Abuse of Children*</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to families in which incidents/complaints/substantiations have never occurred, or has occurred and family successfully been involved in counseling. Caregivers do not condone violence.		Refers to families in which physical abuse has not occurred, or in which complaints/incidents/substantiations of abuse by caregivers has occurred, but satisfactory progress is being made through counseling or the provision of other services.			Refers to incidents/complaints/substantiations of physical abuse by caregivers which have not been acknowledged or addressed, or have been resolved unsatisfactorily. Caregivers may be actively denying substantiated abuse and/or neglect, or actively resisting intervention.



<b>3. Absence/Presence of Sexual Abuse of Children</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to child who has never experienced sexual abuse, and who has learned about such concepts as “good” and “bad” touch. Or, a child who has experienced sexual abuse, and is now being “protected.” Child is in treatment, and has been making excellent progress.		Refers to child who has never experienced sexual abuse, but has not been actively taught concepts such as “good” or “bad” touch. Or, a child who has been sexually abused, but is making satisfactory progress in treatment.			Refers to child having experienced sexual abuse by others, or child sexually abused others. May be inferred or substantiated. Child has been referred for treatment or is in treatment. A judgment is made regarding unsatisfactory progress in treatment. Sexual abuse is ongoing, or risk of sexual abuse is high.

<b>4. Absence/Presence of Emotional Abuse of Children</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to child who has never been emotionally abused, and who exhibits secure feelings and possesses a sense of self-worth. Or, a child who has experienced emotional abuse, and is making excellent progress in treatment.		Refers to child who has never been emotionally abused. Child basically exhibits secure feelings or self-esteem. Or, a child who has been emotionally abused, but is in treatment and is progressing satisfactorily.			Refers to child having been emotionally abused by others. Child has been referred for treatment or is in treatment. Treatment is judged to be progressing unsatisfactorily. Incidents of emotional abuse have increased, are ongoing, or risk is high.

<b>5. Absence/Presence of Neglect of Children</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to families in which incidents/complaints/substantiations of neglect have never occurred, or have occurred and outstanding progress in counseling is made for the family. Caregivers recognize and are successful in meeting children’s physical, social, and emotional needs.		Refers to families in which incidents/complaints/substantiations of neglect have never occurred, or have occurred but some progress in counseling is made for the family. Caregivers usually recognize physical, social, and emotional needs of children and meet most of these needs.			Refers to incidents/complaints/substantiations of child neglect by caregivers which have not been acknowledged or addressed, or have been resolved unsatisfactorily. Caregivers may be actively denying substantiated neglect, or actively resisting intervention.

<b>6. Absence/Presence of Domestic Violence between Parents/Caregivers</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to families in which violence has never occurred between caregivers, and all family members are encouraged to solve problems "non-violently." Also refers to families in which domestic violence has occurred, but no longer occurs due to family's success in counseling, and family actively discourages violence.		Refers to families in which domestic violence has occurred, but no longer occurs. Family is involved in counseling and making some progress. Also, families in which violence has never occurred. Disputes occur, and family members solve problems without violence.			Refers to incidents/complaints/arrests for domestic violence. Violence between caregivers negatively affects ability to parent and/or has resulted in physical or emotional harm to children.
NOTE: This item may not be applicable in all cases. This would be true if there were only one caregiver involved, and there is no significant other. If this is the case, circle NA on the form.					

### E. Child Well-Being

Note: This section pertains to all children in the family.  
Any child having problems may affect the whole family system.

<b>1. Overall Well-Being</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to family receiving very high ratings in the following areas: child's physical health, child's mental health, child's behavior, school performance, relationship with caregivers, relationship with siblings, relationship with peers, and motivation/cooperation & no ratings in: alcohol/substance, sexual, and emotional abuse areas.		Refers to family receiving adequate ratings in all of the areas: child's physical health, child's mental health, child's behavior, school performance, relationship with caregivers, relationship with siblings, relationship with peers, motivation/cooperation, alcohol/substance, sexual, and emotional abuse.			Refers to family receiving very low ratings in the following areas: child's physical health, child's mental health, child's behavior, school performance, relationship with caregivers, relationship with siblings, relationship with peers, motivation/cooperation, alcohol/substance abuse, sexual abuse, and emotional abuse.

<b>2. Child(ren)'s Mental Health</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to child's overall, excellent mental health. Good emotional stability and self concept. Able to handle stress effectively. Child may have mental health issues, but participates in treatment, taking medication, and is making excellent progress.		Refers to child's having good, overall mental health. Basically good emotional stability. Child may have had episodes of anxiety. Or, child may have some mental health issues that are being addressed satisfactorily in treatment.			Refers to child's having poor, overall mental health. Emotional difficulties. Inability to handle stress. Diagnosed with mental illness and/or other emotional disabilities. Child is making unsatisfactory progress in treatment. Treatment is sporadic, and/or medication is not taken regularly.

<b>3. Child(ren)'s Behavior</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to child being well behaved, and there are no discipline problems. Child viewed as cooperative, following rules, and doing chores.		Refers to some problems in managing child's behavior, and some discipline problems. Child is usually cooperative, has some difficulties in following rules or completing chores, but problems do not merit intervention.			Refers to problems managing child's behavior at home, and/or in school. Totally uncooperative. Refuses to follow rules, or do chores. Delinquent and/or highly oppositional behaviors. Problems with courts and law enforcement.

<b>4. School Performance</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to child having excellent attendance at school and an excellent academic record. Child likes school, and/or behaves appropriately in school.		Refers to child having good attendance and an average academic record. Some behavior problems may be evident in school.			Refers to child having poor attendance at school, a poor academic record, and/or many behavior problems in school. Child professes to hate school, and/or avoids school with illnesses or truancy.

NOTE: This item may not be applicable in all cases. This would be true if the child is not of school age. If this is the case, circle NA on the form.

<b>5. Relationship with Caregivers</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to child accepting discipline and supervision. Having open and clear communication with caregivers.		Refers to child having some problems in accepting discipline and supervision. Also, some problems in communication with caregivers, but doesn't warrant intervention.			Refers to discipline and supervision problems with child. Lack of open and clear communication, or no communication with caregivers. Does not respect boundaries, and has an abusive or hostile relationship with caregivers.

<b>6. Relationship with Siblings</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to getting along well with siblings. Help one another when in need. Infrequent fights or problems. Siblings can play together.		Refers to getting along for the most part with siblings. Some fights occur among siblings, and siblings do not play together frequently. Problems among siblings do not merit special attention.			Refers to frequent fights and inability to get along with siblings. No support to or from siblings. Intense rivalry, conflict, and/or scape-goating of siblings. Fights may result in injury, or other behavior may result in emotional damage to siblings.
NOTE: This item may not be applicable in all cases. This would be true if there are no siblings in the family. If this is the case, circle NA on the form.					

<b>7. Relationship with Peers</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to child having peers as friends, and peer group appears to be a positive influence. Gets along well with peers. Has frequent interactions. May play team sports, or participate in other school or church related clubs or groups.		Refers to child having a few peers as friends. Peers do not appear to exhibit much of a positive or negative influence on the child.			Refers to child's inability to form friendships with peers, or inability to get along well with peers. Child may have frequent fights with peers or avoid peers. Also, child may have peers as friends, but peer group appears to be a negative influence, including gangs, or peers involved with drugs, alcohol, and/or delinquent/criminal activities.
NOTE: This item may not be applicable in all cases. This would be true if there were no peers, due to the age of the child. If this is the case, circle NA on the form.					

<b>8. Motivation/Cooperation to Maintain the Family</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Refers to child being interested in staying with family/caregivers. Child is motivated to change behaviors and cooperate.		Refers to child's interest in staying with family/caregivers. Child is not observably motivated to change behaviors and cooperate, but child will accept interventions or services.			Refers to child's lack of interest in staying with family/caregivers. Child is not motivated to change behaviors and does not want to cooperate. Child is against any intervention or services, or child has strong desire to leave family for self-serving reasons.

### F. Caregiver/Child Ambivalence

1. Overall Caregiver/Child Ambivalence					
Clear Strength	Mild S.	Baseline/Adequate	Mild P.	Moderate P.	Serious Problem
+2	+1	0	-1	-2	-3
Both child(ren) and caregiver(s) are eager to reunite, as evidenced by both verbal and behavioral expression of desire to be together. Family receives mild to clear strength rating on the items in this domain: parent/caregiver ambivalence towards child, child ambivalence towards parent/caregiver, ambivalence exhibited by substitute care provider, disrupted attachment, pre-reunification home visitations.		Both child(ren) and caregiver(s) say they want to be together; one or both may be apprehensive or nervous about reunion, but that apprehension is determined to be due to uncertainty about capability rather than competition for affection, substantive inability to parent, or significant unresolved treatment issues. Some mild problems may be present on the items comprising this domain, but family is working to resolve those issues.			Child(ren) and/or caregiver(s) express serious reservations about being together, either due to fear of future harm, strong negative affect by one or both parties towards the other, previous history of removal of this or other child(ren), and or prior failed reunification efforts. Generally problematic or some strongly negative ratings on the items comprising this domain: parent/caregiver ambivalence towards child, child ambivalence towards parent/caregiver, ambivalence exhibited by substitute care provider, disrupted attachment, pre-reunification home visitations.

<b>2. Parent/Caregiver Ambivalence Towards Child</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Caregiver responds appropriately to child, both verbally and non-verbally. Caregiver receptive and responsive to services designed to support reunification by bringing the caregiver and child closer together; is willing to attend to child's needs before their own. Caregiver acknowledges and accepts responsibility for roll in family difficulties leading to removal.		Caregiver generally responds appropriately to child, but may harbor some resentment or occasional feeling of intrusion or excessive demands by child. Caregiver accepts some responsibility for family difficulties leading to removal and is making progress in this area. Generally positive feelings towards child, but may need ongoing support or additional services after reunification.			Caregiver purposefully abused/neglected child in the past; expresses disaffection towards child; associates negative feelings towards child with negative feelings towards child's other caregiver; originally requested removal of child. Caregiver claims not to understand child, fails to respond to child appropriately, or responds very inappropriately; expresses disillusionment with child, feels anger or a sense of violence towards child, and/or resents child's interference with caregiver's own life. Caregiver blames child for family difficulties leading up to removal; caregiver has refused to respond to services intended to achieve reunification.



<b>3. Child Ambivalence Towards Caregiver</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Child is very comfortable in presence of caregiver; expresses love for caregiver. Child responds appropriately to caregiver affect, expressions of love, and exercising of caregiver responsibilities (limit setting, discipline). As appropriate to age, child exhibits a desire to live with caregiver; acknowledges and accepts any responsibility child had for family difficulties leading to removal; has responded to and engaged in treatment or services intended to effect reunification.		Child is generally comfortable in caregiver's presence, but may respond fearfully or withdraw if caregiver becomes angry or if family tensions arise. Generally responds appropriately to caregiver affect, but may resist caregiver limit setting or discipline. Does not always acknowledge caregiver authority or responsibility. Child expresses a desire to be with caregiver, but expresses some reservations about caregiver's desire to be with child. Child is somewhat conflicted by desire to return home, leaving behind feelings of security or comfort afforded during period of substitute care.			Child is fearful of caregiver. Child experienced serious physical or emotional harm prior to removal and holds caregiver responsible (verbally or behaviorally). As appropriate to age, child verbally or otherwise expresses fear, mistrust, anger or feelings of violence towards caregiver, feels that caregiver's limits are too strict, is embarrassed by caregiver; states that he/she will not stay with caregiver to work out problems that may arise in the future.

<b>4. Ambivalence Exhibited by Substitute Care Provider</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Substitute care provider has always expected reunification to occur; supports reunification philosophically; is willing to work with and/or be a resource for caregiver to achieve successful reunification.		Substitute care provider understands policy on reunification, but has bonded with child and is experiencing feelings of separation/loss. As age appropriate, child feels or behaves with reciprocity. Substitute care provider expresses some reservations about caregiver's ability to adequately care for child, but is willing to give caregiver a fair chance at resuming roll as caregiver.			Substitute care provider opposes reunification; threatens or has taken legal steps to block reunification; strongly views caregiver as flawed or unworthy of return of child; has provided/promoted different socio-economic environment (e.g., food, clothing, play items, recreation) for child and uses that difference to sabotage reunification efforts. Substitute care provider has denigrated caregiver to child, actively expressed view of caregiver's inability to resume parental/caregiver roll.

<b>5. Disrupted Attachment</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Both caregiver and child long to resume intimate family relationship. As age appropriate, each acknowledges the strengths and limitations of the other, and is willing/eager to resume relationship with accommodation to limitations.		Child and/or caregiver acknowledge that separation has been painful and have worked/are working to repair relationship. Relationship reparations includes counseling or other treatment regarding development and age-appropriate expectations, to effect reconnection between child and caregiver.			Child or caregiver or both express marked feelings of lost attachment to the other. Period of separation has been very long, and/or child was removed at very young age and has developed/aged/bonded in relation to persons other than the caregiver. Child is at a markedly different stage of development (particularly for older children) than when removal from caregiver occurred. Caregiver may have had another child or joined another family unit and has transferred affection/attention to other persons.

<b>6. Pre-Reunification Home Visitations</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Both caregiver and child (as age appropriate) exhibit positive anticipation of home visits. Caregiver plans activities or special time together with child, and executes those plans. Home visitations have progressed well in terms of increasing frequency and duration and decreasing necessary supervision. Visitations are incident-free; child and caregiver express sadness/sorrow that visitation period ends.		Caregiver and child (as age appropriate) are working out issues and re-establishing roles during home visitations. Some minor incidents may arise, but caregiver discusses them with service provider and uses them as opportunity to learn more and prepare for next visit. Child and/or caregiver complete visits with minor reservations about longer-term reunification, but continue to work to resolve differences or issues.			Caregiver has not participated satisfactorily in scheduled home visits; has missed visits, failed to supervise child adequately during visits; has requested early termination of visits, has allowed family issues to escalate into incidents of high tension or even suspected abuse/neglect of child. Child has requested early termination of visits, has refused to stay with caregiver, has reported maltreatment (substantiated or not) at hands of caregiver during visitations.

Note: Although “Intake” ratings are always important on this subscale, “Closure” ratings may not be appropriate in all cases, depending largely on the reunification model employed and the timing of the assessment.

### G. Readiness for Reunification

<b>1. Overall Readiness for Reunification</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Family has made substantial progress on practical/logistical/legal issues since removal, and is ready to have child returned permanently. Family generally receives mild-to clear-strength ratings on the items associated with this domain: resolution of significant CPS risk factors; completion of case service plans; resolution of legal issues; parent/caregiver understanding of child treatment needs; established back-up supports and/or service plans.		Family has made some progress on practical/logistical/legal issues, and is moving in the right direction. Some issues may remain, but are not viewed as sufficiently serious to prevent reunification. Additional services may be necessary to continue progress on outstanding or unresolved issues. Some mild problem ratings may be evident on domain items, but family is making progress on those items.			Family clearly not ready for return of child due to family chaos, unsatisfactory or high-risk living situations, or dangerous or illegal family lifestyles. Little or no progress made on the issues leading to removal. Family embroiled in contests with the law and with authority figures in general. Family receives numerous problem ratings on items in this domain.

<b>2. Resolution of Significant CPS Risk Factors</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Caregiver has addressed "pre-potent" needs of family (transportation, housing, employment, income, supervision, etc). If appropriate, perpetrator has been removed from family by remaining caregiver. Caregiver has reconstructed living environment to afford protection and care of child.		Caregiver has made substantial progress towards resolution of risk factors that led to removal. Some issues remain unresolved, but improved, and progress continues to be made. Caregiver acknowledges and accepts responsibility for continued work on those issues.			Caregiver has maintained destructive, abusive, or inappropriate relationships with other adults (or perpetrator) or has established new such relationship(s) in child's absence. Caregiver has failed to address pre-potent needs that place family under extreme stress or threat of legal intervention such as continued use of drugs, alcohol, or engaging in prostitution, or criminal lifestyle, etc.

<b>3. Completion of Case Service Plans</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Caregiver has successfully completed required services and/or voluntary services (alcohol/drug abuse, anger management, crisis management, communications) and has demonstrated newly acquired skills/abilities. Caregiver appears gratified by new skills/abilities, and appears to have internalized change. Caregiver is approachable and receptive to the idea of ongoing services, and is eager or willing to participate.		Caregiver has completed required services at least to the extent required by court order or authoritative service plan. Caregiver can verbalize knowledge about skills/behaviors/abilities, but has not necessarily demonstrated same. Caregiver may deny having needed some of the offered services, but acknowledges benefits of some of the services.			Caregiver strongly denies need for services, is oppositional to receipt of services, has failed to participate meaningfully or complete required services. Caregiver repeatedly exhibits behaviors that were the focus of service plan, and/or flaunts non-compliance to service providers or others in authority. Caregiver blames others, including service providers, "the system," adult partner(s), or child for problems and in defense of non-participation.

<b>4. Resolution of Legal Issues</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Caregiver has pursued legal remedies or accepted legal services to resolve specific issues of a legal nature, including obtaining domestic violence restraining order, resolving legal charges resulting from abuse/neglect allegations. If appropriate, paternity has been established and child support is being provided. Other legal/criminal difficulties being experienced by caregiver that may affect future ability to parent or provide care have been resolved (e.g., pending eviction, pending criminal court cases).		Caregiver is engaged in process of resolving legal issues that may affect ability to provide steady competent care. Some issues are still not completely resolved, but caregiver is engaged in the process of resolution, with appropriate and realistic expectations. Caregiver is not resistant to receiving legal assistance when it is necessary. None of the unresolved issues is likely to cause family chaos or removal of caregiver if unsuccessfully resolved.			In spite of restraining order, caregiver continues to maintain destructive or dangerous relationship with other adult(s); caregiver has chosen to legally oppose authority in spite of low probability of "winning," and is expending energy on losing legal conflicts rather than expending energy on becoming a more competent, caring caregiver. Caregiver has serious legal charges pending that may result in incarceration or other serious impediment to future care giving.

5. Parent/Caregiver Understanding of Child's Treatment Needs					
Clear Strength	Mild S.	Baseline/Adequate	Mild P.	Moderate P.	Serious Problem
+2	+1	0	-1	-2	-3
Caregiver has completed education or counseling on child-centered issues and understands what to expect from child, as age appropriate, including possible different developmental stage of child than prior to removal (e.g., puberty). If child has cognitive or developmental disabilities, caregiver knows what to expect and has service plans in place to help child develop. If child is coming out of institution or closed treatment facility, caregiver is aware of and supportive of treatment goals and is prepared to support future treatment.		Caregiver is fairly knowledgeable of treatment provided to child during period of out-of-home care, and seems to understand treatment goals. Caregiver may not understand completely the potential future treatment needs of child, but professes to support future treatment if needed. Caregiver may not fully understand cognitive/developmental disabilities of child, but is willing to accept outside assistance, if needed. Caregiver may not fully understand medication regimen, but is willing to administer medication and to allow child to have access to ongoing psychological services.			Caregiver blames child for cognitive or developmental disabilities, holds child responsible for progress that may not be attainable. Caregiver views normal child developmental processes as deliberately oppositional to caregiver authority or lack of respect. Caregiver unwilling to engage in discussion of child's experiences in institutional or closed facility care, and expects child to return "fixed" or cured. Caregiver denies need for or opposes medications or ongoing psychological or medical services.

Note: This sub-scale may also be used to assess **child's** knowledge of **parent's** treatment needs. Though less common, a child may be being returned to a family in which one or more caregivers have ongoing treatment needs, and the child's understanding and cooperation, if not participation, may be important to successful reunification. To use the sub-scale to assess "Child's Understanding of Caregiver's Treatment Needs" simply substitute "child" and "caregiver" in the text of the definitions.

<b>6. Established Back-Up Supports or Service Plans</b>					
<b>Clear Strength</b>	<b>Mild S.</b>	<b>Baseline/Adequate</b>	<b>Mild P.</b>	<b>Moderate P.</b>	<b>Serious Problem</b>
<b>+2</b>	<b>+1</b>	<b>0</b>	<b>-1</b>	<b>-2</b>	<b>-3</b>
Caregiver has established plans and back-up plans for supervision of child, for accessing emergency family services, for respite if needed. Caregiver has plans for accessing social services, mental health services, or law enforcement, if needed. Friends and family are available for social/emotional support. Plans and mechanisms are in place to provide health care, education, and age-appropriate socialization of child.		Caregiver has some plans in place to provide basic supervision of child or to access services on emergency basis. Caregiver has minimum social/family support. Caregiver does not oppose health, education, or socialization efforts on child behalf, but is fairly passive, relying on external sources such as school system and emergency medical care.			Caregiver has constructed no plans or ineffective plans for child care and supervision. Caregiver opposes outside provision of services (e.g., refuses to respond to requests by school for parent meeting). Caregiver remains oppositional with regard to publicly provided social services, mental health services, psychological services and has not engaged those services for post-reunification support. Caregiver remains estranged from family and/or remains socially isolated and therefore without social or emotional support should a crisis or need for assistance arise.

## Summary Information on the Gordon/Williams Family

This information was gathered through the course of the assessment.

Ms. Williams has had a very inconsistent work history. She was fired from her last job as a factory worker because she called in sick too often. She has a GED, but has no technical training. She would like to go to school to become a nurse's aide, but has done nothing to pursue this. Ms. Williams admits that she worries about having enough money to raise a family. Although she sometimes struggles with having the resources to cover the costs of rent, utilities, and food, Ms. Williams has been able to maintain her household and is current on all of her bills. When she is not using her financial resources to purchase drugs, she can cover her expenses adequately with TANF payments, for which she has one more year of eligibility. Her mother is unwilling to provide any kind of support, including financial; however, her sister, Ruby, has given money to her when things have gotten really bad, i.e., when she is using drugs very heavily.

Ms. Williams says that she has gotten high as a way to deal with life's problems. Her substance abuse counselor does not believe that she uses drugs as a way to self medicate or to deal with depression. The therapist also reports that Ms. Williams has no diagnosable mental illness.

When asked about activities that Ms. Williams might do outside the home that would not involve her drug friends, Ms. Williams says she really doesn't get out much. She has considered going back to her old church, but it is hard to get there by bus. Ms. Williams can meet the basic transportation needs of her family between public transit and rides from Ruby and Mr. Gordon. Ms. Williams' sister is the only support system that Ms. Williams has, but she refuses to come around when Mr. Gordon is there.

Ms. Williams feels that she kicked her drug habit. She does however admit that sometimes life just seems hopeless and that getting high makes things seem better.

You observe that Ms. Williams expresses affection and love for her children and seems well attached to all of them. Still, she does not know what to do when the children misbehave. She typically yells at the children and threatens to spank them as a form of discipline. Ms. Williams admits that although she threatens the children with physical punishment, she doesn't actually follow through with the spankings. She also admits that she has a difficult time following through with other punishments, such as grounding or time out.

Ms. Williams is quite proud of the fact that the children are well fed, clean, and polite. Yolanda is a B student, and, except for language development, Ricky is on target educationally. He does however have a difficult time getting along with both teachers and peers, and has gotten in trouble for hitting other students. Yolanda has many friends at school and gets along well with teachers. Yolanda and Ricky appear to have a close relationship, although Ms. Williams says they do fight at times.

During one visit with Ms. Williams, Mr. Gordon arrives. He appears to be quite unkempt, but he does not appear to be high. When you attempt to ask Mr. Gordon questions, he is reluctant to



answer. You do however get some information. Mr. Gordon works as an auto mechanic. He has worked at the same shop for two years, and he feels he makes a reasonable salary. Sometimes he gives Ms. Williams money to help with the rent, but when the two get into arguments, he stays away and doesn't provide financial support. Mr. Gordon lives with friends when he is not with Ms. Williams because he doesn't feel it makes sense to spend money on rent. Recently, Mr. Gordon has been spending more time at the home and it appears as if they both intend for this arrangement to continue.

When Mr. Gordon was growing up, he felt extremely neglected by his father who was often not home for long periods of time. Mr. Gordon says that his mother often hit him, sometime causing bruises. He has no contact with his mother now, and he does not know where his father is. His only brother was murdered when Mr. Gordon was still in high school. He has no contact with any extended family.

Mr. Gordon admits to "recreational" use of a variety of substances. He feels he can stop using anytime he wants, but he is not currently interested in stopping. He does however admit that his use contributes to Yvette's use of substances.

Three days after Kim was returned home, Ms. Williams' UA came back dirty for cocaine. Two days later, the home health nurse called you to tell you that she was at Ms. Williams' home and that when she arrived at the home, the three children were home alone. According to Yolanda, Ms. Williams and her sister had a fight because Mr. Gordon started spending the night a lot. Ms. Williams' sister moved out. Then, according to Yolanda, "Mom and David left to go to a party." They told Yolanda they would be home later in the day, but had not returned the following day. Yolanda had been taking care of both Kim and Ricky.

The nurse found that the formula given to Kim was inadequate Yolanda did not know how to mix the formula correctly. In addition, Ricky was complaining of hunger and was still wearing the same clothes he was wearing during the nurse's visit the day before.

After the call from the nurse, you called law enforcement to meet you at the home. Because you were unable to reach Ms. Williams, placement appeared to be the only option. You contacted Ms. Williams' mother, Emma, and she was willing to care for Yolanda and Ricky. She was not willing to take Kim, as she is "his" child. Kim was then placed in the Brown foster home.

This assessment was opened as a case for services as all three children were in out-of-home placement, and Ms. Williams entered an in-patient substance abuse program.

#### Current information

During the first visit, you observed that the attachment between Ms. Williams and her children is very good, although the children seem to have a somewhat strained relationship with Mr. Gordon. Yolanda and Ricky seem to also have a strong attachment with one another, and the placement with grandmother seems to be in the children's best interest.

Ricky and Yolanda were placed with their maternal grandmother and aunt, Emma and Ruby Williams. They both are adjusting quite well, as they have a strong relationship with these

caretakers. Yolanda is making the adjustment to her new school, although this change may present difficulties for her in the near future. The Williams' will stay in close contact with Yolanda's teacher to assess her needs, although she has never had any problems in school before. Ricky continues to have behavior problems at Head Start, but according to his recent testing, he does not have a significant impairment. There does not appear to be any changes in his behavior since being placed. The staff continues to work with him on his difficulties in getting along with both staff and peers. He continues to yell at both teachers and peers when he is upset, but is showing some reduction in physical aggression. Both children are concerned about their mother and are anxious to return home. Neither child appears to be in need of individual therapy at this time. The children blame one another for their placement, and Mrs. Williams reports that the two children bicker. They do not however engage in any physical fighting with one another.

Kim is adjusting well to her foster placement with the Browns. Mrs. Brown spent a considerable amount of time talking to Kim's medical provider in order to ensure that her medical and feeding needs are being met. Mrs. Brown will schedule weekly medical appointments until Kim's health has stabilized.

## Case Plan Versus Treatment Plan

### Case Plan

Federal law (P.L. 96-272) requires a separate case plan for each child. This is because of the potentially different needs of children in same family because of age, sex, developmental levels, etc. Colorado meets this requirement in Part 3A of the Family Services Plan. Children may go on the same page, but each child needs a discrete section.

### Treatment Plan

State law [CRS 19-1-103 (IV) (10)] requires that in every case where a child(ren) is (are) adjudicated dependent and neglected, an “appropriate treatment plan” shall be approved by the court. The plan will involve the child(ren) named AND each respondent named and served in the action. The law further states that an appropriate treatment plan means a “treatment plan approved by the court which is reasonably calculated to render the particular respondent first to provide adequate parenting to the child(ren) within a reasonable time and which relates to the child(ren)’s needs.”

Previously, workers had to complete a discrete case plan and a treatment plan. Now, in many counties, the Family Services Plan merges these documentation requirements. These are two separate requirements that have been merged onto the same form, but the requirements are still distinct.

## Permanency Goals Scramble

Other planned permanent living  
arrangement through emancipation

Adoption (non-relative)

Permanent placement with relatives  
through adoption

Other planned permanent living  
arrangement through non-relative

Remain home

Other planned permanent living  
arrangement through relative

Return home

Permanent placement with relatives  
through guardianship/permanent custody

Non-relative guardianship/permanent custody

**7.301.24 O 4**

If this goal (other planned permanent living arrangement) is not achieved through relative care, a family-like network of significant people shall be developed to provide the child/youth with a sense of belonging and with support expected to endure over a lifetime.

## Permanency Pacts

### What is a Permanency Pact?

A pledge by a supportive adult to provide specific supports to a young person in foster care with a goal of establishing a lifelong, kin-like relationship.

### Permanency Pact

Youth transitioning from foster care are often unsure about who they can count on for ongoing support. Many of their significant relationships with adults have been based on professional connections, which will terminate once the transition from care is completed.

It is critical to the youth's success to identify those adults who will continue to provide various supports through and beyond the transition from care. Clarifying exactly what the various supports will include can help to avoid gaps in the youth's safety net and misunderstandings between the youth and the supportive adult.

A Permanency Pact creates a formalized, facilitated process to connect youth in foster care with a supportive adult. The process of bringing the supportive adult together with the youth and developing a pledge or "Permanency Pact" has proven successful in clarifying the relationship and identifying mutual expectations. A committed, caring adult may provide a lifeline for a youth, particularly those who are preparing to transition out of foster care to life on their own.

The facilitator may be a caseworker, independent living provider, or other adult who:

- Is knowledgeable in facilitation Permanency Pacts.
- Is familiar with the youth.
- Can provide insight into the general needs of the youth transitioning from care.

## Concurrent Planning Components

1. **Success Redefined**  
The agency and court define their primary goal as timely permanency, with family reunification as the first, but not only, option
2. **Differential Diagnosis**  
Within the first 90 days of placement, the agency determines (sometimes using LSS standardized instruments) the family's likelihood of being reunited within the next two months, based on the family's history, relationship with the child, and demonstrated progress. Families given a poor prognosis receive concurrent planning.
3. **Timelines**  
The entire case plan is structured by the legal requirements for timely permanency. These timelines are explained to families as part of the "full disclosure."
4. **Visiting**  
Vigorous efforts are made to institute frequent parental visiting, even with ambivalent or unresponsive parents. The agency's zeal in promoting visiting will result in either faster reunification or early decision-making in favor of an alternative permanent plan.
5. **Plan A/Plan B**  
Children are placed with a family willing and able to work cooperatively with the biological parents, but also prepared to become the children's permanent family if needed. This may be a relative or a foster family. The family's commitments to the process and to the child are clearly articulated to the parents.
6. **Written Agreements**  
The case plan is reduced to a series of small steps, written down with or by parents, on a weekly or monthly basis.
7. **Behavior (Not Promises)**  
The agency and the court proceed based only on the progress (or lack of progress) documented by observations, service provider reports, and expert testimony.
8. **Forensic Social Work**  
The agency provides caseworkers with ongoing legal training, consultation, and support, so caseworkers produce legally sound case plans, concise court reports, and competent testimony.
9. **Full Disclosure**  
All families are given information about the detrimental effects of out-of-home care on children, the urgency of reunification, and the agency's concurrent plan to safeguard the child from drifting in care. The family's options are thoroughly and repeatedly reviewed with them.

Colorado Concurrent Planning Guide  
Revised September, 1998 – In Accordance with Statutory Changes  
Expanding Family Options for Permanency #90-CO-0801

Child's Name:	
State I.D. Number	Date
Completed By:	

## Colorado Concurrent Planning Guide – 1998 Statutory Changes

**GUIDELINES:** This tool is for use in all grant-funded E.P.P. cases and may be used for other cases. It is designed to identify children in need of concurrent planning based on a family assessment as outline in the Family Services Plan. The Guide should be completed within 60 days of case opening. This tool seeks to balance a child's need for permanency with recognition that the parents have the capacity for growth and change, and that reunification efforts continue in earnest. It is expected that some children involved with concurrent planning will reunify. *The tool is ideal for team decision-making. For the purpose of this tool, parents are defined as the birth and/or legal parents.*

**SECTION I – EARLY REUNIFICATION PROGNOSIS INDICATORS**

**Prognosis indicators for early reunification – concurrent planning not needed**

**Parent-Child Relationship**

**The parent/s demonstrate:**

- Ability to respond to child's cues
- Empathy for child; balance between own needs and needs of child
- Ability to accept appropriate responsibility for problems that lead to abuse/neglect
- Ability and willingness to modify parenting
- Having raised the child for a significant period of time
- Ability to meet child's special needs (medical, educational, social, cognitive, etc.)
- Evidence of previous effective parenting observed through child's development (age appropriate cognitive & social skills; conscience development; minimal behavior issues)

**Parental History and Functioning**

**The parent/s demonstrate:**

- Stable physical health
- Stable emotional/mental health; any mental illness will controlled
- Economic stability (employment, housing, and/or ability to live independently)
- Freedom from addiction/s (substances, gambling, violence, etc.)
- Consistent contact with child (visitation, parenting time, telephone contacts)
- Historical ability to meet child's needs despite impaired mental function
- Problems leading to placement are of recent origin and situational rather than chronic in nature

**Support Systems**

**The parent/s demonstrate:**

- Positive relationships supportive of safe parenting
- Kin system providing mutual caretaking and shared parenting
- Proximity of support system practical to family needs
- A support system that recognizes strengths and limitations of parents/family

**SECTION II – POOR PROGNOSIS INDICATORS**

**NEED FOR CONCURRENT PLANNING**

**Develop alternative plan (alternative placement as appropriate)**

**Parent-Child Relationship**

**Factors Related to Abuse or Neglect**

- Serious physical abuse, such as burns, fractures, poisoning
- Non third party sexual abuse of child; prognosis likely to require lengthy foster care
- Diagnosed failure to thrive infant
- Child drug-exposed at time of birth (cocaine, crack, heroin, alcohol, etc.)
- Child has been victim of more than one form of abuse
- Significant neglect

**Factors Related to Ambivalence**

- Precious placement of this child or other children
- Previous consideration of relinquishing this child; previous relinquishments of a child
- Repeated pattern of uncertainty as to desire to parent
- Inconsistent contacts with child
- Lack of emotional commitment to child; parent dislikes child due to child's paternity
- Parental mental illness not historically and/or currently well controlled
- Parent/s consistently acknowledge ongoing problems with parenting

**Parental History and Functioning**

- Parent continues to reside with someone dangerous to the child
- Parent/s raised in foster care
- Recent or perpetual history of parental criminal involvement
- Documented history of domestic violence
- Parent has degenerative or terminal illness
- Previous reunification has disrupted
- Intergenerational abuse with lack of historical change in family dynamics
- Parent/s engage in high-risk relationships (drugs, criminal activity, alcohol)
- Progressive signs of family deterioration due to personality disorder/s
- Previous interventions and/or treatment unsuccessful; uncooperative with treatment plan
- Parent/s restricted in ability to parent due to developmental disabilities
- Lifestyle and support system choices place child at risk through inappropriate caregivers
- Visible means of financial support derived from prostitution, drugs, or other crime
- Failure to respond to multiple forms of treatment/intervention despite acceptable participation levels

The Colorado Concurrent Planning Guide has been developed based on modification of the indicators found in Concurrent Planning: From Permanency Planning To Permanency Action. ©1994, Lutheran Social Services of Washington & Idaho. Authors: Katz, Spoonemore, and Robinson.





## S.M.A.R.T. Case Plans

### Objectives Are Specific

Objectives describe the specific behavioral outcomes that will result in achievement of the permanency goal. An objective clearly describes a behavior that must occur, or that must stop occurring, before the case is successfully closed. (Try to word objectives using positive terms.)

This can create confusion for workers when distinguishing between descriptions of parental behaviors that represent “end states” (objectives) and descriptions of parental behaviors that represent activities (action steps). Like objectives, action steps are also always written in behavioral terms, because, by definition, they are statements of a person’s actions.

**The differentiating factor is whether the change in the parent’s behavior is the desired end in itself (an objective)**

**-OR-**

**a step towards and a means of achieving the objective (action steps).**

### Objectives Are Measurable

The parties to the plan must be able to reach consensus regarding whether the stated objectives have been accomplished. Therefore, the objective must include some **easily discernible criteria by which achievement can be measured.**

Writing measurable objectives is one of the most difficult parts of the case planning process. Many of the expected outcomes in child welfare do not lend themselves to easy, precise quantification.

Some criteria are easy to observe, but more difficult to measure. For example, one cannot write a measurable objective related to home cleanliness by quantifying the amount of dirt that is allowable in a home. A practical solution is an objective that includes many observable behaviors that are associated with cleanliness, or to include these observable behaviors in the measurement of success. For example, “the floor will be cleared of dirt, dust, debris, food, and garbage” could be used in the objective itself, or used in the measurement of success to describe the cleanliness of the house that is acceptable in the objective.

Workers may be accustomed to writing objectives that contain the word **improve**, such as “improved child care” or “improved housing conditions.” **Objectives that contain the word improve are neither observable nor measurable.** “Improve” implies the existence of a describable baseline and a describable increase from the baseline. It also sometimes implies underlying values that define some behaviors as more desirable than others. If observers have different values, they may not agree on what can be considered an improvement. In neither case is there an adequate description of an end state that can be measured.

## **Objectives Are Achievable**

Objectives **must be realistic** so that clients are able to accomplish them. For example, “children’s behavior will be managed by using non-physical discipline methods” is achievable; “parent will not discipline child” is neither achievable nor desirable.

## **Objectives Are Relevant and Result Focused**

This characteristic of objectives appears deceptively self-evident. It is not uncommon, however, for workers to derive their objectives from a “laundry list” of potential conditions that might improve parenting or care of the child. For example, “Mother will use non-violent methods of disciplining the child, including time-out and restriction of privileges” could be an appropriately written objective, but not for all situations in which there has been child maltreatment.

**Objectives are tied to the family assessment (NCFAS) and linked to risk factors. An objective must be selected in the context of the factors that put the child at risk.** For example, if the assessed problem is that the mother is alcoholic and has blackouts during which time the child receives no care, the objective stated above is unrelated to the assessed problem. A better (more relevant and result focused) objective would be, “Mother will ensure that children are adequately supervised at all times and ask Grandma to babysit when she plans to drink with friends.”

Note that the example above illustrates MSLC (Minimal Standard Level of Care); in other words, Mom’s sobriety is only relevant when it is related to supervising the children. If she wants to have Grandma watch the kids overnight (as long as Grandma is an adequate caregiver), and then go out on a bender—to be blunt—that’s her choice and none of our business.

## **Action Steps Are Time Limited**

A timeframe within which the objective can reasonably be expected should be specified in the action steps. The assignment of a timeframe provides an additional criterion by which achievement of the objective can be measured.

Time should not be thought of just in terms of “court time.” Smaller blocks of time for specific activities to be completed works best with clients who may be overwhelmed with the prospect of completing the whole case plan.

## Case Plan Components

### Objectives

- ❖ Reflect *changes in behavior* to achieve the permanency goal.
- ❖ Are based on family assessment (NCFAS -2 and -3) and linked to risk factors.
- ❖ Are the behavior change that is needed to accomplish the Permanency Goal.
- ❖ Are not services for parents to participate in or attend.

### Action Steps

- ❖ The *specific actions* taken by the person/agency to achieve the objective/change in behavior.
- ❖ Who has a *role* in completing the action step.
- ❖ Time frame for when the action needs to begin and end.

### Measurement of Success

- ❖ Describes how the person or agency will demonstrate they have completed the actions successfully and achieved the objective.
- ❖ Breaks down the objective into small measurable components.
- ❖ May be used to measure the overall success of the objective.
- ❖ Can be quantitative or qualitative.

## Action Verbs for FSP Objective Statement

Select	Construct	Take
Name	Distinguish	Articulate
Identify	Order	Plan
Solve	Translate	Supports
Compare	Perform	Fulfill
List	Write	Recognize
Recall	Recite	Acts
Complete	State (a rule)	
Describe	Demonstrate	
Define	Adapt	
Explain	Arrange	
Estimate	Intervene	
Implement	Formulate	
Summarize	Follow through with	
Interpret (data)	List	
Utilizes/Use	Knows	
Able	Prioritize	

A behavioral objective is an attempt to answer the question, "What will a client be able to do after he/she goes through a certain period of instruction?"

Adapted from a list provided by Bev Newbanks, Lincoln County DSS.

## Benefits and Purposes of Visits

Visits between parents and children who are not in parental care are important in several ways. Visits provide reassurance to the child and the family; they allow for the assessment of reunification capacity and progress; they provide an opportunity for intervention; and they allow for documentation of progress and barriers. Visits also allow children an opportunity to process their feelings about their parents and to see their parents in a realistic light. Visits not only contribute to the reunification process, but they also can help in the documentation of an alternative permanency plan if reunification does not appear to be a viable option.

### Benefits

- ❖ More frequent parent-child visitation is associated with shorter placements in foster care.
- ❖ Children who are visited frequently by their parents are more likely to be returned to their parents' care.
- ❖ Increased caseworker contact with parents of children in care is associated with more frequent parental visitation and ultimately with shorter time in placement.
- ❖ Parents who are given regularly scheduled visits have a better attendance rate than parents who are told to request visits.
- ❖ When workers do not encourage parents to visit, or use the agency office for the visit, or do not engage in problem solving with parents, children tended to remain in foster care 20 months or more.
- ❖ For children emancipating from care, visits can help them to develop skills to deal with any safety threats that may still exist in their biological families. Knowing that most youth will reconnect with their families once they leave foster care, visits can help them to learn how to deal with the emotions and reactions they have about their families. It can help them to develop a safety plan for visitation.

### Others

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## **Purposes**

- ❖ Visits communicate to the parent that the agency/worker believes that family is important and supports timely reunification.
- ❖ Visits help to reduce the negative effects of separation for children.
- ❖ Visits also allow specific times for parents to learn and practice skills required for positive parent/child interactions.
- ❖ Visits allow for specific times for workers or case aides to model good parenting skills.
- ❖ Visits allow for assessment of baseline parenting skills and assessment of changes in parenting skills.
- ❖ Visits help reduce the child's fantasies and fears about their parents and can help children eliminate "self-blame" for the placement.
- ❖ The psychological well-being and developmental progress of children in placement are enhanced by frequent contacts with their parents.
- ❖ Helps parent gain confidence in their abilities to parent their child.

## **Others**

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## Visitation Chart

	Child Development/ Parenting Skills <b>INFANTS</b>	Child Development/ Parenting Skills <b>TODDLERS</b>	Child Development/ Parenting Skills <b>PRESCHOOL</b>	Child Development/ Parenting Skills <b>ELEMENTARY</b>	Child Development/ Parenting Skills <b>TEENS</b>
<b>How Often</b>	<ul style="list-style-type: none"> <li>• 2 to 5 visits per week</li> <li>• Long enough for parent to feed, change diapers, play – 60 minutes minimum, depending on child's needs</li> <li>• Meets child schedule</li> </ul>	<ul style="list-style-type: none"> <li>• 2 to 4 visits per week</li> <li>• 60 to 90 minutes</li> <li>• Meets child's schedule</li> </ul>	<ul style="list-style-type: none"> <li>• 2 to 4 visits per week</li> <li>• 60 to 90 minutes</li> <li>• Meets child's schedule</li> </ul>	<ul style="list-style-type: none"> <li>• 1 to 2 visits per week</li> <li>• 1 to 3 hours</li> <li>• Meets child's schedule</li> </ul>	<ul style="list-style-type: none"> <li>• At least once a week</li> <li>• 1 to 3 hours</li> <li>• Meets child's schedule</li> </ul>
<b>Where</b>	<ul style="list-style-type: none"> <li>• Home or homelike environment that allows for caring of baby (foster home or day care)</li> <li>• Have items that calm baby (blanket, pacifier, toy)</li> <li>• Visits may include doctor appointments</li> </ul>	<ul style="list-style-type: none"> <li>• Home or homelike environment like foster home or daycare</li> <li>• Community setting: parks, playgrounds, childcare, doctor appointments</li> </ul>	<ul style="list-style-type: none"> <li>• Home or homelike environment like foster home or daycare</li> <li>• Community setting: parks, playgrounds, childcare, doctor appointments</li> </ul>	<ul style="list-style-type: none"> <li>• Child helps to choose</li> <li>• Home or homelike environment like foster care or day care</li> <li>• Where child already is: school, sports, park, restaurant, therapist, doctor</li> </ul>	<ul style="list-style-type: none"> <li>• Teen helps to choose</li> <li>• Where teen already is: school, sports, park, restaurant, mall, therapist, home of parent or caregiver, doctor</li> </ul>
<b>Things to Accomplish</b>	<ul style="list-style-type: none"> <li>• Parent meets child's needs; crying, eating, sleeping</li> <li>• Play on floor or eye level</li> <li>• Music, read book, talk to baby</li> <li>• Bonding activities</li> <li>• Provided safety and supervision</li> </ul>	<ul style="list-style-type: none"> <li>• Parent meets child's needs; learning to do it herself – eating, dressing, toileting</li> <li>• Play games, read, talk, sing</li> <li>• Provide safety, supervision, and discipline</li> </ul>	<ul style="list-style-type: none"> <li>• Child chooses what to do <u>during</u> visit—which book to read, what toy to play with, what game</li> <li>• School activities, sharing, cause/effect</li> <li>• Provide safety, supervision, and discipline</li> </ul>	<ul style="list-style-type: none"> <li>• Child helps to choose</li> <li>• Skill development with what child likes to do</li> <li>• Learning team play</li> <li>• Ask child about his life</li> <li>• Provide safety, supervision, and discipline</li> </ul>	<ul style="list-style-type: none"> <li>• Develop identity</li> <li>• Help develop security to aid in separation</li> <li>• Development of positive self identity</li> <li>• Learn about family to develop sense of self</li> <li>• Ask child about her life</li> <li>• Discipline</li> </ul>



	Child Development/ Parenting Skills <b>INFANTS</b>	Child Development/ Parenting Skills <b>TODDLERS</b>	Child Development/ Parenting Skills <b>PRESCHOOL</b>	Child Development/ Parenting Skills <b>ELEMENTARY</b>	Child Development/ Parenting Skills <b>TEENS</b>
<b>Whom</b>	<ul style="list-style-type: none"> <li>• Birth parents &amp; siblings together or separate</li> <li>• Include other key people to whom child has emotional attachment</li> </ul>	<ul style="list-style-type: none"> <li>• Birth parents &amp; siblings together or separate</li> <li>• Include other key people with emotional attachment</li> </ul>	<ul style="list-style-type: none"> <li>• Ask child who he wants to visit</li> <li>• Birth parents &amp; siblings together or separate</li> <li>• Other key people with emotional attachment</li> </ul>	<ul style="list-style-type: none"> <li>• Ask child who he wants to visit</li> <li>• Birth parents &amp; siblings together or separate</li> <li>• Other key people with emotional attachment</li> </ul>	<ul style="list-style-type: none"> <li>• Ask teen who he wants to visit</li> <li>• Birth parents &amp; siblings together or separate</li> <li>• Other key people with emotional attachment</li> </ul>
<b>What to Bring and Do</b>	<ul style="list-style-type: none"> <li>• Bring food, toys, diapers and comfort items</li> <li>• Have adult who child feels safe with (could be foster parent) help with all transitions</li> </ul>	<ul style="list-style-type: none"> <li>• Bring toys, diapers, food, and comfort items</li> <li>• Have adult who child feels safe with (could be foster parent) help with all transitions</li> </ul>	<ul style="list-style-type: none"> <li>• Bring toys, food, and comfort items</li> <li>• Have adult who child feels safe with (could be foster parent) help with all transitions</li> </ul>	<ul style="list-style-type: none"> <li>• Bring toys, food, homework, and other items for session</li> <li>• Allow child time to adjust to transitions</li> </ul>	<ul style="list-style-type: none"> <li>• Bring toys, food, homework, and other items for session</li> <li>• Allow child time to adjust to transitions</li> </ul>

	Type of Abuse <b>NEGLECT</b>	Type of Abuse <b>SEX ABUSE</b>	Type of Abuse <b>PHYSICAL ABUSE</b>	Type of Abuse <b>EMOTIONAL NEGLECT/ABUSE</b>
<b>Length of Time</b>	<ul style="list-style-type: none"> <li>• Long enough to practice problematic parenting skills</li> <li>• Usually requires 2 hours</li> <li>• Increase time with increased skills of parents</li> </ul>	<ul style="list-style-type: none"> <li>• To meet the child's needs of safety, emotional and developmental needs</li> </ul>	<ul style="list-style-type: none"> <li>• Long enough to have normal parent/child interactions that require parent to practice family rules and discipline</li> </ul>	<ul style="list-style-type: none"> <li>• Long enough to have normal parent/child interactions that require parent to react to child using praise, disapproval, discipline</li> </ul>
<b>Where</b>	<ul style="list-style-type: none"> <li>• Optimal: in parent's home unless the location is unsafe</li> <li>• Home like environment; foster or relative home</li> <li>• Visitation center</li> </ul>	<ul style="list-style-type: none"> <li>• May occur in clinical setting</li> <li>• Location that makes the child feel safe</li> </ul>	<ul style="list-style-type: none"> <li>• In family or home setting</li> <li>• May need to initially avoid site of abuse until counselor approves</li> </ul>	<ul style="list-style-type: none"> <li>• In family or home setting</li> <li>• Location that makes the child feel safe</li> </ul>
<b>Things to Accomplish</b>	<ul style="list-style-type: none"> <li>• Practice the skills that led to removal: feeding, supervision, clothing, cleanliness</li> <li>• Learn to understand child's needs and feelings</li> </ul>	<ul style="list-style-type: none"> <li>• No whispers, alone time, passing notes not reviewed</li> <li>• Learn to understand child's needs and feelings; for offending and non-offending parent</li> </ul>	<ul style="list-style-type: none"> <li>• Learn to understand child's needs and feelings</li> <li>• Practice parenting skills and providing structure for child without use of physical discipline</li> </ul>	<ul style="list-style-type: none"> <li>• Learn to understand child's needs and feelings</li> <li>• Practice parenting skills and providing structure for child without use of emotional abuse</li> <li>• Learn to nurture and support child.</li> </ul>
<b>Level of Supervision</b>	<ul style="list-style-type: none"> <li>• Depends on level of neglect</li> <li>• Severe neglect requires high level of supervision until parent demonstrates improved skills</li> <li>• Usually monitoring is enough</li> </ul>	<ul style="list-style-type: none"> <li>• High supervision needed; vigilance of verbal, non-verbal, body language, pressure to recant</li> <li>• Child has signal to stop visit</li> </ul>	<ul style="list-style-type: none"> <li>• High level of supervision until parent has demonstrated the ability to provide care without physical abuse.</li> <li>• Child has safety plan</li> </ul>	<ul style="list-style-type: none"> <li>• High level of supervision until parent has demonstrated the ability to provide care without emotional abuse</li> <li>• Child has safety plan</li> </ul>
<b>Whom</b>	<ul style="list-style-type: none"> <li>• Birth parent(s) or others in caregiver role, siblings</li> <li>• Later, include entire family doing normal family activities</li> </ul>	<ul style="list-style-type: none"> <li>• Non-offending parent and siblings – same as other types of abuse</li> <li>• Visits begin w/ offending parent with child therapist approval</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical approval when child has a stated fear of abusive parent</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical approval when child has a stated fear of abusive parent</li> </ul>
<b>What to bring/rules</b>	<ul style="list-style-type: none"> <li>• Bring items to practice parenting skills: cooking, homework, toys, bathing, napping</li> </ul>	<ul style="list-style-type: none"> <li>• Clear rules and safety plan is known by all parties</li> <li>• Child may need cell phone or other method to call for help</li> </ul>	<ul style="list-style-type: none"> <li>• Clear rules and safety plan is known by all parties</li> <li>• Child may need cell phone or other method to call for help</li> </ul>	<ul style="list-style-type: none"> <li>• Clear rules and safety plan is known by all parties</li> <li>• Child may need cell phone or other method to call for help</li> </ul>

Special Considerations <b>SUBSTANCE ABUSE</b>	Special Considerations <b>MENTAL ILLNESS</b>	Special Considerations <b>SPECIAL NEEDS OF CHILD</b>	Special Considerations <b>INCARCERATED PARENT</b>
<ul style="list-style-type: none"> <li>• Parent is at high risk for relapse due to conflicted feeling when seeing child.</li> <li>• Grief, loss, guilt for causing placement</li> </ul>	<ul style="list-style-type: none"> <li>• Everyone knows indicators of parent having a mental health crisis</li> <li>• No visits when parent is in “crisis”</li> </ul>	<ul style="list-style-type: none"> <li>• Get professional advice from the therapist, doctor, and birth parent about the special needs and what limitations may need to be considered</li> </ul>	<ul style="list-style-type: none"> <li>• Child may need to see parent while incarcerated to alleviate fears</li> <li>• Reassure child that parent is alive and safe</li> </ul>
<ul style="list-style-type: none"> <li>• Neutral location where drugs would not be available – as homelike as possible</li> </ul>	<ul style="list-style-type: none"> <li>• Communication with parent’s therapist/psychiatrist</li> <li>• Monitoring of parents medication</li> <li>• Side effects that may affect parenting</li> </ul>	<ul style="list-style-type: none"> <li>• Consider visits at doctor, therapist, or school setting</li> </ul>	<ul style="list-style-type: none"> <li>• Determine policies of prison or jail regarding visitation.</li> <li>• Develop working relationship with institution to develop visitation policy</li> </ul>
<ul style="list-style-type: none"> <li>• Use of relapse plan when visits are not supervised and take place away from monitored setting</li> </ul>	<ul style="list-style-type: none"> <li>• If age appropriate, discuss mental illness with child; help them to understand</li> </ul>	<ul style="list-style-type: none"> <li>• Parent should provide for child’s special needs during visit to increase attachment and practice skills</li> </ul>	<ul style="list-style-type: none"> <li>• Creativity may be needed to accomplish many activities</li> </ul>
<ul style="list-style-type: none"> <li>• Parent may have a hard time parenting “sober”</li> <li>• May need to learn or re-learn parenting behaviors</li> </ul>	<ul style="list-style-type: none"> <li>• Observation or supervision until treatment counselor approves</li> </ul>	<ul style="list-style-type: none"> <li>• Clear documentation of parent’s ability to meet child’s special needs</li> </ul>	<ul style="list-style-type: none"> <li>• Prepare child for environment of prison</li> </ul>
<ul style="list-style-type: none"> <li>• Non-addicted parent can be observer of visit if shown ability to make safe decisions</li> </ul>	<ul style="list-style-type: none"> <li>• If parent is hospitalized, determine if visitation in this setting is appropriate for child</li> </ul>		<ul style="list-style-type: none"> <li>• Supplement visits with phone calls, videos, letters, and tape recordings</li> <li>• Work with institution for creative alternatives</li> </ul>
<ul style="list-style-type: none"> <li>• Discuss agency/court policy for visiting if intoxication is suspected</li> <li>• Guidelines for suspicion should be included in court order and visitation plan.</li> <li>• Parent knows policy/expectation prior to visits; no drugs at visits</li> </ul>			<ul style="list-style-type: none"> <li>• Enlist the help of friends, relatives, or volunteers to assist with visitation</li> </ul>

Special Considerations <b>FAMILY CULTURE</b>	Special Considerations <b>NON-OFFENDING PARENT</b>	Special Considerations <b>DOMESTIC VIOLENCE</b>
<ul style="list-style-type: none"> <li>If child does not have contact with cultural community through parent visits or caregiver, this type of "visit" should be added to case plan</li> </ul>	<ul style="list-style-type: none"> <li>Location where no uninvited people can arrive without a method to protect the child or stop the visit</li> </ul>	<ul style="list-style-type: none"> <li>Parents cannot visit together until DV treatment professional approves</li> </ul>
<ul style="list-style-type: none"> <li>In family or relative home</li> <li>In community locations with cultural significance</li> <li>In language of the family</li> </ul>	<ul style="list-style-type: none"> <li>Activities to focus on the child and not adult relationships</li> </ul>	<ul style="list-style-type: none"> <li>Place where child feels safe; may need to avoid location of DV incidents if this upsets the child</li> </ul>
<ul style="list-style-type: none"> <li>Sharing family history, stories</li> <li>Teaching family traditions; holidays, cooking, games, hobbies</li> <li>Religious events and learning</li> </ul>	<ul style="list-style-type: none"> <li>High level of supervision until parent demonstrates ability and empathy to always put child's safety first</li> <li>No pressure to recant allegations</li> </ul>	<ul style="list-style-type: none"> <li>May require close supervision to monitor for common battering behavior that may be subtle: questioning children about other parent, blaming non offending parent, trying to find out location of children or non offending parent, etc.</li> </ul>
<ul style="list-style-type: none"> <li>Use family and people the family knows whenever possible to supervise visits and teach parenting skills, that person can speak the family's language</li> </ul>	<ul style="list-style-type: none"> <li>No discussion that would imply child is responsible for getting the abusive parent in trouble or the family harmed because that parent has left family</li> </ul>	<ul style="list-style-type: none"> <li>High level of supervision until abusive parent begins DV treatment; decrease level only with counselor approval and demonstration of improve skills</li> </ul>
<ul style="list-style-type: none"> <li>Consideration should be given to norms, rules regarding appropriate behavior, spirituality, family roles gender and social position, medical practices, etc.</li> </ul>	<ul style="list-style-type: none"> <li>Offending/abusive parent not included until therapist approves</li> <li>No others attend: new boyfriends, friends, etc., unless approved by parties</li> </ul>	<ul style="list-style-type: none"> <li>Ensure safety between ALL parties</li> <li>Consider need for safety plan or code word/signal for ending visit</li> </ul>
<ul style="list-style-type: none"> <li>Bring information, pictures, reading materials, and other items to teach family culture</li> </ul>		

	<b>BEFORE THE VISIT</b>	<b>DURING THE VISIT</b>	<b>AFTER THE VISIT</b>
<b>Birth Parent</b>	<ul style="list-style-type: none"> <li>• Ask about specific rules.</li> <li>• Ask about expectations.</li> <li>• Bring agreed upon items for visit. This may include food and toys.</li> <li>• Be on time and call if there is a problem.</li> <li>• Come to the visit drug/alcohol free.</li> <li>• Receive approval for any guests.</li> </ul>	<ul style="list-style-type: none"> <li>• Follow the agreed upon rules.</li> <li>• Give child 100% of your attention. Engage your child in activities.</li> <li>• Practice positive parenting.</li> <li>• No false promises.</li> <li>• Ask for help if necessary.</li> <li>• Make goodbye positive.</li> </ul>	<ul style="list-style-type: none"> <li>• Ask for feedback on the visit.</li> <li>• Ask what needs to change or improve.</li> <li>• Provide and ask for suggestions for next visit.</li> <li>• State any concerns to visit supervisor.</li> <li>• Take care of yourself and remember that visits are emotional. Figure out a way to deal with the emotions in a positive way.</li> </ul>
<b>Caseworker</b>	<ul style="list-style-type: none"> <li>• Provide all parties with the visitation plan.</li> <li>• Discuss case and expectations to visit supervisor.</li> <li>• Explain purpose of visit to parent.</li> <li>• Explain rules and expectations to parent.</li> <li>• Help parent decide what to say to child, what to bring, what activities are allowed/expected.</li> <li>• Prepare the parent to have a successful visit.</li> <li>• Prepare parent for possible reactions of child to visit.</li> <li>• Arrange transportation and location.</li> <li>• Explain the visit to child. Support child.</li> <li>• Talk with foster parent about visit.</li> </ul>	<ul style="list-style-type: none"> <li>• Observe visit at least monthly if not the visit supervisor.</li> <li>• See visit supervisor tasks.</li> </ul>	<ul style="list-style-type: none"> <li>• Check in with all parties about how the visit went.</li> <li>• Give parent feedback on the visit if this is not done by the visit supervisor.</li> <li>• Support the parent; assure them that visits are difficult and emotional.</li> <li>• Assess progress on case plan based on parental skills used in visits. Discuss this with parent. Revise case plan and or visitation plan based on progress in visits.</li> <li>• Consider step down in level of supervision, increasing visits, or changing location of visits based on the needs of the family.</li> <li>• Check in with foster parent to see how child is reacting to visits.</li> <li>• Check in with child to get feedback on visits.</li> <li>• Ask all parties how to make visits more meaningful.</li> </ul>

	<b>BEFORE THE VISIT</b>	<b>DURING THE VISIT</b>	<b>AFTER THE VISIT</b>
<b>Caregiver of Child</b>	<ul style="list-style-type: none"> <li>• Prepare child for visit. Let child express emotions.</li> <li>• Ensure child goes to visit prepared (i.e., clothing, medication, homework, comfort item).</li> <li>• Say positive things about parent and visit.</li> <li>• Transport child.</li> <li>• Provide information to parent/visit supervisor about anything that may affect the visit.</li> <li>• Support visits. Understand that family connections are essential for a child's healthy development.</li> </ul>	<ul style="list-style-type: none"> <li>• Have the visit in your home.</li> <li>• Model parenting skills during visits.</li> <li>• Help the child to transition to parent, especially if the child is attached to you.</li> </ul>	<ul style="list-style-type: none"> <li>• Transport child back to your home</li> <li>• Allow child to discuss the visit. Allow for emotions to be safely expressed.</li> <li>• Report reactions the child has to visits.</li> <li>• Support visits and connection with biological family.</li> <li>• Speak positively about the parent.</li> <li>• Discuss your own reaction to the visit with the worker.</li> </ul>
<b>Supervisor of Visit</b>	<ul style="list-style-type: none"> <li>• Discuss family situation with caseworker. Why are the children in placement? What do the parents need to work on? What is your role in the visit? Are there any specific concerns? Are there any specific expectations? What have the parents been told about the visits?</li> <li>• Allow child to talk about feelings. Provide support and positive encouragement to child.</li> <li>• Discuss with parent expectations and rules for visit and your role in the visit.</li> <li>• Support the parents.</li> <li>• Check for parental sobriety.</li> <li>• Discuss documentation requirements with caseworker.</li> </ul>	<ul style="list-style-type: none"> <li>• Encourage the parent to practice positive parenting.</li> <li>• Encourage positive interaction.</li> <li>• Direct the parent towards the child and meeting the child's needs.</li> <li>• Model/teach parenting skills as outlined in visitation plan.</li> <li>• Assist the parent in setting limits and controlling the child's behavior.</li> <li>• Be aware of the parent's subtle behavior toward the child.</li> <li>• Stop the visit if parent cannot follow the rules or if anyone's safety is compromised.</li> <li>• Enforce all the agreed upon rules.</li> <li>• Document visit.</li> <li>• Allow time for parent and child to say goodbye.</li> </ul>	<ul style="list-style-type: none"> <li>• Give feedback to parent on the visit.</li> <li>• Discuss any concerns on the part of the parent.</li> <li>• Support parent.</li> <li>• Discuss next visit. Any changes?</li> <li>• Allow child to discuss visit. Provide support.</li> <li>• Discuss visit with caseworker. Give information on strengths and needs.</li> <li>• Discuss visit with caregiver. While being honest, try to provide information on parental strengths and things that went well during the visit. Try to say something nice about the parent.</li> </ul>

<p>Time in Care <b>INITIAL PLACEMENT</b> <b>0 TO 2 MONTHS</b></p>	<p>Time in Care <b>REASONABLE EFFORTS</b> <b>2 TO 12 MONTHS</b></p>	<p>Time in Care <b>FINAL PERMANENCY</b> <b>DECISION: 12 – 15 MONTHS</b> <b>EPP: 9 – 12 MONTHS</b></p>	<p>Time in Care <b>POST PERMANENCY</b> <b>15 MONTHS TO ONGOING</b></p>
<ul style="list-style-type: none"> <li>• First visit within 48 hours of placement – at least a phone call</li> <li>• 20 minutes to 1 hour</li> <li>• After that follow child development guideline</li> </ul>	<ul style="list-style-type: none"> <li>• At least weekly</li> <li>• At least one hour</li> <li>• Increasing in length and frequency as family gets closer to reunification</li> </ul>	<ul style="list-style-type: none"> <li>• Overnight for reunification</li> <li>• Do not stop visits even if adoption is the final PP</li> <li>• Child’s needs guide frequency of visit for non-reunification</li> </ul>	<ul style="list-style-type: none"> <li>• Yearly letter to regular contact; will vary with developmental needs</li> <li>• Needs to be flexible over time</li> <li>• Weekly with siblings not placed together</li> </ul>
<ul style="list-style-type: none"> <li>• Location that allows high level of supervision for first visit, neutral location</li> <li>• In family home to allow for more assessment of family</li> </ul>	<ul style="list-style-type: none"> <li>• Birth family home whenever possible or home of relative or foster parents</li> <li>• Community locations</li> <li>• Agency office least desirable</li> </ul>	<ul style="list-style-type: none"> <li>• In homes whenever possible</li> <li>• Clinical setting if needed to help child or parent</li> </ul>	<ul style="list-style-type: none"> <li>• Child who will “age out of system”</li> <li>• Birth family home as he will probably visit after out of care.</li> </ul>
<ul style="list-style-type: none"> <li>• Activities that maintain relationships</li> <li>• Parents to talk to child to overcome fear of abandonment</li> <li>• Assessment of family</li> <li>• Expect reactions to visit</li> </ul>	<ul style="list-style-type: none"> <li>• Modeling/teaching of parenting skills</li> <li>• Observation of skill development</li> <li>• Reactions to visits should be decreasing</li> </ul>	<ul style="list-style-type: none"> <li>• Talk about final permanent plans with child</li> <li>• Reactions may occur due to upcoming changes; grief and loss about relationship changes</li> </ul>	<ul style="list-style-type: none"> <li>• Saying “good-bye” to people child will not see frequently</li> <li>• Discussing past and future relationships, rules for future contacts, reactions may occur</li> </ul>
<ul style="list-style-type: none"> <li>• Full supervision for first visits until parenting skills fully assessed and/or improve</li> <li>• Prevent pressure on child to recant</li> <li>• Allow some time alone unless there are safety concerns</li> </ul>	<ul style="list-style-type: none"> <li>• Decreasing level of supervision as parenting skills increase</li> <li>• Safety assessment should be considered in determining level of supervision</li> <li>• Level of supervision should be explained to all parties</li> </ul>	<ul style="list-style-type: none"> <li>• Unsupervised for reunification</li> <li>• Monitored or supervised visits for adoption/guardianship</li> </ul>	<ul style="list-style-type: none"> <li>• Child develop skills to recognize threat and have safety plan for future visits with family members</li> <li>• Support person there for “good-bye” visits</li> </ul>
<ul style="list-style-type: none"> <li>• Birth parent(s), siblings, other caregivers – first visits</li> <li>• Do not forget fathers and paternal family members</li> <li>• Extended family later</li> </ul>	<ul style="list-style-type: none"> <li>• All the people the child would live with if reunification occurs</li> <li>• Sibling even if the child will not live with him/her, extended family</li> <li>• Non-custodial parents</li> </ul>	<ul style="list-style-type: none"> <li>• Sibling and extended family visits occur for any PP</li> <li>• Birth parents unless judge orders no contact</li> </ul>	<ul style="list-style-type: none"> <li>• Birth parents, siblings, extended family, people child has emotional connection – adoption</li> <li>• Foster parents – if child is moving to another home</li> </ul>

<p>Time in Care <b>INITIAL PLACEMENT</b> <b>0 TO 2 MONTHS</b></p>	<p>Time in Care <b>REASONABLE EFFORTS</b> <b>2 TO 12 MONTHS</b></p>	<p>Time in Care <b>FINAL PERMANENCY</b> <b>DECISION: 12 – 15 MONTHS</b> <b>EPP: 9 – 12 MONTHS</b></p>	<p>Time in Care <b>POST PERMANENCY</b> <b>15 MONTHS TO ONGOING</b></p>
<ul style="list-style-type: none"> <li>• Bring child’s clothing, toys, school items – anything left behind</li> <li>• Bring family pictures to give child or other items to remind child of parents</li> <li>• Prepare parties for visit</li> </ul>	<ul style="list-style-type: none"> <li>• Caseworker should observe visit monthly or bi-monthly</li> <li>• Visitation activities connected to case plan</li> <li>• Family involved in planning visit</li> </ul>	<ul style="list-style-type: none"> <li>• Develop relationships between families</li> <li>• Help child with emotions related to potential moves</li> <li>• Change visit to meet final PP</li> <li>• Family involved in planning visit</li> </ul>	<ul style="list-style-type: none"> <li>• Pictures, family history, contact information, other material for Life Book of child</li> <li>• Families involved in planning ongoing visit process</li> </ul>
<ul style="list-style-type: none"> <li>• Worker make copies of pictures and other items brought to visit</li> <li>• Ask for family information</li> </ul>	<ul style="list-style-type: none"> <li>• Be very specific as to parents progress; strengths, and problems</li> <li>• Teach observers how to document visit</li> </ul>		<ul style="list-style-type: none"> <li>• Ensure case record has complete contact information so all parties can reach each other in future</li> </ul>



## Adolescent Case Scenario

### Social Services Intake Referral

DATE: TODAY

FAMILY NAME: BROWN

CHILD'S NAME: GREG SMITH

CHILD'S ADDRESS: 300 SMITH ROAD  
DENVER, CO

TELEPHONE: 987-6543

MOTHER'S NAME: JOANNA BROWN

FATHER'S NAME: DAVID BROWN

FAMILY MEMBERS:	NAME	AGE	SEX
Stepbrother	Mark	8	M
Sister	Stephanie	17	F
Brother	Greg	14	M

Referred by: Sharon White Probation Officer, Denver  
NAME RELATIONSHIP

Referral Information: PLEASE SEE ATTACHED REFERRAL FORM

## **Intake Report of Youth in Conflict**

Greg Smith has one adjudication for theft and one for assault on his stepfather. He has been on probation for one year. His probation officer is making a referral on behalf of the Court. The Court ordered Greg into an RTC placement, because he is not going to school on a regular basis, not abiding by the rules at home, does not consistently show up for his probation appointments, and his drug and alcohol use is increasing according to the UAs that have been administered. There is a Petition to Revoke or Modify Probation (PRMP) pending.

Ms. Brown has been divorced from Greg and Stephanie's father for 11 years. He lives out of town and has little contact with his children. The Brown's have been married for nine years. Greg began acting out when he was 12 but he's "always been difficult." At 12 years old, he began ditching school, hanging around with older boys in the neighborhood, and experimenting with drugs and alcohol. The school filed a Truancy Petition. Greg attended school on a regular basis, but failed most of his classes. He was tested in third grade and was placed in special education classes due to a diagnosis of a learning disability and ADHD. He currently refuses to take his medication, and the parents support the decision—they don't see the medication making any difference, and it is just an added expense.

Greg and his stepfather do not have a good relationship. Ms. Brown has a difficult time following through with consequences, so Mr. Brown tends to be the disciplinarian in the family. Punishment usually consists of loss of privileges and additional chores, but Greg usually does not follow through with the consequences. Instead, he responds to Mr. Brown's attempts to impose the consequences in a hostile and aggressive manner. As mentioned above, one incident ended in Greg assaulting Mr. Brown. Greg reports that Mr. Brown calls him "stupid" and has unreasonable expectations. Greg says that since Mr. Brown is not his real father, his rules do not have to be followed. Mr. Brown is concerned that Greg is setting a bad example for his younger brother, Mark. Mrs. Brown also believes Mark is learning poor behaviors and that someone in the family is going to get hurt.

The PO is concerned about the family's safety, Mr. and Mrs. Brown's parenting abilities, and Greg's continued drug and alcohol use. At the last Court hearing, Greg was ordered by the Court to be placed in a residential treatment center.



## Remember

- ❖ Objectives should address the behavior to be changed.
- ❖ Don't use words with multiple interpretations.
- ❖ Objectives are based on family assessment (NCFAS) and linked to risk factors.
- ❖ Time limited.
- ❖ All components are culturally relevant.
- ❖ Action steps are the specific actions required to complete the objective.
- ❖ Action steps specify a specific role and/or service provider.
- ❖ Action steps specify time frames.

## Measurement of Success

3. Write three questions that will engage the family to develop this case plan.

1.

2.

3.

4. Develop a visitation plan for the family (check your assigned plan).

- Kim and her parents
- Ricky with David and Yvette
- Yolanda with David and Yvette
- Sibling visitation
- Adolescent group: Greg and his parents

## The Purposes of Case Recording



## Characteristics of Good Case Recording



## **Aspects of Supervision**

### **Administrative Supervision**

### **Educational Supervision**

### **Supportive Supervision**

## Self Reflection

- ❖ What do you need most in supervision?
  
  
  
  
  
  
  
  
  
  
- ❖ How do learn best? Have you communicated this to your supervisor?
  
  
  
  
  
  
  
  
  
  
- ❖ How open are you to supervision and feedback? What are personal changes you could make to open up communication?
  
  
  
  
  
  
  
  
  
  
- ❖ What would the “ideal” relationship with your supervisor look like?





## **Six-Month Summary on Gordon/Williams Family**

Once it was determined that Yolanda and Ricky's placement with Emma and Ruby Williams would continue after Yvette's in-patient treatment, the home was licensed as a child-specific foster home. Kim remains in placement at the Brown foster home. Although she continues to gain weight, she is still having some feeding and respiratory problems. The permanency goal continues to be for all three children to go home.

Mr. Gordon and Ms. Williams have increased visitation with all three children, and Yvette has actively participated in meeting the medical needs of Kim. Mr. Gordon has been less involved in Kim's care, but does visit on a regular basis and spends more time holding and feeding Kim.

Mr. Gordon and Ms. William's relationship continues to be somewhat strained. He has moved into Ms. William's apartment and some difficulties have arisen out of this situation. Although she has remained drug free and has stopped associating with her "drug friends," he has not. He occasionally invites his "old" friends over to the apartment and admits to getting "high" on a few occasions. Ms. Williams sees this behavior as unsupportive, but feels helpless to do anything about it. The couple continues to have difficulty communicating with one another and resolving problems.

Ms. Williams is actively participating in her drug treatment, and her counselor feels she is very committed to staying clean. Mr. Gordon is also participating in his treatment, but not on a consistent basis. His commitment to sobriety is less evident.

Both Ms. Williams and Mr. Gordon have been involved in Ricky's Head Start program and are implementing their recommendations during visits.

## **Gordon/Williams Family Update**

Yolanda and Ricky were placed back at home as scheduled. The reunification went very smoothly. Five weeks later, Kim was also placed back at home.

Kim has now been home for four months. You have been having regular contact with the family, as well as regular contact with all treatment providers. All treatment providers report that the family has done extremely well. The only ongoing treatment is support groups at the Drug Treatment Facility for both of the parents. The children appear healthy and happy. Mr. Gordon and Ms. Williams have followed through with all treatment recommendations and feel that if any problems come up in the future, they have sufficient support systems and resources to handle them before they get to the point they did before. Both continue to be drug free.

A court hearing is scheduled in three weeks, and you need to decide if the case should be closed or remain open for continued services.