Module 5:
Out-of-Home Care

Florida Department of Children and Families
June 2016
Module 5:
Out-of-Home Care

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Time: 1 ½ days

Purpose: This module provides an overview of Case Manager’s responsibilities when children are placed out of the home.

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Agenda: Unit 5.1: Placement Considerations
Unit 5.2: Meeting Children’s Needs in Out-of-Home Care
Unit 5.3: Family Visitation and Maintaining Connections
Unit 5.4: Transitions and Achieving Permanency

Materials: • Trainer’s Guide (TG)
• Participant’s Guide (PG)
• PowerPoint slide deck
• Flip chart paper and markers
• Videos:
  o “Nightline” Video https://www.youtube.com/watch?v=NGTvjn-hb4Y
  o Transracial Adoptions
  o Transitions
    ▪ http://centervideo.forest.usf.edu/qpi/bettertransition/bettertransition.html
  o Adult who grew up in Foster Care
    ▪ https://youtube.com/watch?v=YLb_jFPN1ks
  o Partnership Plan For Children in Out-of-Home Care: Training Module 2 video
    ▪ http://centervideo.forest.usf.edu/qpi/pship02/pship02.html
  o Transitioning from Foster Care to Adulthood
    ▪ https://www.youtube.com/watch?v=f4Vw0HS4seM
• ARM:
  o ARM: 9-10, Dependency Case Management Flowchart
  o ARM: 11, Dependency Hearing Map
• Handouts needing to be printed:
  o Blank Other Parent Home Assessment Form
  o Optional: “Locating and Recovering Missing Children” form

References:

Links:
• Florida Statute:
  http://centerforchildwelfare.fmhi.usf.edu/flstat/FloridaStatues.shtml
• Florida Administrative Code:
  http://centerforchildwelfare.fmhi.usf.edu/HorizontalTab/FloridaAdminCode.shtml#
• Operating Procedures/Practice Guidelines:
  http://centerforchildwelfare.fmhi.usf.edu/HorizontalTab/DeptOperatingProcedures.shtml

References:

Unit 5.1
• Section 39.523, F.S., Placement in Residential Group Care
• 65C-43.003. F.A.C., Criteria for Certification of Safe Foster Homes and Safe Houses
• 65C-28.012, F.A.C., Home Studies
• Section 39.0138, F.S., Criminal History Checks
• 65C-28.011, F.A.C., Criminal History
• CFOP 170-7, Chapter 5, Other Parent Home Assessment
• CFOP 175-79 and 65C-28.008, F.A.C., Relative Caregiver Program
• CFOP 175-11, Non-Relative Caregiver Program
• CF-FSP 5323 and CFOP 175-36, Appendix A, Verification of ICWA Eligibility

Unit 5.2
• 65C-28.014, F.A.C., Behavioral Health Services
• 65C-35.001(18), F.A.C., Psychotropic Medications
• 65C-35.001(10), F.A.C., Informed Consent
• 65C-35.003, F.A.C., Efforts for Informed Consent
• CFOP 155-10/175-40, Chapter 3-5, Parent/Guardian Involvement
• Section 39.407, (1)-(3), F.S., Requirements for Administration of Psychotropic Medication
• CFOP 155-10/175-40, Chapter 3-4a, Medical Report
• H.R. 6893- Fostering Connections to Success and Increasing Adoptions Act of 2008
• 20 U.S.C. §1400, Individuals with Disabilities Education Act
• Section 38.0016, F.S., Education for Children in Out-of-Home Care
• Section 39.0016 (1) (c ), F.S., Surrogate Parent
• 65C-30.001 (24), F.A.C., Child Resource Record
• 65C-30.011 (4), F.A.C., Child Resource Record
• CFOP 155-10/175-40, Chapter 1-6, Child Resource Record
• 65C-30.019, F.A.C., Missing Children
• Recovering and Locating Missing Children Form

Unit 5.3
• Section 39.402 (9), F.S., Establishing Visitation at Shelter Hearing
• Section 39.4085 (16), F.S., Goals for Dependent Children
• Section 39.6012 (3)(b), F.S., Case Plan Tasks
• 65C-30.007 (6)(f)2, F.A.C., Documentation of Visitation During Face to Face Contacts
• 65C-28.002, F.A.C., Family Time
• CFOP 170-7, Chapter 10, Establishing Family Time/Visitation Plan
• CFOP 170-1, Chapter 2-11, Family Time/Family Visitation
• Section 39.0139, Keeping Children Safe Act
• H.R. 6893- Fostering Connections to Success and Increasing Adoptions Act of 2008
• Section 39.509, F.S., Grandparent Visitation
Unit 5.4
- 65C-28.017, F.A.C., Exit Interviews
- 65C-30.001 (84), F.A.C., Definition of Permanency
- Section 39. 6221, F.S., Permanent Guardianship
- Section 39.6231, F.S., Placement With A Fit and Willing Relative
- Section 39.6241, F.S., Another Planned Permanent Living Arrangement
- 65C-30.004, F.A.C., Post-Placement Supervision and Services
- CFOP 170-7 , Chapter 12, Implement Reunification and Post-Placement Supervision
- 65C-16.009, F.A.C., Adoption Placement
- Section 39.6035, F.S., Transition Plan
- 65C-41.004, F.A.C., Transition and Case Plans
- 65C-42.002, F.A.C., Postsecondary Education Services and Support

Activities:

Unit 5.1:
- Activity B: Assessing During the Unified Home Study – TG: 23, PG: 15
- Activity C: MEPA and Identity within Transracial Adoptions – TG: 37, PG: 19

Unit 5.2:
- Activity E: Understanding the Medical Report – TG: 58, PG: 31

Unit 5.3:
- Activity F: Family Time – TG: 86, PG: 40

Unit 5.4:
- Activity I: Transitions – TG: 104, PG: 54

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Unit 5.1: Placement Considerations (Out-of-Home Care)

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Unit Overview: The purpose of this unit is to provide basic information on how to make placement decisions for children who are in Out-of-Home Care.

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Learning Objectives

1. Explain case management’s role in removals and explain the difference between “emergency” and “planned” placement of children.
2. Discuss the principles to follow and the complex issues that may exist when considering placement.
3. Explain the requirements for a unified home study.
4. Identify the basic requirements of federal laws affecting placement and the Case Manager’s responsibility for ensuring compliance.

References:

- Section 39.523, F.S., Placement in Residential Group Care
- 65C-43.003. F.A.C., Criteria for Certification of Safe Foster Homes and Safe Houses
- 65C-28.012, F.A.C., Home Studies
- Section 39.0138, F.S., Criminal History Checks
- 65C-28.011, F.A.C., Criminal History
- CFOP 170-7, Chapter 5, Other Parent Home Assessment
- CFOP 175-79 and 65C-28.008, F.A.C., Relative Caregiver Program
Learning Objectives:

1. Explain case management’s role in removals and explain the difference between “emergency” and “planned” placement of children.
2. Discuss the principles to follow and the complex issues that may exist when considering placement.
3. Explain the requirements for a Unified Home Study.
4. Identify the basic requirements of federal laws affecting placement and the Case Manager’s responsibility for ensuring compliance.

Case Management’s Role in Removals and Placement

In Module 3 we discussed the role of Case Managers in safety management after case transfer. Removal is a function of Child Protective Investigators and not Case Managers; however, there are situations when Case Managers will need to be involved in a removal, and subsequently, finding a placement for a child.

Endorse:

When would a Case Manager be involved in a removal?

When the case is open to services and when an In-Home Safety Plan needs to be modified to an Out-of-Home Safety Plan; when at least one of the 5 safety analysis questions changes from a yes to a no.

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Case Managers are responsible for the vigorous ongoing monitoring and management of the Safety Plan. After assessing the Safety Analysis criteria for an
in home Safety Plan, an Out-of-Home Safety Plan must be created when there is a determination made that an In-Home Safety Plan can no longer adequately control or manage the danger threat. To put it very simply, this means one or more of your 5 safety analysis questions change from a “yes” to a “no.” In this situation, the Case Manager will need to immediately discuss the circumstances with their Supervisor, CLS, and a CPI, as Case Managers do not have the authority to remove children. The only time when a Case Manager can remove the child is when there are situations in which a child may be in immediate or life threatening danger. In this instance, the Case Manager may remove the child from the dangerous situation until a CPI or Law Enforcement Officer takes physical custody of the child.

**If a removal is necessary, who is responsible for physically removing the child?**

**Endorse:**

CPI

There are two types of placement; emergency and planned. In an emergency situation, like the need to shelter a child immediately, a child needs a placement as soon as possible. This type of placement is called an “emergency placement.” Most often, the CPI will take responsibility of an emergency placement, but if the emergency placement exists on an open case, the responsibility then becomes that of the Case Manager’s. In most cases, the CPI and the Case Manager will partner together to ensure the child is placed in the most appropriate placement. When this occurs, the Case Manager may place a child in a non-licensed emergency placement without having a completed and approved Home Study prior to the placement; however, emergency background checks would need to be completed prior to the child entering the home. The Home Study then would be completed as soon as possible after the child is in the home.

Another instance that may lead to a need for placement which is not immediate in nature is called a “planned placement.” An example is when a child has disrupted a placement or a relative has been located and is interested in keeping the child. In these examples a “planned placement” will be initiated and the most appropriate placement setting will be acquired. Planned placements are the responsibility of the Case Manager and unlike an emergency placement require the completion of the Home Study and background checks prior to placement of the child in the selected setting.
When considering where to place a child, there are a number of factors that need to be taken into consideration. We will discuss those now.

**Choosing the Best Placement**

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**What are some of the things that you want to consider when choosing an appropriate out-of-home placement for a child?**

**Endorse:**
- Should be based on sound information about the social, emotional, behavioral, mental health, cultural and educational needs of the child.
- Should consider established connections and relationships the child has including family and non-biological relationships, sibling relationships, friend relationships, religious identity, cultural heritage, and community connections.

**What are some of the things that you want to consider when choosing an appropriate out-of-home placement for a child?**

**Endorse:**
- Placement disruption, increased trauma, lost attachments, child’s needs not being met.
There are three “Principles to follow” when considering placement. When utilized, these principles can help assure that the most appropriate placement will be chosen for each child, minimizing stress and subsequent trauma. These principles are:

Meets the child’s individual needs:
- Children's physical, medical, developmental, educational, behavioral, mental health and emotional needs should be carefully assessed prior to choosing the placement.
- Information needs to be provided to the caregivers prior to placement to ensure they are aware and have the capacity to provide for all of the child’s needs.

Placement must be in the least restrictive, most homelike setting.
- Children should be placed with caregivers they are familiar with, when available and appropriate. This could be relatives or non-relatives (close family friends, neighbors, church members, etc.). They should be as close to their home as possible.
- There should be efforts to place children in settings which match their cultural beliefs and religious practices, and within close proximity to their current school/daycare.
- If a setting is not available that matches the child’s beliefs and culture, or is not in close proximity to their home and school, this should not impact the decision to place the child out of the home if an Out-of-Home Safety Plan is necessary.
Minimize Moves:
- Matching the child with the best possible placement option which can meet all of the child’s needs should minimize the number of moves a child may make while in Out-of-Home Care. This will reduce trauma to the child associated with having to change homes and caregivers.

While the principles of meeting the child’s individualized needs and minimizing moves may be quite easy to understand, let’s take a closer look at what is meant by “least” to “most restrictive” placements as improper placements greatly increase the likelihood of placement disruption and trauma to the child.

**Least to Most Restrictive Placements**

*Display Slide 5.1.6 (PG: 8)*

When discussing placements, you will frequently hear the terms “least restrictive” or “most restrictive.” When considering a placement, you need to evaluate a child’s needs and the level of care they require. Children deserve to be in the least restrictive placement; in other words the most family-like setting available to keep them safe and provide them with appropriate care.

Types of Out-of-Home Placements, from least restrictive to most restrictive:
- Non-custodial parents.
- Relatives.
- Non-relatives which include family friends, neighbors, close church members.
- Family foster home which is a licensed family-like placement setting.
- Residential group care which is a placement in a licensed group home setting.
• Medical foster care.
• Therapeutic foster care/therapeutic group care.
• Residential treatment facility which may include residential substance abuse or mental health treatment centers and in most cases is a lock down facility.

Complex Placement Issues

What do you think are some considerations that can complicate finding an appropriate placement?

Endorse:
Big sibling groups, behavior problems, medical problems, disabilities, sexual perpetrators, running away.

Display Slide 5.1.7 *(PG: 9)*

Children with complex medical issues may need to be placed in Medical Foster Care. A Medical Foster Parent receives additional training in order to be able to care for a medically complex child. The Medical Foster program also has social worker staff that provides 24 hour/day oversight and case management services to the children and families. Each program has a Medical Director who reviews each child’s medical needs in the program and provides medical direction to staff and families. In addition, each child has a Primary Care Physician and in most cases, several medical specialists assigned to the child. A child must have a Children’s Multidisciplinary Assessment Team (CMAT) staffing prior to the placement, and must have staffings every 90 days to continue eligibility.
Children with significant mental health or behavioral problems may be difficult to place. They may need specialized treatment and a more restrictive placement, such as a therapeutic foster home, therapeutic group care, or placement in a State Inpatient Psychiatric Program (SIPP). Placement in a SIPP requires an evaluation by a qualified assessor and court authorization (F.S. 39.523). The length of time a child can spend in a SIPP or a therapeutic foster home varies, depending on the child’s needs, their treatment plan, and how the child is responding to treatment.

Victims or perpetrators of sexual abuse may require special placement considerations. They will require a placement agreement that may indicate that the child cannot be placed with other children, or cannot be placed with younger children, or has to have an alarm on their bedroom door.

Children who have been identified as victims of Human Trafficking may be placed in Commercial Sexual Exploitation of Children (CSEC) placements. Young adults who have been identified as potential Human Trafficking victims need to be assessed using the Human Trafficking Screening Tool to determine if they have been involved. CSEC placements are specialized in the behavior and treatment of victims of Human Trafficking and must meet specific certification requirements (F.A.C. 65C-43.003).

Children who are members of sibling groups present placement challenges, because it can be difficult to find a home that will accommodate all of the children. There are times that a placement exception will need to be requested so that a foster home can accommodate more than the five (5) maximum children that they can house in a foster home.

Children with serious disabilities may be placed in a home that provides services from the Agency for Persons with Disabilities (APD). When a child has a specific physical or intellectual disability such as autism, cognitive delays, cerebral palsy, etc., they may qualify for services from APD. APD has group homes for children with these disabilities and other qualifying disabilities.

Remember, we want to place children in the least restrictive, most family-like setting possible for their best interest and safety.
How can you determine ongoing if the placement is appropriate and the child is safe?

**Endorse:**
Face-to-face contact, home visits, observations of the child’s living space and the home, private interviews with the child, communication with the foster parent, and communication with service providers.

**Activity A: Assessing for an Appropriate Placement**

*Display Slide 5.1.8 ([PG: 10])*

- **Time:** 20 minutes
- **Purpose:** Participants will assess factors that can complicate finding an appropriate placement.
- **Materials:**
  - *PG: 10-11, Assessing for an Appropriate Placement worksheet*
  - *Flip chart and markers*
- **Trainer Instructions:**
  - *Split participants into no more than 4 groups.*
  - *Provide each group with a scenario. Have each group identify the factors that they would assess in determining the most appropriate placement.*
  - *Have them write on the flip chart paper their answers and review with the group.*
  - *For each scenario, ask the class what type of factors they identified and what placement might be an appropriate for each child?*
Activity | Instructions: 
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1. In small groups, read your assigned scenario.
2. Identify the significant information that you would utilize to find the most appropriate placement.
3. Write your list on flip chart paper.
4. Be prepared to share with the class.

Scenarios: Trainer Version

**Child 1- Heather**
Heather is a 15-year-old African-American female. She was removed from her mother when she was 4 and placed with her great grandmother due to physical and sexual abuse. Her mother was a severe substance abuse addict and a prostitute. She has been removed from her great grandmother due to her inability to care for the child anymore. Heather’s behavior has gotten out of control. She is no longer attending school, using marijuana, does not come home during her curfew. She has gone through several foster homes and she runs away, sometimes for months at a time. She has been diagnosed with several STD’s and she always seems to have money. A few times, she has been located at hotels. She is verbally aggressive, and does not trust anyone in the system. Most of her relatives have criminal histories that keep the Department from placing with them, and some of them have even helped her run away and allowed her to have sex with older men in their home.
*Answers: possible victim of human trafficking, drug abuse, several placement disruptions, runaway, trauma history*
*Potential placement: evaluate for a CSEC placement, potentially a family foster home*

**Child 2- Bryan**
Bryan is a 2-day-old white male. He was born with methamphetamine in his system. His mother has lost custody of two other children due to her drinking and abusing drugs while pregnant. He is having withdrawal symptoms, and there are concerns that the substance abuse may affect his development. Bryan’s mother was HIV positive. He will need to begin a complicated medication regimen and will need to go to see specialists on a regular basis for the first 6 months of his life.
*Answers: newborn, born drug exposed, potential complex medical issues, potential developmental issues.*
*Potential placement: if no relatives available, medical foster home*

**Child 3- Lynette**
Lynette is a 7-year-old white female. She was removed from her parents due to domestic violence and substance abuse. The father has hit, choked and punched the mother in front of Lynette so severely that the mother had to go to the hospital. Both parents have used crack cocaine and ecstasy in Lynette’s presence and have been so intoxicated that Lynette would have to go without meals because there would be no one to make her food. Lynette is physically aggressive with children at school and is in an ESE class due to her ADHD and a speech delay. She is reading below her grade level. She is on medication for her ADHD.
*Answers: history of trauma (DV and substance exposure), behavioral issues, mental health diagnosis, on medication, academically delayed*
*Potential placement: if no relatives available, a family foster home or therapeutic group home*

**Child 4- Darius**
Darius is a 16-year-old African-American Male. The Department sheltered him when his parents refused
to take custody of him after being released from the juvenile detention center. He has no relatives who are willing or able to cope with his behavioral issues because he is defiant and violent. He has gotten into physical altercations with his parents and siblings. When he was 13, he inappropriately touched his 7-year-old sister on her genitals and has been suspended from school three times for exposing himself to classmates. He is highly intelligent and does well in school academically and is involved in extracurricular activities. He is currently on probation for the recent altercation between himself and his parents that resulted in his detention.

*Answers: teenager, physically aggressive, juvenile sexual behavior, DJJ involvement*

*Potential placement: a family foster home or group home*

### Activity STOP

Relatives are the least restrictive placement option if a non-custodial parent is not involved. However, before placing a child with a relative or non-relative, the Case Manager will need to complete a comprehensive assessment of the potential caregiver. This is known as the Unified Home Study.

#### Unified Home Study

*(PG: 12)*

*If your child or a child you knew was being placed with a relative or non-relative, what would you want to know about that person?*

*Endorse:*

Are they safe, do they have a concerning criminal history, can they afford to care for the child, do they seem invested in caring for the child, do they know the child’s needs, do they have enough room, etc.

When children are removed and are placed into adoptive placements, a Unified Home Study will need to be completed. The Unified Home Study is an assessment of a potential caregiver for placement of a child. The Unified Home Study is completed for all relative and non-relatives, licensed placements, adoptive placement, and for ICPC Home Study requests. Case Managers do not need to complete home studies on licensed placements; those are completed during the licensing process. Home studies are different for placement with a non-custodial parent and will be addressed later in this unit.

The Home Study must be reviewed and approved by your supervisor and given to CLS prior to court; the judge approves or denies placement based upon the Home Study and background checks. The exception to this is an emergency placement. Emergency background checks are conducted, and child may be placed under
emergency circumstances in a home without a Home Study, but the Home Study must be completed as soon as possible after the child is in the home.

Home studies still need to be completed and approved for constructive removals. A constructive removal occurs when a parent leaves a child with a relative, and an intake is received on the child. As a result, the child is "removed" from the parent (by filing a Shelter Petition) and left in the care of the same relative in the same home they were found.

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There are two components of the Unified Home Study. The first is the assessment of the physical condition of the home, the financial ability of the caretakers, and an evaluation of their capacity to care for and protect the child. The other component is the background check, which examines the criminal and abuse history of members of the home and others who are frequently in the home. We will explore background checks in more detail first.

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The purpose of the background check is to ensure that the individuals caring for the child or frequently around the child are safe. Background checks have several important parts, and all must be completed. You will need to gather demographic information (full name, date of birth, social security number, place of birth) in order to complete these checks.

- An abuse history check needs to be completed for all household members and frequent visitors. If a person is named in a report, that report should not be used to deny placement unless that person has been named as the person responsible for abuse or neglect.
- If any individual in the home indicates that they have resided in another state, you will need to attempt to gather information about abuse/neglect history from the other state.
- Any household members and frequent visitors age 12 or older will have to have a local, state and juvenile delinquency records check.
- All household members age 18 and over will be required to submit fingerprints to complete a national history check. If a child is already in a home, fingerprints are required to be completed within 10 days of the placement.

What types of criminal history, or what kind of abuse or neglect history do you think are concerning? Do you think there is any acceptable criminal history?

**Trainer Note:** There is no “right” or “wrong” answer. This question sets up participants for the next section. This will give you an idea of what participants may think about what having criminal history means and if there is any bias present that may need to be addressed.

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There are specific felony offenses that, if found during a background check, will automatically disqualify placement in that home.

There is no time limit on the following felony offenses:
- Murder, sexual battery, or other felony involving violence.
- Child abuse, abandonment, or neglect.
- Spousal abuse.
- Crimes against children including child pornography, lewd and lascivious behavior and statutory rape.

If the following felony offenses were committed and a conviction was completed within the last 5 years:
- Aggravated assault.
- Aggravated battery.
- Drug related charges.
- Possession of chemicals with the intent to manufacture controlled substances.

**Trainer Note:** Felonies and misdemeanors are two classifications of crimes used in most states, with petty offenses being the third. Misdemeanors are punishable by more substantial fines and sometimes jail time, usually less than one year. Felonies are the most serious type of crime and are often classified by degrees, with a first degree felony being the most serious. Felonies are punishable by substantial fines and prison sentences in excess of one year.


Also note to participants that these disqualifying offenses do not pertain to the child’s parents.

If a child is already in relative’s home and any disqualifying felony convictions are found, you should notify your Supervisor and CLS immediately, and the child must be immediately removed. The court will need to be advised without delay of the results regarding the criminal history, removal and disqualification (F.A.C. 65C-28.011).

It is important to note that failure to complete a full background check could put a child’s safety at risk and could result in immediate removal of the child from that home (depending on the charges) after they have already adjusted, resulting in unnecessary trauma to the child. It is imperative to ensure that you have completed all necessary steps before a child is placed in a home.
Background checks are only one part of the Home Study process. As mentioned earlier, the other component of the Home Study is assessing the physical home, and the caregiver’s ability and willingness to provide for all of the child’s needs and safety.

**Why would it be important to assess the physical condition of the home?**

**Endorse:**
Ensure no physical hazards are present, child has an appropriate place to sleep, home is physically sound, has appropriate baby-proofing and to assess if there are any dangers in the home that need to be addressed.

*Display Slide 5.1.12 (PG: 13)*

When we are examining the physical condition of the home, we want to make sure we are placing a child in a home that is safe and free of hazards. Some things you will be examining when you are at the home include:

- Is there an appropriate sleeping arrangement for the child? Is there a bed for the child? Will they be sharing a room with another child?
- Are there physical hazards in the home such as excessive garbage, exposed wires, cleaning agents in reach of young children, urine and feces, etc.? Any broken windows, missing doors?
- Are there physical hazards outside of the home such as excessive garbage, tools or other things a child could injure themselves on? A pool the child could have unrestricted access to?
- If the placement is of a very young child, is the home baby-proofed appropriately?
- Are there appropriate security measures in the home? Fire alarms? Locks...
on the doors?

Is there anything else you think would be important in assessing the physical condition of the home and if it is safe and appropriate for the child?

Endorse:
Check to see if they have food or baby supplies, if warranted. If they have pets, are the pets taken care of or dangerous, etc. Redirect class if their responses become too subjective (if house is dusty, if they have dishes in the sink, can’t place child if there is a dog, etc.)

In addition to evaluating the physical condition of the home, Case Managers are required to assess the caregiver’s ability to care and protect the child.

Display Slide 5.1.13 (PG: 14)

Trainer Note: Please note, when we are referring to “protective capacities”, these are different from the Caregiver Protective Capacities that you assess for parents to complete your FFA-Ongoing and progress updates.

Here are some important factors that you will be exploring when assessing the caregivers ability to keep the child safe and to care for the child’s needs:

- Are they able to financially care for the child without causing a substantial hardship? You will need to collect their income information as well as their monthly expenses.
- Are they aligned with the child? Do they believe the child is unsafe and requires protection, or do they think the child is not telling the truth or the situation is not as bad as the Department makes it?
• Do they understand the child’s specific physical, educational, emotional needs? Are they willing to ensure the child gets services they need?
• Are they willing to work cooperatively with the family, to facilitate visitation and family time?

Display Slide 5.1.14 \textit{(PG: 14)}

Before you submit your Home Study for approval to your supervisor, there are several attachments that you may need to include:

• **The Acknowledgement of Firearms Safety Requirements** - Florida law prohibits Case Managers or other agents of the Department from asking about or documenting the possession of firearms and their owners. The Law also requires that anyone who owns a firearm must keep it secure from any minor who could gain access to it without lawful permission. This form should be reviewed with the caregivers so they know their responsibilities if they have a firearm in the home. Even if a caregiver voluntarily provides information about having a firearm, you cannot document it.

• **Water Addendum** - This is reviewed with the caregiver to understand water safety, such as securing a pool and supervising children in and around bodies of water.

• **Sudden Infant Death Syndrome (SIDS)** - This is reviewed with caregivers who are having a child placed with them under the age of 1. It outlines safe sleeping procedures such as having an infant sleep on their back, keeping the crib clear of hazards, and other factors that can reduce the risk of SIDS.

• **Photos of the Home** - You may be required to take photos of the inside and outside of the home to demonstrate that the placement is/is not appropriate based on your assessment of the living environment.
- **Sex Offender Neighborhood Search** - You may need to attach a copy of your FDLE Sexual Offender Neighborhood Search to show the caregiver and parties of the case so they can take appropriate precautionary measures.

- **Financial Documentation** - You may also be required to attach documentation of household expenses as well as proof of income.

**Trainer Note:** Review with participants any agency requirements for the Unified Home Study.

**Activity B: Assessing During the Unified Home Study**

*Display Slide 5.1.15 (PG: 15)*

- **Time:** 20 minutes
- **Purpose:** Participants will learn how to obtain necessary information during the interview portion of the Unified Home Study.
- **Materials:**
  - **Handout:** Blank Unified Home Study, section 3
  - **PG: 15, Assessing During the Unified Home Study worksheet**
- **Trainer Instructions:**
  - **Break into groups of 3 or 4.**
  - **Assign each group a set of items from section 3 of the Unified Home Study.**
  - **Ask each group to develop questions or statements that would help them assess each item.**
  - **Have each group share their results and discuss with the whole class.**
<table>
<thead>
<tr>
<th>Activity</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Review the blank Unified Home Study.</td>
</tr>
<tr>
<td></td>
<td>2. Identify ways to collect the information needed for each item.</td>
</tr>
<tr>
<td></td>
<td>3. Be prepared to share with the class.</td>
</tr>
</tbody>
</table>
## Unified Home Study Assessment Prompts

### Section III. ASSESSMENT and HOME STUDY

The purpose of this section is to assess the caregiver’s ability to provide a safe and nurturing environment. For children placed in Out-of-Home care, also in accordance with licensing requirements and the "Partnership Plan."

<table>
<thead>
<tr>
<th>Prompt</th>
<th>Answer Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain how any current or past experiences with child abuse or neglect, alcohol and/or substance abuse, alcohol and/or substance abuse treatment or domestic violence may impede the caregiver(s) ability to meet the expectations set out in the “Partnership Plan” in caring for a child.</td>
<td>Document the factors and explain for each individual.</td>
</tr>
<tr>
<td></td>
<td>Have you ever had treatment for substance abuse? Has anyone close to you ever questioned your use of alcohol or other substances? Have you been the victim of child abuse or neglect or domestic violence? Have you ever had counseling or other interventions for domestic violence, child abuse or neglect?</td>
</tr>
<tr>
<td>2. Explain how any health or mental health conditions, including medication(s), may interfere with the caregiver(s) ability to meet the expectations set out in the “Partnership Plan.”</td>
<td>Document for each individual, including the medication.</td>
</tr>
<tr>
<td></td>
<td>Have you ever had treatment for health, mental health, or substance abuse issues? Has your health, mental health, or substance abuse ever affected your personal relationships? Are you currently on medications for any of these conditions?</td>
</tr>
<tr>
<td>3. How is the caregiver(s) able to participate in a professional team supporting the child by:</td>
<td>Document details and examples for each individual.</td>
</tr>
<tr>
<td>a) sharing necessary information with other professionals on the team and maintaining the confidentiality of the child and caregiver as required by law, regulation and professional ethics; and</td>
<td>Are you aware of confidentiality requirements?</td>
</tr>
<tr>
<td>b) participating in planning activities, court hearings, staffings and other key meetings?</td>
<td>The foster care team sometimes involves a lot of people and steps. Are you dedicated to the best outcome for the child, no matter how many people become involved in the process? What are your strengths/weaknesses in communicating with others?</td>
</tr>
</tbody>
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**UHS User Guide_A_22_2013**
### Unified Home Study Assessment Prompts

<p>| | |</p>
<table>
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</table>
| 4. | Explain how the caregiver(s) are willing and able to make a loving commitment to the child(ren)'s safety and well-being by:  
  a) providing appropriate supervision and positive methods of discipline;  
  b) encouraging the child in his/her strengths and respecting the child's individuality and likes and dislikes;  
  c) maintaining awareness of the impact of trauma on behavior  
  d) involving the child in family and community activities by providing transportation to school, child care, extracurricular activities, etc.;  
  e) ensuring the child's safety by employing appropriate physical safety measures, including in the household, for transportation, and with pets. |
|   | Document details and examples for each individual.  
  Do you know what trauma-informed care means? (Explain)  
  Do you know what “normalcy” means when talking about children in out-of-home care?  
  How can you help maintain “normalcy” for this child?  
  Do you have any pet issues in the house?  
  What are some activities you plan to do with your child(ren)? |
| 5. | Explain how the caregiver(s) are willing and able to:  
  a) respect and honor any child's culture, religion and ethnicity.  
  b) meet any child's special, physical or psychological needs.  
  c) adapt to and support any child's individual situation, including sexual orientation and family relationships.  
   If the caregiving family's religion, culture, or other factors will impair their ability to meet the needs of certain children, please explain what the family's limitations are, and how limitations could impact children placed in their home. |
|   | Document details and examples for each individual.  
  Have you ever been treated differently because of your cultural or religious beliefs?  
  How will you help a child preserve connections to cultural and ethnic ties?  
  How would you treat a child of a different sexual orientation than you? |
| 6. | Explain how the caregiver(s) are willing and able to commit to maintaining any child they accept in their home until such time as it is in the child's best interest to leave the home. Explain any problems a long-term |
|   | Document details and examples for each individual.  
  How will you feel if a child is placed for a very short time?  
  Are you prepared to parent any child indefinitely? |
<table>
<thead>
<tr>
<th>Unified Home Study Assessment Prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td>commitment may present for the caregiver.</td>
</tr>
<tr>
<td>Document details and examples for each individual.</td>
</tr>
<tr>
<td>What if a child tries to run away?</td>
</tr>
<tr>
<td>Have you ever dealt with a child who has behavioral challenges?</td>
</tr>
<tr>
<td>7. Explain how the caregiver(s) will address challenges in caring for a child, including available supports and resources. These challenges may include fire setting, sexual reactive behaviors, mental health, substance abuse, reactive attachment behaviors, etc and may potentially require a safety plan.</td>
</tr>
<tr>
<td>Document details and examples for each individual.</td>
</tr>
<tr>
<td>Do you have any children who are grown and have left home?</td>
</tr>
<tr>
<td>What will your response be if the child is reunified with parents who do not want you to have any contact?</td>
</tr>
<tr>
<td>Will you feel comfortable advocating for the child even after he/she has left your home?</td>
</tr>
<tr>
<td>8. Explain how the caregiver(s) are willing and able, in appropriate circumstances, to participate in transition planning for any child, and to maintaining a relationship with any child after he or she leaves the home.</td>
</tr>
<tr>
<td>Document details and examples for each individual.</td>
</tr>
<tr>
<td>What do you think would be most important in working with/mentoring biological parents?</td>
</tr>
<tr>
<td>What is something you feel you do really well (parenting)? Do you think you could teach that skill to someone else?</td>
</tr>
<tr>
<td>9. Explain how the caregiver(s) are willing and able to assist the biological caregiver(s) in improving their ability to care for and protect their children and to provide continuity for the child after reunification.</td>
</tr>
<tr>
<td>Document details and examples for each individual.</td>
</tr>
<tr>
<td>Can you maintain an accepting attitude, even when you know family members may have mistreated the child in your care?</td>
</tr>
<tr>
<td>What will you do if a child in your care does not want to visit or communicate with family members?</td>
</tr>
<tr>
<td>10. Explain how the caregiver(s) are willing and able to assist any child in family time/visitation and other forms of communication with family members, when appropriate.</td>
</tr>
</tbody>
</table>
### Unified Home Study Assessment Prompts

<table>
<thead>
<tr>
<th>11. Explain how the caregiver(s) will:</th>
<th>Document details and examples for each individual.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) maintain records that are important to any child's</td>
<td>Do you think you are organized?</td>
</tr>
<tr>
<td>well-being including child resources records, medical</td>
<td>If you have your own children, how do you keep track of their vital records?</td>
</tr>
<tr>
<td>records, school records, photographs, and records</td>
<td>Do you have any questions about confidentiality requirements?</td>
</tr>
<tr>
<td>of special events and achievements.</td>
<td></td>
</tr>
<tr>
<td>b) ensure that these records are made available to</td>
<td></td>
</tr>
<tr>
<td>other partners in the child welfare system and to the</td>
<td></td>
</tr>
<tr>
<td>child and family, as appropriate.</td>
<td></td>
</tr>
</tbody>
</table>

| 12. Explain how the caregiver(s) are willing and able to | Document details and examples for each individual. |
| advocate for children in their care, as needed, with the |                                                   |
| child welfare system, the court, and community agencies,  |                                                   |
| including schools, child care, health and mental health  |                                                   |
| providers, and employers. Describe previous parenting    |                                                   |
| experience, if applicable.                               |                                                   |
|                                                          | Have you ever had to advocate on your child’s behalf with a teacher, doctor, or other |
|                                                          | professional in charge? Describe the situation and how you worked to help resolve it. |
|                                                          | How would you respond if a case manager made a decision for the child in your care, and |
|                                                          | you did not agree?                               |

| 13. Explain how the caregiver(s) are willing and able to | Document details and examples for each individual. |
| participate fully in any child’s medical, psychological  |                                                   |
| and dental care, including providing transportation to/from, |                                                   |
| attending appointments and communicating with professionals. |                                                   |
|                                                          | What if a child you care for has extensive medical needs? |
|                                                          | Are you willing to train to become a medical foster parent? (Give details.) |
|                                                          | Have you had any problems with transportation in the past six months? |
Unified Home Study Assessment Prompts

14. Explain how the caregiver(s) are willing and able to support any child's school success by:
   a) participating in school activities and meetings, including disciplinary and/or IEP (Individualized Education Plan) meetings.
   b) assisting with school assignments, supporting tutoring programs, meeting with teachers and working with an Educational Surrogate, if one has been appointed, and encouraging any child's participation in extra-curricular activities.
   c) (for any child who has a disability, or is suspected of having a disability) attending Educational Surrogate Parent training, if needed or recommended by the court, and thereafter advocate for the child(ren) in the school system.
   d) maintaining any child(ren) in the school of origin, if it is in the child(ren)'s best interest to do so.
   e) maintaining any child(ren) in the school of origin until an appropriate grading break in the academic year, if not possible or not in the child(ren)'s best interest to remain in the school of origin for the remainder of the school year.

Document details and examples for each individual.

If a child in your care is struggling with reading, how would you partner with the teacher and school to help him/her?

What do you think an appropriate homework routine would be:
   - For an elementary student?
   - For a middle school student?
   - For a high school student?
Other Parent Home Assessment  
*(PG: 16)*

Before we conclude this section on home studies, we will review the Other Parent Home Assessment. The Other Parent Home Assessment (OPHA) provides formal assessment and documentation as to whether a child should or should not be released to a non-custodial parent. The process of the OPHA is outlined in CFOP 170-7, Chapter 5.

*Training Note: Provide Handout: Blank Other Parent Home Assessment Form for participants to review while discussing this section.*

Prior to completing the OPHA, the Case Manager will have a supervisor case consultation. The discussion should include:

1. If the parent and child have an established relationship
2. If age appropriate, the child’s expressed wishes
3. Input from the removal parent and other family members
4. Removal parent’s proximity to completing Conditions for Return
5. Child’s stability in current placement if applicable
6. The Case Manager will then proceed with the OPHA.

*Display Slide 5.1.16 (PG: 16)*

There are four parts to the OPHA:

- The child abuse history-check to determine if there has been any past incident or pattern of maltreatment.
- An interview of the parent to assess the parent’s protective capacities, their bond with the child, their understanding of the child’s needs, and plan to keep the child safe.
• Criminal history checks. If the child is placed on an emergency basis, then fingerprints must be completed within 10 days. Fingerprints are required for the non-custodial parent.
• Walk through of the home to ensure the physical home is safe and has accommodations for the child.

If a criminal history check identifies a history which creates a presumption of detriment (addressed in more detail in Unit 3), then the Case Manager and Supervisor should request a staffing with CLS to determine any legal actions necessary.

**Relative and Non-Relative Caregiver Program**

If a Home Study is approved for a relative or non-relative and a child is placed in their home, they may qualify for the Relative/Non-Relative Caregiver Program. This program offers monthly cash assistance and Medicaid for a child under the age of 18 who, under certain circumstances, is placed by the court with a relative. The monthly cash assistance varies depending on child’s age and other circumstances.

*Display Slide 5.1.17 (PG: 16)*

In order for the caregiver to be eligible for the Relative Caregiver Program, they must be a relative of the 5th degree, by blood or by marriage. This includes:
• Siblings, half-siblings, step-siblings.
• Aunts and uncles, nieces and nephews.
• Grandparents and great-grandparents.
• First cousins or first cousins once removed. Once removed means that
there is a generation between. Your aunt’s and uncle’s children are your first cousins. Your mother’s first cousin would be your first cousin, once removed.

- Non-relative caregivers are also eligible for funding through the Non-Relative Caregiver Program. There is no relation requirement.

Display Slide 5.1.18 (PG: 17)

The other requirements for the Relative Caregiver Program are outlined in CFOP 175-79, CFOP 175-11, Non-Relative Caregiver Program and F.A.C. 65C-28.008.

- A Home Study must be completed and approved.
- Placement must be approved by the Court in a Court Order.
- The child must be adjudicated dependent.
- The child cannot be included in any other Temporary Cash Assistance case.
- Child must be a US Citizen or qualified non-citizen.
- Parent cannot reside in the home.
- Must be placed in Florida, by Florida. Children placed in Florida by the Interstate Compact on the Placement of Children (ICPC) process do not qualify for the Relative Caregiver Program from Florida. They may receive financial assistance from their state of jurisdiction.
You as the Case Manager, have some responsibility within the Relative Caregiver Program process. These include:

- Informing the caregiver at the time of the child’s placement about the financial assistance available.
- Completing the Home Study.
- Completing the Relative Caregiver Communication Form.

**Trainer Note:** Discuss any local existing protocols in conjunction with this topic.

The caregiver also has some responsibilities initially and ongoing to maintain the Relative Caregiver payment.

- Cooperate with Child Support Enforcement.
- Provide immunization documentation and other paperwork.
- Participate with the re-determination process every 6 months or as required.
- Notify the Case Manager and Economic Self-Sufficiency if there are any changes in household composition or address.

Display Slide 5.1.21 *(PG: 17)*

There is also a Non-Relative Caregiver Program as outlined in CFOP 175-11 that provides financial assistance to caregivers who are not related to the child by blood or marriage.

This also requires an approved Home Study, a Court Order placing the child in the custody of the caregiver, and adjudicating the child dependent. Eligibility also requires that the non-relative provide a signed statement by the caregiver that they would require financial assistance to care for the child. Their eligibility is re-assessed annually. Your responsibilities are the same for a Non-Relative caregiver.

In this section, we have talked about relative and non-relative placements and benefits that are available to them. In this next section, we will talk about some federal laws that can affect all types of placement.
Federal Laws Affecting Placement Decisions

There are several Federal Laws that provide important and specific guidelines when placing a child in Out-of-Home Care. They are the Multi-Ethnic Placement Act, the Interstate Compact for the Placement of Children, and the Indian Child Welfare Act.

**Multiethnic Placement Act**

The Multiethnic Placement Act (MEPA) was passed as part of federal efforts to reduce delays in the permanent placement of children in Out-of-Home Care.

There are three basic mandates that come from MEPA:

- Prohibits the denial or delay in placement of a child due to race, color, or national origin.
• Prohibits the denial of anyone the opportunity to become a foster parent on the basis of race, color or national origin.
• Requires states to diligently recruit foster/adoptive parents who reflect the racial and ethnic diversity of the state.

The intentions of MEPA are to decrease the wait time for children to be adopted. For example, if an African-American child is sheltered, and there is no available foster home of the same race, that child should not be denied placement with a family who is not African-American if they are willing to accept placement of the child.

MEPA’s intention at the same time is to encourage recruitment of foster families that reflect racial and ethnic diversity within their local area so there are more foster homes available for the population of children being served.

MEPA drives Case Managers to:

• Make individual decisions based on sound child welfare practice and the best interest of the child.
• Address specific or distinctive needs related to race or ethnicity that requires consideration as soon as the child comes into the child protection system.
• Consider permanency from the first contact with the child.
• Review state laws and agency policies regarding placement.
• Document the reasons for placement decisions.
• Be honest with prospective foster/adoptive parents and treat them with respect.

The next activity focuses on racial identity within transracial adoptions. MEPA mandated that foster parents could not be denied the ability to foster and adopt across racial and ethnic lines. That can create complex issues regarding the identity of the children being adopted. The activity will help think about and process some of those issues.
Activity C: MEPA and Identity within Transracial Adoptions

Display Slide 5.1.24 (PG: 19)

Time: 30-35 minutes

Purpose: Learners will watch a video and identify issues that may exist regarding children’s identity when they are part of a transracial adoption.

Materials:
- PG: 19, MEPA and Identity within Transracial Adoption worksheet

Trainer Instructions:
- Show the video “Struggle for Identity”.
- Instruct participants to consider these questions during the video and write down answers that will be discussed after the video. Inform them that this video and discussion involves race and culture, which can become intense conversations and to keep in mind to respect each other’s viewpoints during discussion. Allow 10-15 minutes after the video for discussion.

How do you think children are affected being placed outside their race/religion/ethnicity, etc.?

What can you do to help as a Case Manager?
- Discuss as a class.

Activity Instructions:
1. Watch the video, “Struggle for Identity”.
2. Consider the following questions:
How do you think children are affected being placed outside their race/religion/ethnicity, etc.?

Endorse:
Possible answers include: feeling different within the family, feeling like they don’t really belong anywhere, feeling like they are missing a part of who they really are, confused about who they are.

What can you do to help as a Case Manager?

Endorse:
Encourage caregivers to learn about the child’s biological family or to learn about their race/culture, encourage caregivers to have open discussions with children about race, Case Managers can talk to caregivers about how they can help their child deal with identity issues by having open communication, Case Managers can talk to children about what makes them comfortable, talk to children about how they feel about living with a family who is different from them.

Activity STOP

Interstate Compact Placement of Children (ICPC)

The Interstate Compact on the Placement of Children (ICPC) was created in the 1950’s as an agreement between the states to provide a process to move children between states under court jurisdiction. This allows you to place children who are involved in a dependency case in other states.
ICPC is utilized to ensure that there are rules and regulations guiding supervision of child welfare cases between the states. It ensures that the state the children reside in retain jurisdiction over the case. It ensures child safety through home studies, monitoring, and supervision as documented in reports that are sent back to the sending state. It outlines the financial responsibility for the child while placed in the receiving state.

As a Case Manager, you will use ICPC most often when you need a Home Study completed on a parent or relative in another state. The two most common types of ICPC a Case Manager will use are Regulation 2 (general placement) or Regulation 7 (Priority placement). In order to send a request for an ICPC Home Study, there is a specific packet of information that needs to be provided to the sending state. The Case Manager will need to contact the prospective placement (or Resource) and complete a form confirming that they have the ability and desire for the Home Study (Statement of Case Manager). If that is approved, then
you will request supervision for the child in that state if you are sending the child.

Case Managers not only send requests for home studies and supervision in other states, but also receive requests for home studies and supervision. You may be required to complete a Home Study for a relative or parent residing in your local area, or provide supervision to children placed from another state.

You will be responsible for conducting home visits every 30 days and sending quarterly reports through ICPC to the sending state. These quarterly reports will include a print out of your case notes, photos of the child, medical, mental health, and educational records, as well as any other information that would be pertinent for the sending state to have. You will document information in FSFN for this case as you would your primary cases.

**Trainer Note:** Review with participants the Outgoing ICPC Reg 2 checklist and the Reg 2 Case Manager statement form, pointing out the material needed for an ICPC Home Study request. [http://centerforchildwelfare.fmhi.usf.edu/ICPC/ICPCFormsandResources.shtml](http://centerforchildwelfare.fmhi.usf.edu/ICPC/ICPCFormsandResources.shtml) Explain to participants that they can locate these forms, like all other forms, on the Center’s website.

**The Indian Child Welfare Act (ICWA)**

The Indian Child Welfare Act, or ICWA, governs all dependency actions and certain private proceedings involving American Indian or Alaskan Native children who meet the federal criteria for the protections of the Indian Child Welfare Act. ICWA was enacted in 1978 to protect the best interests of Indian children while promoting stability and security of Indian tribes and families by establishing minimum standards for removal and placement of Indian children that reflect the values of the Indian culture. 25 U.S.C. §1902.
As defined by the ICWA, an Indian child is any unmarried person who is under age 18 and is either a member of an Indian tribe or is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe. Children who are identified as having some or all Native American/Alaskan Native heritage may be subject to the jurisdiction of the tribe. The CPI is required to initiate an inquiry as to the child’s heritage and document in FSFN. A Case Manager may have to initiate the inquiry if it was unable to be completed during the investigation, or the Case Manager may have to continue efforts.

If you have a child who a parent identifies as an Indian child, you will need to notify your supervisor and CLS immediately so that they can assist you with ensuring compliance with ICWA. You will need to notify the specific tribe, in writing, or the Bureau of Indian Affairs if the tribe is not known within 24 hours of receiving the information about the child.

The tribe may choose to intervene and assume legal jurisdiction in a case and take custody of the child. The tribe can also dictate placement preferences for an Indian child, which are, in preferred order:

1. A member of the child’s extended family as determined by the tribe
2. Other members of the Indian child’s tribe
3. Other Indian families

Even if the tribe chooses not to assume legal jurisdiction, it is required that they be noticed of any legal proceedings and case planning activities. The tribe may decide to intervene at any time during the case.
**Trainer Note:** Review form CF-FSP 5323, Verification of ICWA Eligibility and key points in Appendix A to CFOP 175-36 regarding procedures to notify a tribe about a child involved in a case. Also note to the class that if the parents indicate the child has Indian heritage but do not know what tribe, ongoing efforts must be made to determine if the child is eligible for registration with a tribe.

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**Activity D: The Indian Child Welfare Act**

*Display Slide 5.1.28 (PG: 22)*

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**Time:** 20 minutes

**Purpose:** Learners will review a real-life utilization of the Indian Child Welfare Act and understand the importance of following the protocol mandated by it.

**Materials:**
- “Nightline” Video [https://www.youtube.com/watch?v=NGTvn-hb4Y](https://www.youtube.com/watch?v=NGTvn-hb4Y)
- **PG: 22, Indian Child Welfare Act worksheet**
- **Handout: Form CF-FSP 5323, Verification of ICWA Eligibility**
- **Appendix A to CFOP 175-36**

**Trainer Instructions:**
- Show the video from “Nightline” Heated Custody Battle Over Native American Girl Removed From California Foster Family
- While watching the video, have participants answer these questions:
  - How did ICWA affect this case?
  - Why is it important to determine a child’s Indian heritage as quickly as possible?
  - What responsibilities do you think you have when determining if a child is of Indian heritage?
- Discuss as a group and answer any additional questions.
Activity 1. Watch the video “Nightline”.
Instructions: 2. Answer the following questions:
   • How did ICWA affect this case?
   • Why is it important to determine a child’s Indian heritage as quickly as possible?
   • What responsibilities do you think you have when determining if a child is of Indian heritage?
3. Be prepared to discuss.

**Trainer Version**

**How did ICWA affect this case?**

*Endorse:* The child had Indian Heritage that was recognized by her father’s tribe so the tribe had the legal authority to intervene in the case and dictate her placement. Other relevant answers may apply.

**Why is it important to determine a child’s Indian heritage as quickly as possible?**

*Endorse:* To involve the tribe early on in the case if the child has Indian heritage to prevent trauma to the child and/or caregivers; to ensure a child’s Indian heritage is being taken into consideration; to prevent an adoption from being overturned because the child had Indian heritage and it was not explored. Other relevant answers may apply.

**What responsibilities do you think you have when determining if a child is of Indian heritage?**

*Endorse:* Asking parents if they have any Indian heritage; having parents complete the ICWA form and the family tree; to find out what tribe the child may be registered with or eligible to be registered with; documenting ICWA verification in FSFN; notifying CLS; sending letters to the tribe or the Bureau of Indian Affairs; communicating with the tribe about court events and placement. Other relevant answers may apply.

**Activity STOP**

In this unit, we have reviewed placement considerations when a child is entering Out-of-Home Care. In the next unit, we will discuss specific needs of children who are removed and how you will ensure that these needs are being met.
Unit 5.2: Meeting Children’s Needs in Out-of-Home Care

Display Slide 5.2.1

Unit Overview: The purpose of this unit is to provide participants a review of how the needs for children in Out-of-Home Care are addressed.

References:
- 65C-28.014, F.A.C., Behavioral Health Services
- 65C-35.001(18), F.A.C., Psychotropic Medications
- 65C-35.001(10), F.A.C., Informed Consent
- 65C-35.003, F.A.C., Efforts for Informed Consent
- CFOP 155-10/175-40, Chapter 3-5, Parent/Guardian Involvement
- Section 39.407, (1)-(3), F.S., Requirements for Administration of Psychotropic Medication
- CFOP 155-10/175-40, Chapter 3-4a, Medical Report
- H.R. 6893- Fostering Connections to Success and Increasing Adoptions Act of 2008
- 20 U.S.C. §1400, Individuals with Disabilities Education Act
- Section 38.0016, F.S., Education for Children in Out-of-Home Care
- Section 39.0016 (1) (c ), F.S., Surrogate Parent
- 65C-30.001 (24), F.A.C., Child Resource Record
- 65C-30.011 (4), F.A.C., Child Resource Record
- CFOP 155-10/175-40, Chapter 1-6, Child Resource Record
- 65C-30.019, F.A.C., Missing Children
- Recovering and Locating Missing Children Form
Display Slide 5.2.2 (PG: 23)

Learning Objectives:

1. Explain what a Child Resource Record is and case management responsibilities associated with it.
2. Explain what a CBHA is and how it is utilized.
3. List the steps to follow when a child enters care on medication or needs medication while in care.
4. Explain informed consent and what reasonable efforts are to obtain it.
5. Evaluate a medical report to demonstrate knowledge of what needs to be included.
6. Specify information relating to psychotropic medication required to be entered in FSFN.
7. Explain case management’s role in children’s medical and dental care.
9. Explain what an IEP is.
10. Define a surrogate parent and who can be that surrogate.
11. List the steps of reporting a child missing and reporting when a child has returned.
12. Explain reasonable efforts to locate a child.

When a child is removed from a parent due to abuse, abandonment or neglect, what do you think might be some of their needs that need to be addressed as soon as possible?

Endorse:
Immediate medical care, immediate dental care, counseling due to circumstances that resulted in removal, educational needs, untreated mental health issues, etc.
Comprehensive Behavioral Health Assessment

Display Slide 5.2.3  *(PG: 24)*

When a child enters Out-of-Home Care, they are initially assessed for any service needs they may have. This is done by a Comprehensive Behavioral Health Assessment (CBHA). A referral for a CBHA is required within 7 days of a shelter. If the child has been in care but is exhibiting substantial behavioral or mental health issues, another CBHA can be requested annually.

A CBHA assessor will interview the child, parents, caregivers, and anyone else significant to the child or case; review the case record, review medical history, and will observe the child in the community.

The CBHA will provide recommendations for services the child may need such as counseling, Psychiatric or Psychological Evaluation, tutoring, mentoring, evaluation by a medical professional, etc. As the Case Manager, you are responsible for reviewing and implementing the recommendations of the CBHA and adding the recommendations to the Case Plan for the child if applicable. You will also be responsible for filing the CBHA with the court.
The CBHA is a beginning step in evaluating a child’s needs while in Out-of-Home Care to determine how we can best provide services to them. Thus, it is imperative that we document within the medical tab in FSFN, the date the CBHA was completed. The actual CBHA should also be uploaded into the FSFN file cabinet under the child’s electronic medical record tab so that it is easily available.

**General Medical Care**

Children in Out-of-Home Care require consistent monitoring of their general physical needs. This is addressed with routine and ongoing medical and dental care. When a child enters Out-of-Home Care, they are required to have an initial medical screening within 72 hours of the removal episode. As the Case Manager, you will need to follow up with any needs or recommendations identified in the initial medical screening. You will also need to ensure the child is attending all required medical appointments.
Children are required to have medical screenings beginning when they are a newborn. They are required frequently until the child turns 2. At that point, they are then required annually or if the child is sick. Dental checks begin at age 3 unless it is medically necessary to go prior. After that, they are required every 6 months or more frequently as recommended by the provider. Hearing and vision checks are done during routine physicals at specific ages.

**Types of Medical Care**

There are three types of medical treatment for a child: ordinary, extraordinary, and emergency. Each has different requirements for consent.

1. **Ordinary medical care and treatment:**
   - This is ongoing regular health care and treatment.
   - When a child is initially removed, the CPI will ask the parents to provide
written consent for ordinary medical treatment and medication. If the parents decline to authorize this Children Legal Services will ask at the Shelter hearing for a court authorizing consent for ordinary medical treatment and medication.

- Once a child is adjudicated dependent a Court Order will be filed specifying who is authorized to consent to regular medical care and treatment for the child. The Out-of-Home Caregiver can be one of these authorized persons.

2. **Extraordinary Medical Care and Treatment:**

- This is provided when the health care provider determines that an illness or injury requires non-emergency medical treatment beyond ordinary medical care and treatment (an example would be surgery, or sedation required for a procedure).
- Must have expressed and informed consent of the child’s parent.
- If the parent refuses or is unable to consent to the treatment or the parents’ rights are terminated and consultation with the medical provider results in a determination that the treatment is required the Case Manager will seek a Court Order to authorize the treatment.

3. **Emergency Medical Care and Treatment:**

- When the healthcare provider determines that the situation is an emergency and the care is needed to ensure the child’s health or physical well-being.
- Although parents shall be involved whenever possible, obtaining consent is not required for emergency care and treatment. If treatment is provided without parental consent, the Case Manager must notify the GAL and parent as soon as possible after the treatment is provided.

**Trainer Note:** Review some examples of extraordinary medical care that would require a Court Order or parental consent that may be common for children: Being generally sedated for dental work, getting tubes put in ears, getting tonsils removed, surgery to repair a hernia, sedation for an MRI, an organ transplant, heart surgery to repair a defect, chemotherapy for cancer.

It is the Case Manager’s responsibility to ensure children attend all of their routine medical appointments and to ensure any recommendations or follow up is completed and that proper consents are obtained.
**Documentation**

*Display Slide 5.2.7 (PG: 26)*

Case Managers need to ensure that the medical tab in FSFN is completed with information for the child’s physician, dentist and other applicable providers. This is also where you would indicate that you have the child’s immunization records and they are up-to-date.

*Display Slide 5.2.8 (PG: 26)*

It is vital that we track and maintain documentation of the child’s medical needs, appointments and follow up treatment. Thus, Case Managers need to document the child’s appointments, recommendations and treatment in the medical tab in FSFN.

In addition, during monthly face to face contacts with children and caregivers, a discussion should be had about any upcoming appointments or the results of any appointments the child has had and documented in FSFN.
We will now discuss in depth a specific type of medical care that requires significant attention from the Case Manager: Psychotropic Medication.

**Psychotropic Medication**

(Trainer Note: Begin the Psychotropic Medication section with the class by having the class read this article and then a follow-up discussion:)


**Based on the article, can you identify some of the mistakes that were made concerning Gabriel’s case?**

Endorse:

- They did not get proper consent, they gave medication to a child that was not supposed to be given to a child, Case Manager did not follow procedures, didn’t follow recommendation for residential treatment, didn’t involve the family

**Why would a judge and/or a child’s parents need to be involved in prescribing medication?**

Endorse:

- To make sure a child is taking the right medication, to make sure the child really needs medication, to prevent a child being harmed or dying, to protect the parent’s right to be involved in the child’s medical decisions

(Trainer Note: Transition into the topic of psychotropic medication by stating that the current monitoring and procedures for psychotropic medication were influenced by this case.)
Some children in Out-of-Home Care are prescribed medications, either prior to coming in to care or after they have been sheltered. According to F.A.C. 65C-35.001 (18), Psychotropic medications are any chemical substance prescribed with the intent to treat psychiatric disorders; and those substances, which though prescribed with the intent to treat other medical conditions, have the effect of altering brain chemistry. They can be prescribed for mental health/behavioral conditions such as bi-polar disorder, depression, anxiety, ADHD, or for medical conditions like seizures or headaches. Common psychotropic medications are Seroquel, Xanax, Adderall, Zoloft, Lithium, Trazodone, Risperdal, Abilify, Remeron, Vyvanse, and Depakote. This is not an exhaustive list, as there are dozens of psychotropic medications.

In order for a child in Out-of-Home Care to take any psychotropic medication, a Court Order or parental consent is required and there are strict FSFN documentation guidelines. Before discussing this procedure in depth, we will first define and explain what is meant by “informed consent”.

**What do you think is meant by informed consent?**

*Class may give varied answers. Allow them to provide their thoughts, and then introduce the definition of informed consent.*
Informed Consent

Informed consent is defined in F.A.C. 65C-35.001 (10). It is:

- Voluntary, written consent from a competent person who has received full, accurate and sufficient information and explanation about a child’s medical condition, medication, and treatment to enable the person to make a knowledgeable decision without being subjected to any deceit or coercion.

Sufficient information includes, but is not limited to:

- The medication and reason for prescribing it
- Intended results of the medication
- Side effects, risks, and contraindications, including effects of stopping the medication
- Method for administering the medication, and dosage range
- Potential drug interactions
- Alternative treatments
- Behavioral health or other services used to complement the use of the medication.

Reasonable efforts to engage parents in the process of obtaining informed consent and to provide parents information regarding medication if they did not attend the appointment must be documented in FSFN.

If a parent attends the appointment and has had all of their questions answered and were provided sufficient information, they may consent to the medication and court authorization is not required.

**Trainer Note:** Refer participants to F.A.C. 65C-35.003 and CFOP 155-10/175-40, Chapter 3-5 and review key points of reasonable efforts to obtain informed consent.
Display Slide 5.2.10 (PG: 28)

There are specific rules for when a child is on medication and they enter Out-of-Home Care. This is important for Case Managers to understand. If an In-Home Safety Plan you are managing needs to be changed to an out-of-home plan and a child is removed, Case Managers will be responsible for completing these steps.

- A child should continue on the medication they were already on until the shelter hearing.
- At the shelter hearing, CLS will need to request court authorization to continue the child on medication until the arraignment date or 28 days after shelter, whichever is sooner, unless written authorization is obtained from the parents to continue the medication.
- The child will need to be seen by a physician within the timeframe and have an updated, completed medical report for the continuation of medication.
- The Case Manager will need to provide and document reasonable efforts to engage the parents in the appointment to provide informed consent for the medication.
- The Case Manager will file the Medical report within 3 days with CLS and document in FSFN.
- If parental consent was not obtained, then CLS will file a motion for administration of medication. The child CANNOT begin medication until the Court Orders unless it meets one of the emergency conditions.
- Documentation of the Medical Report being filed with CLS and the medication information in the Medication Tab must be in FSFN within 3 business days.

**Trainer Note:** Refer participants to F.S. 39.407 (1)-(3) to review requirements for administering psychotropic medication while completing this section.
When a child is already in Out-of-Home Care, the process is similar. If it is determined that a child needs to be evaluated potentially for medication, the Case Manager will also provide reasonable efforts to engage the parents in the process to provide informed consent. If the parents attend the evaluation and provide informed consent, the medical report with their authorization can be provided to CLS within 3 days of receipt and the child may receive medication. If the parents' rights are terminated, or could not be located to attend the appointment, then a Court Order must be obtained.

There are emergency situations in which a child may need to be administered medication without parental consent or a Court Order. When filling out a medical report, if a physician checks the box stating “a delay in providing a prescribed psychotropic medication would more likely than not cause significant harm to the child”, the medication may be issued immediately but a motion for continuation of the medication and the med report must be filed with the court within 3 days. This also applies to emergency situations like a child being admitted to the hospital, crisis stabilization unit, or inpatient psychiatric facility.

Remember, all of your efforts to engage parents, obtain informed consent, obtain the medication report and/or Court Order, or any other tasks related to psychotropic medication must be documented in FSFN.
Another step that can be utilized when a child is on psychotropic medication is what is known as a MedLine Consult. This is done through the University of Florida, and is done when additional information is requested or required (such as the Court Orders it). However, it is a required action, when done when a child under the age of 11 is prescribed two or more medications or a child 5 or under is prescribed any psychotropic medication.

**Documentation**

If a child is placed on psychotropic medication, it must be documented in the medication tab within 3 days of it being administered. Most of the information that needs to be input into the medical tab can be found on the medical report.

- Physician’s name prescribing medication.
- Type of medication and indication it is psychotropic.
- Whether psychotherapeutic or medical.
- Date medication prescribed.
- Current dosage and dosage range.
- Date of Court Order or informed consent. If medication is prescribed on an emergency basis, the date of 1/1/1900 should be entered until actual Court Order is obtained. Reason should be documented in comments section.
- The reason for the medication- what is the medication addressing?
- Instructions/additional comments: should have at a minimum the potential side effects.

During monthly contact with the children and caregiver, it should also be documented that conversations were had with the caregiver and the child about the medication, how the child is responding to it, if there are any side effects, and if anything needs to be addressed with the physician.
Activity E: Understanding the Medical Report

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Time: 20 minutes

Purpose: Participants will be able to review a Medical Report and identify the information required in it.

Materials:
- Handout: Medical Report Correct and Incorrect examples
- PG: 31, Understanding the Medical Report worksheet
- CFOP 155-10/175-40, Chapter 3-4a regarding the Medical Report

Trainer Instructions:
- Trainer will take 10-15 minutes to review the Medical Report and indicate the required fields and how they should be filled-out and by whom.
- Next, provide the participants with copies of the incorrectly completed Medical Report.
- Allow participants 5-10 minutes to identify the problems with the report.
- After, trainer will review the answers and answer any questions.

Activity Instructions:
1. Review the example of a correct Medical Report.
2. Next, review the sample Medical Report and indicate the errors you find.
3. Be prepared to discuss.
Dear Physician:

The attached Medical Report has been developed to guide the treatment of children in the custody of the Florida Department of Children and Families who are prescribed a psychotropic medication. These children are not residing with their parent or legal guardian.

- Prior to prescribing a psychotropic medication, s. 39.407, F.S. requires the prescribing physician to attempt to obtain express and informed consent from the child’s parent or legal guardian. This is required even when the medication is prescribed for medical reasons unrelated to behavioral healthcare.

- In the absence of the parent’s express and informed consent or in emergency situations, the completed and signed Medical Report will be submitted to the court and admitted into evidence at the hearing. The information in the report will be used in lieu of a court appearance by the physician. Therefore, it is critical that all information contained in the report be complete and thorough.

- Express and informed consent may only be given by the child’s parent or legal guardian. In no case may the dependency case manager, child protective investigator, or the child’s foster parents provide express and informed consent for a child to be prescribed a psychotropic medication.

Florida Statute 39.407 requires physicians who prescribe psychotropic medications to children in foster care complete a medical report that includes the following information:

1. A statement indicating that the physician has reviewed all medical information which has been provided concerning the child.

2. A statement indicating that the psychotropic medication, at its prescribed dosage, is appropriate for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, at its prescribed dosage, is expected to address.

3. An explanation of the nature and purpose of the treatment; the recognized side effects, risks, and contraindications of the medication; drug-interaction precautions; the possible effects of stopping the medication; and how the treatment will be monitored, followed by a statement indicating that this explanation was provided to the child if age appropriate and to the child's caregiver.

4. Documentation addressing whether the psychotropic medication will replace or supplement any other currently prescribed medications or treatments; the length of time the child is expected to be taking the medication; and any additional medical, mental health, behavioral, counseling, or other services that the prescribing physician recommends.

Thank you for your work with children in the foster care system.

An electronic version of this form can be downloaded from:
http://www.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx
Medical Report for
Children in Out-of-Home Care
(to be completed by the physician)

SECTION 1: CHILD’S INFORMATION

Name: Sue Smith                  Date of Birth: 2/25/2007

Height: ______  Weight: ______  Gender: F

SECTION 2: INFORMATION RECEIVED BY PHYSICIAN. Briefly list any persons consulted, tests performed, and documents reviewed in conjunction with this child’s evaluation. (NOTE: The dependency case manager is responsible for providing all pertinent medical information known to the Department concerning the child.)

Documents Provided: (check all that apply)

☒ Comprehensive Behavioral Health Assessment.
☒ Previous psychological evaluation.
☒ Current Health Physical Examination or recent well child exam.
☒ Referral Information including all medications currently prescribed, health status, health services and therapy currently receiving.
☒ Current school records, including assessments (e.g., Functional Behavioral Assessments, etc.)
☐ Other (list):

Persons Consulted: (Name, title/relationship to child, date of consultation)

Angel Johnson- Case Manager, 3/13/16
Jessica Smith- Mother, 3/13/16
Ron Smith-Father, 3/13/16

☒ Does child’s medical history include conditions that may indicate the presence of brain injury (for example, blows to head, fetal alcohol syndrome, loss of consciousness, head scars, fever above 104°)?

☐ Yes  ☐ No  ☐ Further assessment needed (see Section 4)

Other health conditions considered (list):

Comments:
Case Management Pre-Service Curriculum | Module 5-TG

Child's Name: Sue Smith  
Date of Birth: 2/25/2007

SECTION 3: DIAGNOSED CONDITIONS, SYMPTOMS, BEHAVIORS. Details should be provided for each separate diagnosis. If necessary, continue on page 9 for additional diagnoses/medications. List all diagnosed conditions, symptoms, and behaviors that support the need for the requested medications, including current medications that will be continued, for a complete profile. Please provide the Axis diagnosis(es) if known.

- **Diagnosis # 1:**  
  - [ ] ADHD/ADD  
  - [ ] Oppositional Defiant Disorder  
  - [ ] Adjustment Disorder  
  - [ ] Depression  
  - [ ] Post Traumatic Stress Disorder  
  - [ ] Reactive Attachment Disorder  
  - [ ] Bipolar Disorder  
  - [ ] Mood Disorder  
  - [ ] Other (specify):  
  
  Medication recommended: Guanfacine.

- **Starting dose:** ___  
  Dosage Range: 0-4

- **Expected length of medication treatment/Plan to reduce or eliminate the medication (Titration Plan):** 
  
- **Side effects for caregiver to monitor:** 

  Target symptoms/behaviors medication will address and expected results:

  - This Medication is NEW [X]  
  - This Medication is for [ ] Medical Condition  
  - [X] Behavioral Health Condition  

  **Comments regarding medication:**

---

- **Diagnosis # 2:**  
  - [ ] ADHD/ADD  
  - [ ] Oppositional Defiant Disorder  
  - [ ] Adjustment Disorder  
  - [ ] Depression  
  - [ ] Post Traumatic Stress Disorder  
  - [ ] Reactive Attachment Disorder  
  - [X] Bipolar Disorder  
  - [ ] Mood Disorder  
  - [ ] Other (specify):  
  
  Medication recommended: Abilify.

- **Starting dose:** 10 mg  
  Dosage Range: 0-15

- **Expected length of medication treatment/Plan to reduce or eliminate the medication (Titration Plan):** 
  
  **Side effects for caregiver to monitor:**  
  - Lightheadedness, nausea, vomiting, stomach upset, tiredness, excessive saliva or drooling, weight gain, drowsiness.

  **Target symptoms/behaviors medication will address and expected results:**

  - This Medication is NEW [ ]

  - This Medication is for [ ] Medical Condition  
  - [ ] Behavioral Health Condition  

  **Comments regarding medication:**

---
Case Management Pre-Service Curriculum | Module 5-TG

Child's Name: Sue Smith
Date of Birth: 2/25/2007

SECTION 4: RECOMMENDED SERVICES, OTHER TREATMENTS. Please include any psycho-social services, medical or psychiatric follow-ups, or treatments the child should receive in conjunction with this medication profile including a recommended schedule.

Medication Monitoring Plan and Follow-up: Next Appointment: ___

Treatment monitoring frequency recommended:

☐ Weekly  ☐ monthly  ☐ 2months  ☐ 3months  ☐ 4 months  ☐ 6 months  ☐ annually

Follow-up visit frequency recommended:

☐ Weekly  ☐ monthly  ☐ 2months  ☐ 3months  ☐ 4 months  ☐ 6 months  ☐ annually

Lab Monitoring:

☐ CBC ☐ with differential ☐ without differential frequency: ___
☐ Comprehensive metabolic panel frequency: ___
☐ Basic metabolic panel frequency: ___
☐ Urinalysis frequency: ___
☐ Urine Toxicology Screen frequency: ___
☐ Pregnancy test ☐ Urine ☐ Blood
☐ TSH frequency: ___
☐ Lipid profile (HDL, LDL, Chol, Trig) frequency: ___
☐ Lithium level ☐ Depakote/Depakene level ☐ Tegretol level
☐ Other laboratory tests not noted above:

Other Tests/Therapies/Services:

☐ Electrocardiogram (ECG/EKG) ☐ Neurological exam/assessment
☐ Other (specify):

☐ Therapy recommended:

☐ Psycho-social services recommended:
SECTION 5: CERTIFICATION OF SIGNIFICANT HARM. This section must be completed when it is likely that any delay in taking the prescribed medication would cause significant harm to the child.

I, the physician, have reviewed all medical information concerning this child provided to me by DCF/CBC and/or the child’s caregivers, and certify that a delay in providing the prescribed psychotropic is likely to cause significant harm to the child as noted below:

☑️ I find that it is likely that any delay in taking this medication would cause significant harm to this child. I recognize that this finding statutorily pre-authorizes the Department to provide the proposed medication profile to the child immediately and prior to obtaining a court order. Delay in taking the psychotropic medication(s) will more likely than not harm the child.

Please provide detailed explanation of the nature and extent of harm the child will likely experience:

☒ ADHD - does not provide detailed explanation of the nature and extent of harm.

☐ This child is currently in a hospital, crisis stabilization unit, or psychiatric residential treatment center. I recognize that this finding statutorily pre-authorizes the Department to provide the proposed medication profile to the child immediately and prior to obtaining a court order. A court order must then be sought within 3 business days.

SECTION 6: MEDICATION INFORMATION. Section 39.407(3)(c)4., Florida Statutes (2009), requires that the Medical Report include information covering the recognized side effects, risks, contraindications, drug-interaction precautions, and possible effects of stopping medication for each medication. This information must be attached to this medical report. Medical reports without such information attached cannot be filed with the court.

Please attach the appropriate information for all psychotropic medications listed in section 3 of this report.

☒ ☐ I have provided a copy of the attached medical information to the child and to the child’s caregiver.

☒ ☐ I have also discussed this information with the child and with the child’s caregiver.
Child's Name: Sue Smith  Date of Birth: 2/25/2007

SECTION 7: SUPPLEMENTAL INFORMATION. Please describe below information on other treatment options. In addition please attach any supplemental information that might explain or support this medical report.

1. Are there other treatment options available in lieu of administering the psychotropic medications recommended above?  ☑ Yes  □ No
   If yes, what are those alternatives?
   ☑

2. Have these alternatives been tried?  □ Yes  ☑ No
   If yes, what was the response to the alternative treatments?
   ☑

3. If the alternative treatments were not tried, explain why:
   ☑

4. Other supplemental information:
SECTION 8: EXPRESS AND INFORMED CONSENT BY PARENT OR GUARDIAN. To be completed by parent or guardian in consultation with the physician.

By signing this section I am certifying that I am a parent or guardian of the above-named child, and that the physician has explained to me each of the following (initial each):

- the reason for treatment;
- the proposed treatment;
- the purpose of the treatment to be provided;
- the common risks, benefits, and side effects of the treatment;
- what results are expected;
- the specific dosage range for the medication;
- alternative treatment options and the risks and benefits thereof;
- the approximate length of treatment;
- the potential effects of stopping treatment; and,
- how treatment will be monitored.

Further, by signing this section I am certifying the following (initial each):

- The physician has answered all of my questions about this medical report.
- I understand that I am not required to consent to this medical report. The Department may, after consultation with the prescribing physician, seek court authorization to provide the psychotropic medication to my child.
- I understand that any consent given for treatment in this medical report may be revoked orally or in writing before or during the treatment period and the Department will then be required to obtain a court order to continue the medication.

SIGN HERE IF YOU CONSENT TO THE TREATMENT:

[Signature]

Signature of parent or guardian CONSENTING

3/18/14

Date

SIGN HERE IF YOU DO NOT CONSENT:

[Signature]

Signature of parent or guardian NOT CONSENTING

Date

Jessica Smith
Print Name

Mother
Relationship to Child

CF-FSP 5339, Jan 2010 [65C-35, F.A.C.]
Child's Name: Sue Smith  
Date of Birth: 2/25/2007

SECTION 9: SIGNATURE OF PHYSICIAN.

By signing this document, I am certifying that I have reviewed all medical information concerning the child which has been provided, and I am certifying that the psychotropic medication, at its prescribed dosage, is medically necessary for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, and its prescribed dosage, is expected to address.

☒ I have discussed with the child's parent/legal guardian the reason for treatment; the proposed treatment; the purpose of the treatment to be provided; the common risks, benefits, and side effects of the treatment; the specific dosage range for the medication; alternative treatment options; the approximate length of care; the potential effects of stopping treatment; and how treatment will be monitored.

☐ by phone  ☒ in person

☒ I have discussed with the child the reason for treatment; the proposed treatment; the purpose of the treatment to be provided; the common risks, benefits, and side effects of the treatment; the specific dosage range for the medication; alternative treatment options; the approximate length of care; the potential effects of stopping treatment; and how treatment will be monitored.

☒ Child assents  ☐ Child does not assent  ☐ Child is not age/developmentally appropriate

Comments, especially reason for nonassent:

☐ I have not discussed this treatment with the parent/legal guardian and have not obtained express and informed consent for administration of this medication.

[Signature of prescribing physician]

3/13/10

Date Signed

Dr. Mental Health
Print Name

License: XX1114

Telephone Number: 555-555-4444

Emergency Contact Telephone Number: 911
SECTION 3: DIAGNOSED CONDITIONS, SYMPTOMS, BEHAVIORS (continued from page 3). Use this page only if it is necessary to continue from page 3 with additional diagnoses/medications. List all diagnosed conditions, symptoms, and behaviors that support the need for the requested medications, including current medications that will be continued, for a complete profile. Please provide the Axis diagnosis(es) if known.

Diagnosis # ___:  [ ] ADHD/ADD  [ ] Oppositional Defiant Disorder  [ ] Adjustment Disorder  [ ] Depression  
[ ] Post Traumatic Stress Disorder  [ ] Reactive Attachment Disorder  [ ] Bipolar Disorder  [ ] Mood Disorder  
[ ] Other (specify): ______

Medication recommended: ______

Starting dose: _____ Dosage Range: _____

Expected length of medication treatment/Plan to reduce or eliminate the medication (Titration Plan):

_____

Side effects for caregiver to monitor:

Target symptoms/behaviors medication will address and expected results:

This Medication is NEW [ ]

This Medication is for [ ] Medical Condition  [ ] Behavioral Health Condition

Comments regarding medication:

Diagnosis # ___:  [ ] ADHD/ADD  [ ] Oppositional Defiant Disorder  [ ] Adjustment Disorder  [ ] Depression  
[ ] Post Traumatic Stress Disorder  [ ] Reactive Attachment Disorder  [ ] Bipolar Disorder  [ ] Mood Disorder  
[ ] Other (specify): ______

Medication recommended: ______

Starting dose: _____ Dosage Range: _____

Expected length of medication treatment/Plan to reduce or eliminate the medication (Titration Plan):

_____

Side effects for caregiver to monitor:

Target symptoms/behaviors medication will address and expected results:

This Medication is NEW [ ]

This Medication is for [ ] Medical Condition  [ ] Behavioral Health Condition

Comments regarding medication:
Child’s Name: _______  Date of Birth: _______

SECTION 3: DIAGNOSED CONDITIONS, SYMPTOMS, BEHAVIORS (continued from page 9).
Use this page only if it is necessary to continue from page 9 with additional diagnoses/medications. List all diagnosed conditions, symptoms, and behaviors that support the need for the requested medications, including current medications that will be continued, for a complete profile. Please provide the Axis diagnosis(es) if known.

**Diagnosis #1:**  □ ADHD/ADD  □ Oppositional Defiant Disorder  □ Adjustment Disorder  □ Depression
□ Post Traumatic Stress Disorder  □ Reactive Attachment Disorder  □ Bipolar Disorder  □ Mood Disorder
□ Other (specify): ______
Medication recommended: ______
Starting dose: ______ Dosage Range: ______
Expected length of medication treatment/Plan to reduce or eliminate the medication (Titration Plan): ______

Side effects for caregiver to monitor:

Target symptoms/behaviors medication will address and expected results:

This Medication is NEW  □
This Medication is for  □ Medical Condition  □ Behavioral Health Condition
Comments regarding medication:

**Diagnosis #2:**  □ ADHD/ADD  □ Oppositional Defiant Disorder  □ Adjustment Disorder  □ Depression
□ Post Traumatic Stress Disorder  □ Reactive Attachment Disorder  □ Bipolar Disorder  □ Mood Disorder
□ Other (specify): ______
Medication recommended: ______
Starting dose: ______ Dosage Range: ______
Expected length of medication treatment/Plan to reduce or eliminate the medication (Titration Plan): ______

Side effects for caregiver to monitor:

Target symptoms/behaviors medication will address and expected results:

This Medication is NEW  □
This Medication is for  □ Medical Condition  □ Behavioral Health Condition
Comments regarding medication:
Educational Needs

Meeting a child’s educational needs is imperative, and is a part of child well-being. Here are some challenges for children in Out-of-Home Care compared to the rest of the population:

- More frequent school changes
- Miss more days of school (more unexcused absences)
- Are more often suspended or expelled from school
- Often score lower on academic tests
- Are more often held back a grade
- Drop out/ don’t graduate
- More often in special education classes or have special education needs
- Are more likely to obtain a GED rather than a high school diploma

**Why do you think that these issues disproportionately affect children in Out-of-Home Care?**

**Endorse:**
Effects of abuse or neglect, moving around from different foster homes, trauma not being treated, not receiving right services, changing schools, needs not being addressed.

**Trainer Note:** Show the video of an adult who grew up in foster care as she recalls her educational experiences, and after the video ask participants for their reaction:

[https://youtube.com/watch?v=YLB_jFPMNks](https://youtube.com/watch?v=YLB_jFPMNks)
Before we discuss Case Manager responsibilities regarding education for children in Out-of-Home Care, we will go over some of the laws affecting education.

**Laws Affecting Educational Needs**

Display Slide 5.2.16 *(PG: 32)*

There are several laws that provide guidance for children within the Dependency System. The Fostering Connections and Increasing Adoptions Act is a Federal Law that added educational stability requirements for children in foster care. This includes creating a plan for educational stability. It states the placement takes account the school setting at the time of placement in Out-of-Home Care and that the state will ensure the child remains in the same school or, if moved due to not being in the best interests of the child, that the child is immediately enrolled in a new school and that school is provided the child’s educational records.

The Individuals with Disabilities Education Act, or IDEA, is a Federal Law addressing the educational needs of children who have or are suspected to have a disability. This law mandates that those children are identified, evaluated, and provided individualized services to meet their unique needs. This law also defines who can serve as a parent for educational purposes. It includes biological or adoptive parents, a foster parent, a guardian with authority to act as a parent (excludes Case Managers), or a surrogate parent. We will address what a surrogate parent is a little later in this section.

Chapter 39.0016 of the Florida Statutes also addresses education for children out-of-home. Chapter 39 states that children should remain in their current school if possible. It also states the School Board will determine if transportation is
available to maintain the school placement, and it outlines how a surrogate parent is appointed.

Why do you think that there can be difficulty keeping children in the same school they were in at removal?

Endorse:
Placed with relatives out of the area, multiple placement disruptions, needing a higher level of care than available in the local area, shortage of foster homes.

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As a Case Manager, you are responsible for keeping up with the educational needs for children in Out-of-Home Care. You should be obtaining their progress reports, report cards, and copies of their Individual Education Plans (IEP), and reviewing them to see how the children are doing academically. You will also need to file those documents with the court and ensure they are in the Child’s Resource Record (CRR). You should be communicating with school personnel, child’s caregiver and GAL regarding your child’s educational progress. Engaging the parents by inviting them to participate in school meetings or discussing their child’s progress is also part of a Case Manager’s responsibility. You will sometimes need to attend meetings at school and ensure that a child is receiving the appropriate services, like an evaluation or tutoring. Most of all, you should be advocating for the best interest.

As discussed previously, many children in foster care are working below their academic potential and have specific special education needs. We will review some of the information you will need to know as a Case Manager relating to your
children’s individual educational needs.

**Individualized Education Plans**

There are a number of children in Out-of-Home Care that are classified as ESE in their educational setting. ESE stands for Exceptional Student Education. A team will assess a child if there is suspicion the child may need ESE services. If it is determined the child needs to be in an ESE class or part of an ESE program, an Individualized Education Plan will be developed for the child. Some common type of ESE programs are Autism Spectrum Disorder, Language Impairment, Emotional/Behavioral Disability, Intellectual Impairment, and Vision Impairment.

*Display Slide 5.2.18 (PG: 33)*

An Individualized Education Plan (IEP) is created by a team that will include the child’s teacher, and ESE teacher, whoever completed an evaluation on the child (psychologist, speech pathologist, behavioral specialist, etc.). The child, his/her parent, caregiver, Case Manager, and GAL should also attend this meeting to provide information for the child, understand the plan for the child, and advocate for the child’s needs. During the development, current academic progress and functioning will be discussed, as well as the goals for the child. The IEP will outline how the student’s progress will be measured and reported, list the ESE services, other services, and support for personnel. An IEP can last for up to 12 months.

Generally, a parent would need to sign written consent for implementation of the IEP. However, if a parent is unavailable, as is sometimes the case for children in Out-of-Home Care, a surrogate parent may provide consent.
What is a Surrogate Parent?

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If a child is in Out-of-Home Care and a parent is unable to be located or parental rights have been terminated, and the child meets the requirements for an IEP, then a “surrogate parent” will be appointed for the child. A surrogate parent cannot be the child’s Case Manager, group home staff or therapeutic foster parents, but can include other Out-of-Home Caregivers such as a relative, non-relative, or a foster parent. A GAL may also be appointed a child’s surrogate parent. The surrogate parent will be responsible for signing the written consent for the implementation of the plan; however, the Case Manager should contribute to the planning process.

**Trainer Note:** Refer participants to the IEP example. Review with class briefly to familiarize them with the contents of an IEP.

Child Resource Record

Display Slide 5.2.20 *(PG: 34)*
We reviewed several areas of child well-being that the Case Manager needs to assist in maintaining. The Child Resource Record is where documentation of all of these well-being services is kept.

Under Chapter 65C-30.001 (24), F.A.C., a Child Resource Record (CRR) means a standardized record developed and maintained for every child entering Out-of-Home Care that contains copies of the basic legal, demographic, available and accessible educational, and available and accessible medical and psychological information pertaining to a specific child, as well as any documents necessary for a child to receive medical treatment and educational services.

A CRR is an important component for an Out-of-Home Care provider in meeting a child’s needs. It contains medical, educational, mental health, and other current and historical information for the caregiver to reference and to update with new information.

The CRR remains in the home where the child is placed and will go with the child if there is a change in placement. This allows consistent and complete information to be available to those who are caring for the child. The CRR accompanies the child to every health encounter and must be updated as events occur. All information contained in the CRR must also be recorded in FSFN.

When children are initially removed on a new case, the CPI will initiate the CRR. If the child is being removed on an open services case or on the first visit with the child the Case Manager finds a CRR has not been started, the Case Manager will provide the CRR to the foster parent.

Display Slide 5.2.21 *(PG: 34)*
The CRR contains very private information and it is critical that strict measures be taken to ensure confidentiality. All confidentiality requirements must be reviewed with the foster parent. The foster parent must maintain the CRR in a secure manner, which ensures confidentiality of the child’s resource record documents, such as a locked file cabinet.

**Why is confidentiality of the CRR so important?**

**Endorse:**
It has confidential medical information and history, it has information about the child’s family and the reasons for abuse and neglect, and it has information about a child’s mental health history.

*Display Slide 5.22 (PG: 34)*

**Trainer Note:** Refer class to F.A.C. 65C-30.011(4) and CFOP 155-10/175-40, Chapter 1-6 and discuss the requirements of the CRR.

*Display Slide 5.23 (PG: 34)*
CPIs and Case Managers are responsible for:

- Ensuring all caregivers (licensed care, relative care, non-relative care, and adoptive placements) have a Child Resource Record (CRR) for each child.
- Reviewing the CRR with the caregiver including the purpose, requirements and who is responsible.
- Updating the documents when the child has new medical, mental health, educational, or court records.
- Ensuring the CRR follows the child to every placement.

The foster parent is responsible for:

- Ensuring they receive CRR for every child placed in their home.
- Ensuring information is present and organized in CRR.
- Bringing CRR to every staffing, visit and healthcare visit.
- Maintaining the CRR in a secure manner, which ensures confidentiality, is expected as the child’s sensitive information should be stored in a safe place in the home (i.e., foster parents’ room or a locked file cabinet) in the home.

**Missing Children**

*Display Slide 5.2.24 (PG: 35)*

What does a child being missing have to do with child well-being?

**Endorse:**

Doesn’t have access to medical care, school, food, money, could be in danger, could be with someone who is abusing or exploiting them, caregiver can’t ensure safety.
When a child goes missing, it is a very serious situation. You or the caregivers may not know whether the child ran away or was taken involuntarily; if they just wanted to “hang out late” with friends after curfew or if they are being exploited by Human Traffickers. There is specific protocol for when children are determined to be missing. Every incident when a child’s location is unknown needs to be taken seriously.

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**Trainer Note:** When teaching the missing children section, review with participants to F.A.C. 65C-30.019 and the Optional Handout: “Locating and Recovering Missing Children” form. Also review any specific protocol for your local agency.

When a child goes missing, there are several steps that need to be taken. Once you are informed that a child is missing, you will need to contact Law Enforcement if not already contacted. If a child is 12 or under or there are special circumstances that put the child at high risk, Law Enforcement needs to be contacted immediately. If a child is 13 or older, law enforcement should be contacted within 4 hours. Within those 4 hours, there should be active efforts to locate the child. You will need to provide to Law Enforcement:

- Child’s full name, date of birth and social security number,
- Current photo of child,
- Contact information for relatives and friends that child might reach out to,
- Current caregivers information,
- Circumstances of why child ran away.

After Law Enforcement is contacted, then the parents (If their rights are intact) and the caregiver (if unaware already) need to be notified. CLS, the child’s GAL
attorney and the Attorney ad Litem if the child has one should also be notified immediately, but no later than 24 hours. CLS will have to notify the court within 24 hours of the child being missing.

All of the documentation from Law Enforcement contact, notification of all parties, and other efforts made to locate need to be documented within 24 hours.

**What types of actions might you take to try to locate a missing child?**

*Endorse:*

> Checking friend’s houses or areas the child frequents such as the mall, putting up flyers, calling parents and relatives, etc.

When a child is missing, efforts must be made by the Case Manager to locate the child. Location efforts should be made weekly for the first three months. These efforts can include:

- Contacting friends.
- Contacting parents and relatives.
- Contacting the school to see if child showed up at school.
- Unannounced home visits and field visits to places the child is known to frequent.
- Putting up flyers.
- Contacting hospitals, runaway shelters, DJJ facilities.
- Checking Medicaid billing, contacting child’s doctor’s office.
- Checking ESS, Vital Statistics, Social Security to see if anyone is attempting to obtain records on the child or claim benefits.
When a child is recovered, the protocol is similar. Law enforcement must be contacted so they can confirm the child has been located and remove the child from “missing” status. The parent, guardian, attorneys, CLS and the Court must also be notified within 24 hours.

Also, within 24 hours, the child will need to be debriefed. You will need to assess the child’s well-being to determine if the child needs any medical care or any other immediate services. This includes interviewing the child to find out why they ran away, where they were, who they were with, if they were engaging in illegal activity, or were they engaging in any activity that would indicate they were victims of Human Trafficking. This will help determine any ongoing needs the child may have that may prevent another missing child episode and to also identify patterns of behavior should the child go missing again. The interview with the child should be entered in FSFN as a Missing Child-Debriefing note and recovery notes need to be entered within 1 business day.

This concludes the unit on meeting children’s needs while in Out-of-Home Care. The next unit will focus on how to maintain relationships after removal.
Unit 5.3:
Family Visitation and Maintaining Connections

Display Slide 5.3.1

Unit Overview: The purpose of this unit is to provide participants a review of what family time is, how to assess family time for progress updates, and the importance of maintaining sibling and other connections.

References:
- Section 39.402 (9), F.S., Establishing Visitation at Shelter Hearing
- Section 39.4085 (16), F.S., Goals for Dependent Children
- Section 39.6012 (3)(b), F.S., Case Plan Tasks
- 65C-30.007 (6)(f)2, F.A.C., Documentation of Visitation During Face to Face Contacts
- 65C-28.002, F.A.C., Family Time
- CFOP 170-7, Chapter 10, Establishing Family Time/Visitation Plan
- CFOP 170-1, Chapter 2-11, Family Time/Family Visitation
- Section 39.0139, Keeping Children Safe Act
- H.R. 6893- Fostering Connections to Success and Increasing Adoptions Act of 2008
- Section 39.50-9, F.S., Grandparent Visitation
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Learning Objectives:
1. Explain what Family Time is.
2. Demonstrate ability to evaluate frequency and quality of family time.
3. Explain how the Keeping Families Safe Act affects visitation.
4. Identify why sibling visitation is important.
5. Explain the Case Manager’s role in helping a child maintain family and important connections.

Family Time – What is it?

What do you think are some other ways to support the child’s connections with the family and other relationships, in addition to visitation?

Endorse:
- Face-to-face contact (the preferred form of visits)
- Telephone conversations
- Letters
- Email or text messages
- Video or audio tapes
- Pictures
- Webcasts
- Attendance at religious events
- Participation in family or cultural activities
- Any appropriate creative method of maintaining connections
Family time is meaningful and regular contact is intended to allow the parents the opportunity to gain confidence and practice the behaviors they are learning/gaining from service providers. It affords parents the opportunity to see how their children are doing. Family time also allows children the opportunity to be with parents and other family members they care about.

Family time includes regularly scheduled visitation times, but also includes opportunities for the parents to:

- Attend any type of school, sporting, or extracurricular activity;
- Attend (in person or by phone) a doctor’s appointment, medication management, therapy sessions (such as family, speech, vocational, or physical), or special needs training;
- Participate in monitored telephone calls, facetime, skyping, e-mails, letters, exchange of photographs, etc. Even while in court with a speaker phone, a quick “hello” or “I love you” between an absent parent and child is enormously impactful for both.

In addition to being aware of the parents’ progress in achieving Case Plan outcomes; Florida law requires Case Managers to specifically evaluate the family time/visitation occurring between parents and their children in Out-of-Home Care.

Chapter 39 addresses and encourages family time on three family relationship levels:

1) Family time between the parent and child;
2) Family time among siblings who are separated in various placements; and
3) Grandparent visitation.

Courts are expected to provide oversight on matters related to family time and ensure that the caseworker, caregiver, family, and appropriate child welfare partners engage in developing and maintaining a safe visitation plan.

First, we will discuss family time with parents. We will address sibling visitation and other family connections later in this unit.

**Laws Governing Family Time**

There are several Florida Statutes and Administrative Code that addresses the expectations and requirements of visitation for children who are in Out-of-Home Care.

*Display Slide 5.3.4* *(PG: 38)*

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**Trainer Note:** Refer participants to Florida Administrative Code, 65C-30 and Florida Statutes.

Ask participants to locate the citations in the Administrative Code and Statute if they have the hard copy at their tables. If not, print out or provide the citations below for reading.

Ask volunteers to read the citation out loud. 65C-28.002 is a longer section, so have one participant read section (1) and another participant read section 2.

While the Florida Statute and Florida Administrative Code provide a minimum monthly requirement for visitation between children and parents, best practice
guides that visitation should occur as often as possible, unless there is a restriction on visitation for the best interest of the child. A common timeframe is once a week visitation. For younger children and infants, it may need to be more often to establish and preserve a bond. The frequency of phone contact, letter writing, and other forms of communication can be discussed between yourself, the parents, the caregiver and the child if age appropriate.

**Why do you think it is important to have frequent visitation with very young children, such as newborns and infants?**

**Endorse:**

*Infants and newborns need to bond with their parents and form an attachment. If contact with their parents is infrequent and sporadic, the child may not be able to attach to the parent. The child will form an attachment with their caregiver and not the parent. Infancy is a crucial time of bonding and attachment between a parent and child.*

A visitation plan is developed as part of the Safety Plan. It should outline how to keep the child safe during visitation. Any relatives or persons outside of the Department who will be supervising the contact between the parents and children must be approved by the Department as in informal safety provider.

As the Case Manager, you will be responsible for communicating with the supervisor of contact between the parents and children. You will want them to understand what should be observed during contact so you can obtain feedback from them to assess protective capacities to inform Safety Plan monitoring, progress update and conditions for return. Assessing Family Time is also part of the Judicial Review Worksheet. Progress updates and Judicial Reviews will be detailed further in Module 9.

**Trainer Note:** Refer participants to CFOP 170-7, Chapter 10 on establishing Family Time/Visitation Plan and have them read.
Measuring Family Time/Visitation

We will now review the process of evaluating family time for your progress update and evaluation of Conditions of Return.

*Display Slide 5.3.5* (PG: 38)

![Family Time/Visitation Evaluation Diagram]

**Trainer Note:** Refer participants to CFOP 170-1 Chapter 2-11 to review along as you discuss each rating. Encourage participants to ask questions and seek to clarify the ratings for them.

**Visitation Frequency—“Compliance” with Case Plan**

a. Missed Visits: Visits that are appreciably shortened by late arrival/earn departure are considered missed.

b. Consistent: Caregiver regularly attends visits or calls in advance to reschedule (90-100% compliance).

c. Routine: Caregiver may miss visits occasionally and rarely requests to reschedule visits (65-89% compliance).

d. Sporadic: Caregiver misses or reschedules many scheduled visits (26-64% compliance).

e. Rarely or Never: Caregiver does not visit or visits 25% or fewer of the allowed visits (0-25% compliance).

**Quality of Face-to-Face Visits (include other family time opportunities offered).**

a. Quality of visit is based on Case Manager’s direct observation whenever possible, supplemented by observation of child, reports of foster parents, etc.

b. Excellent: Parent/Legal Guardian/Caregiver Consistently:
   i. Demonstrates parental role.
   ii. Demonstrates knowledge of child’s development.
iii. Responds appropriately to child’s verbal/non-verbal signals.
iv. Puts child’s needs ahead of his/her own.
v. Shows empathy toward child.

c. Adequate: Parent/Legal Guardian/Caregiver Occasionally:
i. Demonstrates parental role.
ii. Demonstrates knowledge of child’s development.
iii. Responds appropriately to child’s verbal/non-verbal signals.
iv. Puts child’s needs ahead of his/her own.
v. Shows empathy toward child.

d. Not Adequate: Parent/Legal Guardian/ Caregiver Rarely:
i. Demonstrates parental role.
ii. Demonstrates knowledge of child’s development.
iii. Responds appropriately to child’s verbal/non-verbal signals.
iv. Puts child’s needs ahead of his/her own.
v. Shows empathy toward child.

e. Adverse: Parent/Legal Guardian/Caregiver Never:
i. Demonstrates parental role.
ii. Demonstrates knowledge of child’s development.
iii. Responds appropriately to child’s verbal/non-verbal signals.
iv. Puts child’s needs ahead of his/her own.
v. Shows empathy toward child.

**Activity F: Family Time**

*Display Slide 5.3.6 (PG: 40)*

- **Instructions:**
  1. Each group has been assigned a rating for Quality.
  2. Using your Quality Rating Category, write down 3 action/behavioral indicators of how parents would demonstrate the quality rating.
  3. Write your response on flip chart paper and be prepared to share.

- **Time:** 20 minutes
- **Purpose:** To develop skills in evaluating Family Time/Visitation for a Progress Update.
Materials:
- CFOP 170-1, Chapter 2-11
- PG: 40, Family Time worksheet
- Flip chart paper

Trainer Instructions:
- Inform the participants that we will be using these ratings to further define behaviors and actions of parents that would be indicative of each rating of quality.
- Working in small groups, each group will be assigned one of the ratings for Quality. (Based on the group size, the trainer may have to have two groups complete one rating).
  a. Excellent
  b. Adequate
  c. Not Adequate
  d. Adverse
- Instruct participants to develop 3 action/behavioral indicators of how parents would demonstrate the quality rating for family time. Have the groups write their answers on flip chart paper.
  
  For example:
  Excellent Rating of “Shows empathy toward child.” – Child is sick and parent shows concern by not wanting to leave child alone and wanting to care for them rather than going out to a party.
- Have the groups display their answers and discuss each Quality rating as a class.

Activity Instructions:
1. Each group has been assigned a rating for Quality.
2. Using your Quality Rating Category, write down 3 action/behavioral indicators of how parents would demonstrate the quality rating.
3. Write your response on flip chart paper and be prepared to share.
**Family Time/Visitation Quality Ratings**

An assessment of the “frequency” and “quality” of visitation is a required component of Judicial Reviews. In order to standardize the criteria used for frequency and quality, the following ratings have been developed.

<table>
<thead>
<tr>
<th>Visitation Frequency</th>
<th>“Compliance” with Case Plan</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits that are appreciably shortened by late arrival/early departure are considered missed.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Consistent:** Caregiver regularly attends visits or calls in advance to reschedule (90-100% compliance).

**Routine:** Caregiver may miss visits occasionally and rarely requests to reschedule visits (65-89% compliance).

**Sporadic:** Caregiver misses or reschedules many scheduled visits (26-64% compliance).

**Rarely or Never:** Caregiver does not visit or visits 25% or fewer of the allowed visits (0-25% compliance).

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**Quality of Face-to-Face Visits**

Quality of visit and other family time opportunities is based on Case Manager’s direct observation whenever possible, supplemented by observation of child, reports of foster parents, etc.

**Excellent**

Parent/Legal Guardian/Caregiver **Consistently**

- Demonstrates parental role.
- Demonstrates knowledge of child’s development.
- Responds appropriately to child’s verbal/non-verbal signals.
- Puts child’s needs ahead of his/her own.
- Shows empathy toward child.

**Adequate**

Parent/Legal Guardian/Caregiver **Occasionally**:

- Demonstrates parental role.
- Demonstrates knowledge of child’s development.
- Responds appropriately to child’s verbal/non-verbal signals.
- Puts child’s needs ahead of his/her own.
- Shows empathy toward child.
**Not Adequate**  
Parent/Legal Guardian/Caregiver **Rarely:**  
- Demonstrates parental role.  
- Demonstrates knowledge of child’s development.  
- Responds appropriately to child’s verbal/non-verbal signals.  
- Puts child’s needs ahead of his/her own.  
- Shows empathy toward child.

**Adverse**  
Parent/Legal Guardian/Caregiver **Never:**  
- Demonstrates parental role.  
- Demonstrates knowledge of child’s development.  
- Responds appropriately to child’s verbal/non-verbal signals.  
- Puts child’s needs ahead of his/her own.  
- Shows empathy toward child.

**Activity STOP**

A part of the evaluation of family time is to ensure that no harm is being done to the child. If family time with the parents becomes unsafe, Case Managers will need to take steps to protect the child. If family time has been Court Ordered, only the Court can modify it. You will need to have discussions with CLS and your Supervisor immediately to take action. Sometimes family time will need to cease completely, or sometimes family time may need to be modified so that only a therapist can supervise the family time. This is known as “therapeutic visitation”.

**What are some reasons that contact between a child and parent might need to be therapeutic?**

**Endorse:**  
- *Child and parent have had no previous relationship*  
- *The relationship is so strained that they need professional guidance with communication*  
- *The children express significant fear of the parent, or the abuse was so severe that a professional needs to be present to observe how the parent interacts with the child*  
- *The parent’s cognitive ability to understand their child’s needs and respond appropriately needs to be monitored by a professional*  
- *There is a question of bonding and attachment between the parent and child which needs to be observed and evaluated by a professional*
The Keeping Children Safe Act impacts visitation, placement and contact between a parent and child. It provides for the protection and reduction of risk of further harm to children who have been sexually abused/exploited by a parent/caregiver by placing additional requirements on judicial decisions related to visitation/contact.

- The court may receive and rely upon relevant oral and/or written reports, even if these reports may not be competent in an adjudicatory hearing.
- If the court finds the person proves by clear and convincing evidence that the safety, and well-being of the child is not endangered by visitation/contact, the court may allow visitation, and will issue an order specifying any conditions it finds necessary to protect the child.
- If the court finds that the parent did not rebut the “presumption of
detriment,” and the safety/well-being of the child may be endangered by visitation/other contact with the parent, the court will issue an order restricting parental visitation/contact.

- If the child is in therapy as a result of the allegations and the child’s therapist reports that the visitation/other contact is impeding the child’s therapeutic progress, a hearing must be held within 7 business days to review the case.

This procedure does not have to only pertain to children who have been sexually abused. You can request a modification of visitation for other reasons that may require more restrictive contact.

**Sibling Visitation**

_How do you think it feels to have a sibling taken away from you suddenly, to go live somewhere else and you didn’t know where they were or how they were doing? Even if you do not have siblings, try to think of someone close to you._

_Endorse all answers._

Another part of family time is sibling visitation. We discussed in Placement Considerations that placing siblings together can often be difficult. The availability of out-of-home placements that are willing and able to take sibling groups are usually limited. However, if siblings are not placed together, they still have a right to visitation and to maintain their relationship. There are specific laws that enforce this.

(Display Slide 5.3.9 [PG: 44])
The Federal Fostering Connections and Increasing Adoptions Act states that reasonable efforts should be made to provide frequent visitation or other interaction between siblings. These efforts should include opportunities for children to spend time with their siblings outside of visitation with parents. Chapter 39 39.4085(16), F.S., establishes as goals for children in shelter and foster care “to enjoy regular visitation, at least once a week, with their siblings unless the Court Orders otherwise”, and 39.6012 (3)(b), F.S., requires that the Case Plan must include, “a description of the parent's visitation rights and obligations and the plan for sibling visitation if the child has siblings and is separated from them.”

The Court, during a Judicial Review will examine the frequency and quality of sibling visitation and any efforts to try to place the siblings together.

Documentation of sibling visitation and reasonable efforts to facilitate should be in FSFN and also in your progress updates.

**Activity G: Sibling Separation and its Effects**

*Display Slide 5.3.10 (PG: 45)*

**Time:** 20 minutes

**Purpose:** Learners will answer questions after watching the scenario to describe the effects of separating siblings.

**Materials:**
- Video: [https://www.youtube.com/watch?v=ZYU-QloCfNg](https://www.youtube.com/watch?v=ZYU-QloCfNg)
- *PG: 45, Sibling Separation and its Effects* worksheet

**Trainer Instructions:**
- Ask participants to watch the video about siblings being placed apart.
• Have the participants think about and record answers to the following question while watching the video: *How do you think not seeing their siblings affected the children?*

• First, as a class, discuss how the participants felt the children in the video not seeing their siblings affected them. Then, discuss the following:

  - Why do you think maintaining siblings’ relationships are important?
  - How can separating siblings impact a child short term? Long term?
  - What can a Case Manager do to help maintain siblings’ relationships?
  - What conversations would you have with the children’s caregivers if the children are placed apart?

• Endorse all relevant answers.

**Activity Instructions:**

1. Watch the video about siblings being placed apart.
2. Record your answer to the following question: *How do you think not seeing their siblings affected the children?*
3. Be prepared to discuss.

**Activity STOP**

**Visitation with other Family Members**

Chapter 39.509 outlines visitation rights for grandparents. Unless found detrimental to the child, or the Court Orders otherwise, grandparents have the right to visitation with a child who has been adjudicated dependent and removed from the parent. Visitation with other family members, such as aunts, uncles, etc. is not specifically outlined in statute. However, in order to maintain connections with family members and to provide a sense of normalcy to the child, visitation and contact with other relatives is encouraged.

**Trainer Note:** Have participants review Chapter 39.509 regarding grandparents rights
**How else could you encourage a child to maintain connections with extended family?**

**Endorse:**
- Phone calls
- Family reunions
- Spending time together on weekends
- Talking through social media
- Informing extended family of child’s activities like sports events, recitals, etc
- Taking them out to dinner during the week
- Encouraging communication between family members and the caregiver

Another way of helping a child maintain connections to their family members, as well as their own identity, is through the creation of a Lifebook. It is important that children maintain that sense of self, whether they are going to be returning to biological parents, living with relatives, or being adopted by a new family.

**Lifebooks to Help Maintain Connection to Birth Family and Identity**

*Display Slide 5.3.11 (PG: 46)*

A Lifebook is a tool and process to help children understand their life experiences so that they feel valued, connected and rooted in their history and culture. The Lifebook is a combination of a story, a diary, and a scrapbook. The Lifebook is an important part of a child’s connections to his or her birth family. It is an important collection of the child’s history and aids the child in his or her identity.
The best time to begin a Lifebook is when a child comes into the foster care system, when the birth family and child’s developmental and family history information are more readily available. The Case Manager and the foster parents, or even the adoptive parents (if no one else had done this job,) retrieve and collect important identity information for the child. If the child is old enough to participate, the Lifebook is developed with the child, not for the child.

Information for a Lifebook may be collected from such sources as:

- Case records
- Case records from other agencies that have had contact with child and or family
- Birth parents
- Foster parents
- Grandparents or other relatives
- Previous social workers
- Hospital where born
- Well-baby clinics
- Other medical personnel
- Previous neighbors
- Teachers and schools
- Court records
- Newspapers – birth announcements, marriage announcements, obituaries
- School pictures (from school records)
- Policemen who have had previous contact with the birth family
- Church and Sunday school records
Contents of Lifebooks

The information to be included in the Lifebook could be:

**Birth Information**
- Birth certificate
- Weight, height, special medical information
- Picture of the hospital

**Birth Family Information**
- Pictures of birth family
- Names, birthdates of parents
- Genogram
- Names, birth dates of siblings, and where they are
- Physical description of parents, especially pictures of parents and siblings
- Occupational/educational information about birth parents
- Any information about extended family members

**Placement Information**
- Pictures of all families
- List of all homes and places of residence (name, area)
- Names of children they were close to
- Names of social workers
- Pictures of social workers to whom child was especially close to

**Medical Information**
- List of clinics, hospitals etc., where child received care; and care given (surgery, etc.)
- Immunization record
- Any medical information that might be needed by the child as they grow up, or as an adult
- Height/weight changes
- Loss of teeth
- When walked, talked, etc.

**School Information**
- Names of schools
- Pictures of schools, friends and teachers
- Report cards, school activities

**Religious Information**
- Places of worship child attended
- Confirmation, baptism and other similar records
Other Information

- Papers and other materials from Sunday School
- Any pictures of child at different ages of development
- Stories about the child from parents, foster parents, and social workers
- Accomplishments, awards, special skills, likes and dislikes

Beginning and Share a Lifebook

It is never too late to start a Lifebook. Foster and Adoptive parents have an important role in collecting information and working with the social worker to help the child develop the Lifebook. Foster and Adoptive parents can share the Lifebook with the child’s birth parents when the child is leaving foster care, to help the birth parents share in their child’s past. Or, they can share the Lifebook with new adoptive parents to help with the child’s move from one family to another.

Adoptive parents can begin helping with the Lifebook at the time of placement. Again, foster parents will want to share the Lifebook with the adoptive parents. Adoptive parents may want to share their own Lifebook with the child as a way of getting to know each other.

Benefits

The process of constructing a Lifebook can:

- Help the child welfare worker, foster parents, adoptive parent, birth parent and child to form an alliance;
- Help a child understand events in the past;
- Help a child feel good about self and record memories;
- Provide a way for the child to share his or her past with others;
- Increase a child’s self-esteem by providing a record of the child’s growth and development;
- Help the birth family share in that part of the child’s past when they were living apart; and
- Contribute to the adoptive family’s understanding of the child’s past, to better help the child develop a positive identity and self-concept.

In the next unit, we will discuss some of the transitions that children in Out-of-Home Care have to navigate.

Unit 5.4: Transitions and Achieving Permanency

Display Slide 5.4.1

Unit Overview: The purpose of this unit is to help participants understand the type of transitions children in Out-of-Home Care face and how to help them navigate through the process.

References:
- 65C-28.017, F.A.C., Exit Interviews
- 65C-30.001 (84), F.A.C., Definition of Permanency
- Section 39.6221, F.S., Permanent Guardianship
- Section 39.6231, F.S., Placement With A Fit and Willing Relative
- Section 39.6241, F.S., Another Planned Permanent Living Arrangement
- 65C-30.004, F.A.C., Post-Placement Supervision and Services
- CFOP 170-7, Chapter 12, Implement Reunification and Post-Placement Supervision
- 65C-16.009, F.A.C., Adoption Placement
- Section 39.6035, F.S., Transition Plan
- 65C-41.004, F.A.C., Transition and Case Plans
- 65C-42.002, F.A.C., Postsecondary Education Services and Support
Display Slide 5.4.2 (PG: 49)

Learning Objectives:
1. Name the different transitions for children in Out-of-Home Care.
2. Describe how transitions affect the child and caregiver and what a Case Manager’s role is in helping them through transitions.
3. Explain what an exit interview is and how it is utilized.
4. Identify Case Management’s responsibilities when a child is reunified.
5. Explain what a transition plan is.
6. Identify what life skills are and how Case Managers ensure life skills are being provided.
7. List the services available after a child turns 18 and the requirements to qualify.

Transitions in the Dependency System (PG: 49)
Transitions and change are a part of childhood and youth for everyone. Moving to a new home, attending a new school, parents divorcing, losing a family member...these are all transitions. Children in Out-of-Home Care experience some very specific transitions. Your goal as a Case Manager is to transition your children into permanency. That could be reunification with parents, adoption, or another goal. Before we move on to discuss some of their specific transitions, we will do an activity to help remind us of the emotions and feelings encountered during a transition.
Activity H: The Process of Transitioning

Display Slide 5.4.3 (PG: 50)

Instructions:
1. Think of a transition you experienced in childhood.
2. Draw the feelings you remember and the memories you have in terms of senses, smell, sounds, sight, etc.
3. Answer these questions:
   - How comfortable were you in this activity? Why?
   - What stands out to you about this activity?
   - What part of the training helped you most in completing this activity?
   - How did others around you in your memory handle the situation and what would you do the same or differently as an adult?

Time: 30 minutes

Purpose: Participants will have a better understanding and perspective of the impact of transitioning by identifying with their own experiences of transition during childhood. Participants will identify positive and negative aspects of a transitioning memory. In addition, this activity will serve as a primer for the next topic, stages of loss and grief.

Materials: • PG 50, The Process of Transitioning worksheet

Trainer Instructions:
- Inform participants that they will be recalling a memory where they transitioned in childhood. Participants should select a memory they have mostly resolved; however, let them know that the next few topics deal with loss and grief so feeling a low degree of loss and grief during this activity is expected.

- Stimulate participants’ memories of a transition they experienced in childhood. It could be a family member going into the military or coming back from conflict, a new school, a new neighborhood and home, a close death in the family, a pet death. Encourage them to draw the feelings they remember and the memories they have in terms of senses, smell, sounds, sights, a transitioning object they touched and held, etc. Assure participants that their drawing skills are not being assessed and that this activity is designed to place them in a child’s world.

- Debrief by asking the following questions:
  - Who can summarize this activity?
  - How comfortable were you in this activity? Why?
  - What stands out to you about this activity?
Activity Instructions:

1. Think of a transition you experience in childhood.
2. Draw the feelings you remember and the memories you have in terms of senses, smell, sounds, sight, etc.
3. Answer these questions:
   - Who can summarize this activity?
   - How comfortable were you in this activity? Why?
   - What stands out to you about this activity?
   - What part of the training helped you most in completing this activity?
   - How did others around you in your memory handle the situation and what would you do the same or differently as an adult?

Activity STOP

Display Slide 5.4.4

Transitions out of the child’s placement can include:

- Movement to a new foster home or licensed placement, due to disruption or change in family that requires the child to move
- Reunification, which can be planned or unplanned (Court Order).
- Relative placement/guardianship, which can also be planned or unplanned (Court Order).
- Adoption with another family.
- Aging out or entering into extended foster care.

**Trainer Note:** Also note other transitions: relative placement into foster care, or child going into a DJJ facility or an Inpatient Psychiatric Facility.

**What are some of the things a child might lose or feel like they are losing when leaving a home?**

**Endorse:**
*Loss of the foster parents and family, familiar routine, safety, friends or familiar teachers (if moving a substantial distance)*

These times of transition can result in children cycling through the stages of grief from their sense of loss.

*Display Slide 5.4.5 (PG: 53)*

Every child handles the stages of grieving differently. There are 5 stages:
- Stage 1 = Shock and Denial
- Stage 2 = Anger
- Stage 3 = Bargaining
- Stage 4 = Despair/Depression
- Stage 5 = Understanding

No matter the reason for a placement move (reunification, permanent placement or disruption), when the child’s experience in a home comes to an end, the child will experience loss and will probably cycle through some or all of the stages of grief. As a Case Manager, you will want to recognize these stages to help you respond appropriately.
A good transition is characterized by the following:

- Talking with children about the changes that occur with transition.
- Helping children understand their own history.
- Helping children adjust to losses.

A good transition requires planning as well as anticipation of how foster parents will support children through the emotional highs and lows they experience. You must also be prepared, in advance, for short-notice transitions. Sometimes there is little to no time to prepare anyone for transition (such as a Court Order requiring an immediate move).

In preparing to talk to children about the changes that occur with transition, you and foster parents and other caring adults in children’s lives should remember to engage the child in the process and listen carefully to the words the child uses and
to the questions the child asks.

- It is important to always tell the truth—even if it is painful—and to validate the child’s experience and feelings. While these talks may bring up painful feelings for children, and for parents who love them, helping children to grieve can also help them to move on to a feeling of permanency with their new family.
- Talks between you, foster parents and children about the changes that will occur with transition will probably need to be repeated several times and in a variety of ways, so children can fully understand at their own level.
- Allow the child talk about the perceived difference in his or her own words. The child should feel safe to talk. Ask open-ended questions of the child such as:
  - “How do you think being adopted will be different from being in foster care?”
  - “What do you think the biggest difference will be, when you’re living with your mom and dad again?”

**Activity I: Transitions**

*Display Slide 5.4.8 (PG: 54)*

**Time:** 20 minutes

**Purpose:** Participants will understand the impact of transitions on foster parents and children and will be able to identify ways to improve the transition process.

**Materials:**
- *PG: 54, Transitions worksheet*
- *Video:*
  
  http://centervideo.forest.usf.edu/qpi/bettertransition/bettertransition.html
**Trainer Instructions:**

- **Break class into small groups** (can be 2 people) and assign each of them one of the video participants:
  - Jennifer Cardinal, Dania Guzman, Erik Guzman, Anna Brown, or KK

- **Play the video for the class,** and have each group take notes for their assigned person. Pause the video at 15:47 and give participants 5-10 minutes to answer the following question: **What could have been done differently?**

- **Have each group present to the class** what they felt could have been done differently, and supplement with any key points they may have missed.

- **Resume video for the class** to watch the remaining content where the video participants describe transitions that went well.

- **Discuss with the class** that it should be encouraged for foster parents and biological parents and relatives to communicate and foster parents can be involved in transitions and transition planning. Parents and relatives should be encouraged to see foster parents as partners in the care of a child. Foster parents are not restricted from transporting children, assisting in moving children or facilitating visitation.

**Activity Instructions:**

1. You have been assigned one of the individuals in the video.
2. Watch the video and takes notes on your assigned role.
3. Write down what you think could have been done differently.
4. Be prepared to discuss with the class.

**Trainer Version**

**Jennifer Cardinal:**
The Case Manager could have gone to the home to assist with packing items and talked with children and family about the immediate transition, Case Manager could have communicated with the relatives to see if they would allow some phone calls or visits to help ease the transition to a strange home or to let the daughter come to say goodbye.

**Dania Guzman:**
The Case Manager should have communicated when the decision was made that the child was not coming back, could have encouraged communication between relatives and foster parent while child was gone so foster parent could provide information and support, Case Manager could have discussed with relatives to see if they would allow the foster parent to drop the child off to ease the transition, could have given foster parent advanced notice of when child was leaving to prepare her and her children, could have communicated with relatives to see if
the foster parent could take the child’s items to them

**Erik Guzman:**  
The Case Manager should have kept his word, or should have been honest if he was not allowed to bring the items with him

**Anna Brown:**  
The Case Manager could have facilitated visits and/or phone calls between the relatives, child and foster parent to help ease the transition, should have communicated the plan to move him or developed a transition plan with the foster parent and relatives, should have provided more notice to the foster parent so she could say goodbye and prepare her own child

**KK:**  
Could have discussed with the placement about not moving the child on her birthday, could have done something special for the child on her birthday if there was no choice, communicated to the new placement that he child was having to move on her birthday and had them help ease that transition

**Activity STOP**

**How can the Case Manager help foster parents talk with children about transition?**

**Endorse:**  
Participants should identify ways to manage a child’s emotions/behaviors that include, but are not limited to:

- Talk to the foster parent about how to best handle the transition.
- Explain what happens during the transition process.
- While you want to discuss the transition under ideal circumstances, you must also be prepare the foster parents for and discuss what happens if a child is pulled out of the foster home without warning. A judge may decide to physically pull a child from the home, but that does not mean that the case is closed or that the foster parent cannot work to create a transition for the child once removed.
- Help the foster parent advocate for a transition plan and ensure they attend court throughout the process.
While it is comforting for caregivers to know that they are doing an extraordinary thing by providing a child the care he/she needs to heal and to thrive in the future, it takes a lot of courage to be a foster parent or other Out-of-Home Caregiver. Foster parents often feel more loss because as a rule, they are a temporary placement for this child. (Caregivers who are relatives are more likely to continue a relationship with the child.)

They have nurtured and cared for a child for months or even years. They have become deeply attached to the child and now the child is leaving their home because he/she is transitioning to a permanent placement, independence or back home. Or, they cannot meet this child's needs and he/she must be placed in a different foster home. Either way, it can be an emotionally draining time for everyone!

During this time, as we know, both the child and the caregiver will experience grief and loss. They may experience the stages of grief we talked about earlier: denial, anger, bargaining, depression and acceptance.
How can you help foster parents prepare for the separation in advance?

Endorse:
Participants should identify ways to help Foster Families prepare for separation in advance that include, but are not limited to:

- Encourage them to work with the birth family as much as they can so they can ALL feel a sense of continuity and connection.
- Encourage them to reach out, through visitation, conversations, letters, phone calls and emails, to the new family to help the transition and to build connections.
- Encourage them to reach out to the team when they need extra support.
- Encourage them to share their grief with their partner, the birth parent(s), children, and team.

When the child leaves the home an exit interview will be conducted as part of the transition process.

The Exit Interview

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The exit interview is a tool utilized when a child leaves a licensed foster home. It is a way to empower youth by providing them a voice, and it enables the Department to provide feedback for foster parents. In order to assess the quality of care in the placement, it is necessary to get the child’s perspective about his or her experience in the home. The exit interview is outlined in FAC 65C-28.017.
• Exit interviews are completed for any child 5-years-old until their 18th birthday that leaves a licensed Out-of-Home Care placement and resided in that placement for 30 days or more.
• Exit interviews are completed within 5 days of leaving placement regardless of why the placement ended (i.e., child was arrested, reunification, aging out, etc.).
• The interview should be conducted based on the child’s level of comprehension and age level.
• The interviewer’s observations and any information to explain the child’s responses must be recorded on the interview tool.
• Exit interviews should be done in a private setting to allow the child to be comfortable in being interviewed.
• Follow-up must occur based on the responses by the child.

**Trainer Note:** Have participants review an exit interview tool used by their agency and discuss how this tool helps assess the quality of care in foster homes. Note the differences in questions for children ages 5-8 and 9-18.

The exit interview tool involves a staff member, usually the child’s Case Manager, interviewing a child. It is important that the staff member uses effective interviewing techniques, really listens to what the child is saying, and uses great sensitivity during the interaction. We want to make sure that our children are heard! Just as with adult partners, we should use the practice principals of mutual respect, positive practice and solving problems rather than assigning blame. If the child was unable to participate or failed to participate, these reasons shall be documented (i.e., child’s mental capacity provided a challenge, child was aggressive towards staff member and ultimately uncooperative). Licensing specialist’s role is to utilize feedback provided the child in the exit interview. If a foster parent receives feedback that is unfavorable, this information shall be addressed which may identify training opportunities.

**Trainer Note:** Have participants review child interviewing techniques. View the Partnership Plan For Children in Out-of-Home Care: Training Module 2 video

[http://centervideo.forest.usf.edu/qpi/pship02/pship02.html](http://centervideo.forest.usf.edu/qpi/pship02/pship02.html) Start at 18:01, end at 31:22.
How does the Case Manager use interviewing techniques as well as practice the principals of mutual respect, positive practice and solving problems rather than assigning blame?

Endorse:
Participants should identify techniques that include, but are not limited to:

- Establishes rapport and engages the youth. For example, she thanks the child for participating in the interview and acknowledges her time.
- Follows a process of using mutual respect to build a positive relationship. For example, although the youth was resistant, the Case Manager explains that the youth’s input is important because she was the one who was in the foster home. She explains how the youth’s input will be used create change and to give the foster parents feedback. She compliments the child for her resiliency and how well she has done throughout the experience.
- Sets up expectations and the boundaries for the interview by paying attention to what the youth needs and keeping in mind where she wants to go with the interview. She recognizes the child’s dislike of paperwork and suggests a conversation instead. She also explains why the interview is important. She negotiates a time limit with the child and the Case Manager works to respect this time while gathering great information.
- Solving problems rather than assigning blame. For example, the Case Manager asked the child to provide a suggestion/fix for the awkwardness she felt when the foster parents introduced her to their friends. The Case Manager acknowledges the transportation issue, but asks the youth for advice on how the foster parents and the team can help youth feel a sense of normalcy.
- Probing. For example, the child acknowledges that the subject of her birth family was a touchy subject with the foster parents and the Case Manager asks follow-up questions to attempt to gather more information.
- Positive Practice. Explored ways the foster parent helped child stay connected with the family by posing the question “What did she do to help” instead of “What didn’t she do.”
Exit Interview Follow-Up

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The following tasks are completed as part of the Exit Interview follow-up:

- If the child alleges abuse, neglect or any maltreatment during the exit interview, the interviewer must contact his/her supervisor to advise of the disclosure and then make an immediate report to the Florida Abuse Hotline. We will discuss this in further detail in Module 6.

- If the child reports issues relating to the quality of care that do not rise to the level of abuse, neglect, or maltreatment, the interviewer report this disclosure to his or her supervisor in order to gain a consensus that this issue does not rise to the level of an abuse report. If agreed, the staff person may be directed contact the hotline in order for a foster care referral to be generated or complete an internal licensing concern to the licensing unit. By contacting the Hotline for the acceptance of a foster care referral, the staff is further confirming the decision he/she and their supervision have made. We will discuss this in further detail in Module 6.

- If needed, the licensing specialist will develop a corrective action plan with the foster parent. Corrective action plans must be approved by the DCF Regional Licensing Authority prior to implementation.
  - More intense supervision, support, or training for the foster parent.
  - Formal corrective action plan.
  - Recommendation for revocation of the license.

- When corrective action is necessary, written follow-up is due within 90 days.

- The completed interview form, agency response, if any, and follow-up tasks shall be handled as follows:
The record of follow-up must be placed in the child’s case record.
A copy of the completed interview form is provided to the licensing staff and uploaded into FSFN with a provider note or within UHS if during the licensing and relicensing process.

**What do you think the follow-up should be based on the video we watched of the exit interview?**

*Pause and let participants respond.*

Now that we have completed the exit interview for when a child leaves a foster home, we will explore the types of transitions related to permanency. We will start with explaining Permanency.

**What is Permanency?**

*Display Slide 5.4.12 (PG: 56)*

Who knows what we mean when we say the word permanency?

**Endorse:**
- A safe, stable and secure parenting relationship
- Love
- Unconditional commitment
- Lifelong support
- A forever home
- A permanent place to live
- Case is closed and the Department no longer needs to be involved
The definition of permanency, according to F.A.C. 65C-30.001(84) is achieving a permanent home for a child through reunification, adoption, guardianship, placement with a fit and willing, or another planned permanent living arrangement.

Display Slide 5.4.13 (PG: 56)

The permanency goals available under this chapter, listed in order of preference, are:
- Reunification;
- Adoption, if a petition for termination of parental rights has been or will be filed;
- Permanent guardianship of a dependent child under s. 39.6221;
- Permanent placement with a fit and willing relative under s. 39.6231; or
- Placement in another planned permanent living arrangement under s. 39.6241.

Permanency will also be discussed in more detail in Module 9.

**Reunification**

The transition to Reunification occurs when a parent has met conditions for return and has increased protective capacities so that a child can go home and the family can be managed with an In-Home Safety Plan. How conditions of return are measured and met will be discussed in detail in another module. Once reunification occurs, the ongoing monitoring of the family is called “Post-Placement Supervision.” A family is monitored for a minimum of 6 months after reunification.
Often times, there is a transition plan developed to determine how a child will transition back into the home with the parents. This would include unsupervised and overnight visitations and a date for full reunification to prepare the child, parent, and Out-of-Home Caregiver. Sometimes, the reunification is not planned, such as when the Court Orders immediate reunification. In that case, there is little ability to create a transition period.

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The Case Manager’s responsibility once a family is reunified is outlined in Administrative Code and the CFOP.

- **Visitation-** In the initial phase of post placement supervision, your contact with the family will be more frequent. This time is a significant period of adjustment for both the child and the parent. There will often be changes to routines, different rules, and a testing of boundaries.
- **An updated Case Plan will need to be completed for the post-placement period outlining services for the family and child during this period. This Case Plan may include services to help stabilize the family and adjust to living together again.**
- **Ongoing monitoring of the Safety Plan.**
- **Continuing to assess child well-being even though the child has returned to the custody of the parents**

**Trainer Note:** Refer to your area’s policy on frequency of post-placement home visits.

If there are any concerns for closing the case, such as a need to modify the Safety Plan or a new maltreatment, post-placement supervision may exceed 6 months. However, if the Safety Plan is able to be terminated and the Court approves case
closure, then protective supervision will be terminated and the family will have achieved their permanency goal. Case closure will be addressed further in Module 9.

**Adoption**

A child may transition from a licensed foster home to an adoptive placement. Sometimes a child is placed in a foster home or group home that is unable or unwilling to adopt the child. In that case, there are recruitment efforts to try to locate a relative, non-relative, or potential adoptive family for the child. Potential adoptive placements must go through a rigorous adoption study prior to placing the child (adoptive home studies are also required if the current caregiver is adopting). Generally, if a match for a child and adoptive family are found, there is a transition period. The transition period allows the child and the family to get to know each other. There is generally a period of daytime, then overnight visitations and a final date of transition is set.

**Trainer Note:** Refer participants to F.A.C. 65C-16.009 and review the steps for an adoption placement.

*Display Slide 5.4.15 (PG: 57)*

Transitioning from a home that has been caring for them through the Dependency process to a new, potential adoptive family can be very difficult. There are some things a Case Manager can do when working with the youth, the current caregivers, and the adoptive family. They are:

- Talk with the youth about changes that occur with an adoption
- Validate the child’s memories, experiences, and feelings
- Tell the truth to the child when they ask a question
- Help children grieve their past so they can move on to a feeling of permanency
- Inform adoptive parents of the issues the Case Manager and child are discussing so they can be engaged in supporting the child
• Help children grieve their past so they can move on to a feeling of permanency
• Inform adoptive parents of the issues the Case Manager and child are discussing so they can be engaged in supporting the child.

Display Slide 5.4.16 *(PG: 57)*

In order to make these discussions beneficial to the youth and for the transition to be successful, there are some steps that can be followed. They are:

• Help the child talk about their feelings in their own words. Asking open ended questions like: How do you think being adopted will differ from foster care? What do you think will be the biggest difference once you are adopted?
• Help them understand legal differences by explaining the adoption court hearing and what will happen, like the case will close and they will no longer have Case Manager.
• Help them understand parenting differences, like their adoptive parents will become their permanent parent, and can sign and give permission for things without having to ask the Case Manager.
• Help children adjust to losses by creating a life book, eco-map, etc. so the child can see and know their history. It is also important for the youth to hear and feel from people that are important that it is alright to love another family.
• Be mindful of the child’s needs in the context of age, mental and physical health, personality and ethnic or racial experiences.

The important message is that adoption, while viewed as a positive experience, can be very difficult for the youth and families going through it. The transition
should be viewed as a team approach, involving the Case Manager, the youth, the foster family, the adoptive family, the child’s therapist, family members, and anyone else important to the process.

**Permanent Guardianship**  
*(PG: 57)*

Reunification or adoption is the preferred permanency goal for children. However, if a relative is located, and the relative is unable or unwilling to adopt, the child may achieve permanency through Permanent Guardianship. There may be other circumstances for Permanent Guardianship, for example TPR is not in the child’s best interest but the child cannot return home. This means that the caregivers become the permanent custodians, but the parent’s rights are not terminated. The court would retain jurisdiction and the parents would be able to re-open the case if they improved their diminished protective capacities. Because of this ability to re-open the case, this is not considered a “permanent” option and why it is not the preferred permanency goal.

**Independent Living**

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If a youth is unable to achieve permanency through Reunification, Permanent Guardianship, or Adoption, they may be eligible for programs available to them after they turn 18. Any time a child is in Out-of-Home Care, there is some preparation prior to 18 for living independently. Once a youth turns 18, there are several options with specific eligibility requirements: Extended Foster Care (EFC), Post-Secondary Educational Supports and services (PESS), or Aftercare services. A young adult also has the option to choose none of these options when they turn 18 and live completely on their own without the assistance of the Department.
This is an important transition for the youth. The Case Manager is integral in helping the young adult transition to adulthood.

*Have participants watch the following video, and then answer the questions:*

[https://www.youtube.com/watch?v=f4Vw0HS4seM](https://www.youtube.com/watch?v=f4Vw0HS4seM)

*What do you think are some of the emotions youth transitioning to adulthood feel?*

*What did you have when you became an adult that you think youth in foster care don’t have?*

*What should you do to help prepare youth for transitioning out of foster care into adulthood?*

*Endorse all answers.*

**Life Skills and Transition Planning**

Preparation for Independent Living begins years before a child turns 18. Youth who are in any out-of-home placement and are 13 or older should be provided with life skills training by their caregiver, regardless of what their permanency goal is.

*What are some life skills that you would need as you approach adulthood?*

*Endorse all answers.*
Life skills are those skills that are necessary or desirable for full participation in everyday life. Most of us learn these skills from parents, relatives, or other important, consistent people in our lives. Youth in foster care need special consideration to ensure that they are also being taught the necessary skills they need to prepare them to live independently.

The Case Manager has the responsibility to discuss with the caregiver and youth monthly the youth’s life skills needs and how they are being addressed in the placement. If the youth is struggling with any particular life skills, the Case Manager in conjunction with the caregiver and youth need to determine what services or training needs to be done to improve those areas of improvement.

These discussions need to be documented in FSFN.
Transition plans are required, per Statute and Administrative Code, for children in licensed foster care. Transition planning begins when a youth turns 17, and a transition plan must be completed at least 90 days before the youth turns 18. The transition plan must include specific information about what the youth’s plans are when they turn 18.

**Trainer Note:** Provide an example of your local transition plan and review with participants.

Case Managers are responsible for participating in transition planning with the youth. Case Managers should also be providing assistance to the youth prior to aging out, such as finding housing, filling out school/financial aid applications, reviewing transition plan to see if changes need to be made, and assisting youth with gathering important documentation like birth certificate, Medicaid card, social security card, and ID card.

**Extended Foster Care (EFC)**

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When a youth turns 18 and in licensed foster care, Extended Foster Care (EFC) is available. A youth must be in a licensed foster care placement at the time they turn 18 to qualify. There is no requirement on how long the youth was in a licensed placement. In order to qualify for EFC, the young adult must also be enrolled in a qualifying program. This includes:

- An educational program (high school, GED, vocational, college)
- Working minimum of 80 hours per month
- Enrolled in a program designed to promote or eliminate barriers to employment
• Documentation of a physical, intellectual, emotional, or psychiatric condition that limits participation in any of the above
EFC requires face to face contact with a Case Manager monthly, and requires a Case Plan and Judicial Reviews until termination of the young adult from the program. Eligibility ends once a young adult turns 21 (22 if there is a disability).

The continuing eligibility of the youth is monitored by the Case Manager responsible for supervising the youth after 18, and if qualifications are not met or the youth is not cooperating with requirements than they will be terminated from the program. If eligibility is met again after termination, the youth may re-apply.

Postsecondary Education Services and Support (PESS)

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Some youth in foster care will have their high school diploma or an equivalent by the time they turn 18. If they do, they may apply for PESS. It is important to note that a youth may not be eligible when they age out of foster care, but may be eligible at a later time. A youth can apply for the program at any time as long as they meet the age and eligibility requirements.

F.A.C. 65C-42.002 outlines the requirements for PESS. A youth must be in licensed foster care when they turned 18, or was 16 or older when they were adopted. They had to have been in foster care for a total of 6 months while in Out-of-Home Care. They have to be at least 18, but not older than 23. Eligibility ends when a young adult has obtained their first Bachelor’s Degree or turns 23. They must have a high school diploma or an equivalent when applying, as being enrolled in a postsecondary education program (vocational school, community
college, university) is also an eligibility requirement. The Case Manager will have to obtain ongoing academic progress reports to determine continuing eligibility for the program, and renewal is required annually.

**Aftercare Services**

*PG: 60*

If a youth does not qualify for PESS or EFC, but has an emergency need, they can apply for Aftercare Services. An aftercare plan would be developed with the youth that outlines the amount of temporary assistance and what activities the young adult will complete to achieve self-sufficiency or to qualify for PESS or EFC. The plan is reviewed every three months and the plan can be terminated if the youth is not making efforts to complete the activities.

Referrals for services should be completed within 10 days, and cash assistance is generally provided directly to the vendor (landlord, utility company, etc.). Documentation of requests for service referrals, requests for cash assistance, the after care plan, and case management efforts to assist should be documented in FSFN.

**Trainer Note:** *Discuss any important requirements of your local policy regarding EFC, PESS, and aftercare.*

This concludes Module 5 on Out-of-Home Care. In Module 6, you will learn in detail the Preparation and Introduction stages of Family Engagement.