Child Welfare Pre-Service Training

Case Planning

Participant Guide

July 2013
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Module 1: Client Relationships and Case Planning

Small Group Exercise

Your job is to prepare a summary of your group’s experience in working in ongoing case management services, and to consider and discuss your perspective(s) regarding a series of questions related to case planning, concept of change, focus of change intervention, and ongoing case management success.

Have someone in your group write down your responses. It is anticipated that there may be more than one perspective for each of the questions. That’s fine…this exercise is not necessarily asking for you to have consensus among practice teams.

Be prepared to summarize your discussion and perspective(s) with the rest of the group.

Your summary to the rest of the group should include the following:

? What should be the primary reason for “opening” a family for ongoing case management?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

? What is the “bottom line” for what represents success in ongoing case management?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

? What is the treatment focus of the case plan?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

? What is the ongoing case manager role in working with caregivers?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
The Trans-Theoretical Model (TTM) for the First Five Stages

Trans-Theoretical Model (TTM) (Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992) provides a way to understand the cognitive process for human change. The knowledge regarding how and why change occurs among individuals is important for understanding the rationale for the design of the ongoing family functioning assessment, and has direct implications for how ongoing case managers should behave when intervening with caregivers.

The premise of TTM is that human change is a progressive cyclical mental and behavioral process that occurs as a matter of personal caregiver choice and intention. Working from this perspective, the ongoing case manager seeks to engage caregivers in conversations that are intended to promote problem recognition, if not acceptance, and reinforce a caregiver’s internal desire for change. Adopting the principle assertion of TTM that change can be facilitated by influencing internal motivation, the conversations that occur with caregivers during the ongoing family functioning assessment attempt to raise self-awareness regarding the need for change, to instill hope for change and to elicit caregiver input regarding what must change related to caregiver protective capacities.

Stages of Change

The stages of change embody the dynamic and motivational aspects of the process of change described in TTM. There are five sequential stages that people move through when considering the impact of personal problems, thinking about the need for change and eventually making choices about doing something to change. Rarely do individuals move through the stages of change in a prescriptive linear way. More often, when individuals are struggling to make choices regarding the need for change, there is a tendency to vacillate between problem recognition and problem denial; between wanting to do something to change and insecurity about the ability to change; between taking steps to change and relapsing back into problem behavior.

The stages of change provide ongoing case managers with a realistic model for understanding the difficulties that caregiver face in making choices regarding change and the challenges that are evident when intervening with caregivers to help facilitate that change. Understanding the stages that a caregiver goes through to make choices regarding change is crucial for providing ongoing case managers with a rationale for how to interact with caregivers during the ongoing family functioning process including being non-judgmental; supporting self-determination; creating discrepancy for change; exploring intentions for change; considering what caregivers are ready, willing and able to do; encouraging and instilling hope for change; and providing options.

Pre-Contemplation: Not Ready To Change!

The caregiver is communicating during ongoing family functioning assessment conversations that he does not acknowledge that there are problems and he does not consider the need to change. The caregiver who is in the pre-contemplation stage of change tends to demonstrate some level of resistance. They are reluctant to participate in conversations during the ongoing family functioning assessment. They may express “fake cooperation” as a form of resistant and may even acknowledge that they are willing to complete services, but in reality they do not have intentions to change or they do not believe that change is possible. They may be rationalizing problems or blaming others; make excuses; or accusing the ongoing case manager of interfering in their lives. They could be actively rebelling against intervention by being overtly argumentative during conversations.
The majority of caregivers who begin the ongoing case management process do so as involuntary clients. These caregivers tend to be in pre-contemplation about all or some of the problems that were identified during the investigation, they likely feel forced or coerced to be involved with case management and as a result, they feel a sense of powerlessness.

**Contemplation: Thinking About Change**

Caregivers may begin the ongoing family functioning process thinking about problems and considering the need to change but they have likely not made a decision that change is necessary. The conversations that occur during the ongoing family functioning assessment are intended to facilitate caregivers to begin weighing the pros and cons for change. Caregivers who are in the contemplation stage for change are ambivalent. They consider the need for change, but they are hesitant to fully acknowledge problems, and they are not sure they want to give up negative patterns of behavior.

When caregivers begin the assessment as highly resistant, efforts to facilitate change should concentrate on moving caregivers from pre-contemplation to a mindset of contemplating the need for change. Simply getting caregivers to minimally acknowledge problems and start thinking about the need for change is a realistic objective for intervention in the short term when caregivers are very resistant to participating in the ongoing family functioning assessment much less open to thinking about change.

**Preparation: Getting Ready to Make a Change**

As a result of the self-awareness raising that occurs during the ongoing family functioning assessment, many caregivers will move toward taking increased ownership for their problems (or at least some of their problems) and they will start talking about not only the need for change, but what specific behavioral change would look like. When conversations are productive with respect to eliciting caregiver feedback regarding what must change, there emerges a period of time when a window of opportunity opens for engaging caregivers to commit to taking steps to change.

**Action: Ready to Make a Change**

Caregivers who are in the action stage are not only taking steps to change, including participating in a change process with the ongoing case manager and other changed focused services, but they also express a belief and attitude that the actions taken to address problems will result in things being different. In effect, when a caregiver completes the ongoing family functioning process and commits herself to participating in services and working toward achieving outcomes and case plan outcomes, she is moving into action stage. If at the conclusion of the ongoing family functioning assessment or in the months following the implementation of the case plan, a caregiver communicates that she is ready, willing and able to make change and then proceeds to take the steps to do so, she is in the action stage.

**Maintenance: Continuing to Support the Behavior Change**

A caregiver does not reach the maintenance stage of change until she demonstrates sustained behavioral change for at least 6 months. Caregivers may still be actively involved in completing their case plans and participating in services, but significant progress has been made toward the achievement of outcomes and outcomes related to caregiver protective capacities and child well-being. It is important to note that a caregiver is not likely to be in the maintenance stage for all outcomes in the case plan at the same time. In most cases, it will be more likely that caregivers could be in the maintenance stage for one outcome related to caregiver protective capacities while still remaining in the action stage or even contemplation stage related to other outcomes. In ongoing case management, the change process is evaluated at least every 90 days, or at critical juncture, during the ongoing case management and services to determine
when sufficient change has occurred such that no intervention is required and the case can be closed.

**Stage of Change Specific to Substance Use: SAMSHA and NCSAW**

Relapse
The assessment of stage of change has been incorporated into most substance abuse treatment programs, and treatment interventions should be thoughtfully matched to the stage of change an individual is in. Addiction programs may use stages of change models that have been customized around addiction. The first five stages of change in this curriculum are appropriate for a range of challenges. The six stage of “relapse” has been added and is specific to addictions.

Relapse
Substance abuse is a complex and chronic disease that has biological and behavioral components. A comprehensive treatment program, tailored to the individual, is necessary for the treatment success. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. Most people working to overcome an addiction experience relapse. It is much more common to have at least one relapse than not.

Relapse is not the same as treatment failure. Recurrence of substance use can happen at any point during recovery. When a parent relapses, it is important to help the parent recognize the difference between lapses (a period of substance use) and relapse (the return to problem behaviors associated with substance use), and to work with the parent to re-engage him or her in treatment as soon as possible. It also important to note that a urine toxicology screen will not tell you whether the individual has had a lapse versus a relapse. Part of effecting long-term change includes working with parents to identify the specific factors that preceded their substance use—what were the emotional, cognitive, environmental, situational, and behavioral precedents to the relapse?

Child welfare workers can help a parent plan for the potential of relapse and for ensuring safety of the child. Parents who learn triggers can become empowered to plan proactively for the safety of their children and to seek healthy ways to neutralize or mitigate the trigger. One element in the process of recovery is to develop a relapse prevention plan.

Parent/Caregiver Protective Capacities: Definitions and Scaling Criteria

Caregiver Protective Capacities: Personal and caregiving behavioral, cognitive and emotional characteristics that through research have been shown to be specifically and directly associated with being protective to one’s young. Protective capacities are personal qualities or characteristics that contribute to vigilant child protection. Criteria for determining caregiver protective capacities include:

1. The characteristic prepares the person to be protective.
2. The characteristic enables or empowers the person to be protective.
3. The characteristic is necessary or fundamental to being protective.
4. The characteristic must exist prior to being protective.
5. The characteristic can be related to acting or being able to act on behalf of a child.

Note: Protective capacities are distinct from “protective factors.” Protective factors are conditions or attributes that have been shown through research to mitigate or eliminate risk in families for maltreatment. Protective factors are correlated with the ability of parents to find resources, support, or coping strategies that allow them to parent effectively. Risk of future maltreatment is commonly assessed on a continuum from low to high and refers to the probability that any form of child maltreatment, regardless of severity, may occur or recur in the future.

Organizing Constructs for Scaling

Caregiver protective capacities will be assessed for each person in the household who is in a caregiving role using the following four-point scale. For each specific capacity, this criterion has been individualized. An “A” or “B” rating for any indicator reflects that the protective capacity is dependable; a “C” or “D” rating reflects that the protective capacity is not dependable and may require attention.

This assessment should be used to systematically identify protective capacities that should be the focus of thoughtful, case plan interventions. The information gathered from the case manager to complete this assessment will be gathered from the child, parent, and collateral sources such as an extended family member, a substance abuse or mental health treatment provider, and/or professional evaluator.

A= EXCEPTIONAL
The protective capacity in this area is exceptional and not only leads to positive functioning in the area, but serves or can serve to compensate for limitations in other areas.

B=ACCEPTABLE
The protective capacity in this area is typical of most families. While there may be occasional struggles in the area, there is no significant adverse impact on child.

C=SOMewhat DIMINISHED
Protective capacity in this area is somewhat diminished and the child may be experiencing more substantial adverse impact, however this area has not directly led to serious harm or danger.

D=INADEQUATE
Protective capacity in this area is so limited that there are clear connections between the lack of this protective capacity and serious harm that has already occurred or danger that serious harm is likely.
**Behavioral protective capacities** refer to specific action, activity or performance that is consistent with and results in parenting and protective vigilance. The following parent/caregiver capacities are behavioral.

1. **The parent/caregiver demonstrates impulse control.** This refers to a parent/caregiver who is deliberate and careful, who acts in managed and self-controlled ways.

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<th>Description</th>
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<tbody>
<tr>
<td>A</td>
<td>Parent/Caregiver consistently does not act on their urges or desires, does not act as a result of outside stimulation, avoids whimsical responses, and thinks before they take action. Parent/Caregiver is thoughtful in their actions when caring for children and making life choices.</td>
</tr>
<tr>
<td>B</td>
<td>Parent/Caregiver regularly does not act on their urges or desires, does not act as a result of outside stimulation, avoids whimsical responses, thinks before they take action, and are plan full when caring for children and making life choices. When parent/caregiver does act on urges/desires, they do not result in negative affects to their children or family.</td>
</tr>
<tr>
<td>C</td>
<td>Parent/Caregiver routinely (weekly/monthly) acts upon their urges/desires, is influenced by outside stimulation, thinks minimally before they take action, and are not deliberate, resulting in their actions having negative effects on their children and family.</td>
</tr>
<tr>
<td>D</td>
<td>Parent/Caregiver frequently (daily) acts upon their urges/desires, is highly influenced by outside stimulation, does not think before taking action, and does not plan. Parent/Caregiver’s inability to control their impulses results in negative effects on their children and family.</td>
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2. **The parent/caregiver takes action.** This refers to a person who is action orientated, sufficiently healthy and physically able, assertive and responsive.

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<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>A</td>
<td>Parent/Caregiver takes action, is assertive and response, and is physically able to respond to caregiving needs, such as chasing down children, lifting children, and is able to physically protect their children from harm consistently. Parent/Caregiver may have physical limitations, however demonstrates the ability to accommodate those physical limitations in order to take action.</td>
</tr>
<tr>
<td>B</td>
<td>Parent/Caregiver is able to take action, is assertive and responsive, and/or is physically able to respond to caregiving needs, however requires assistance on occasion to be able to meet children’s needs. Parent/Caregiver may have a physical limitation, and occasionally is not able to demonstrate the ability to accommodate those physical limitations in order to take action.</td>
</tr>
<tr>
<td>C</td>
<td>Parent/Caregiver regularly is not able to take action, be assertive and responsive, and/or physically respond to caregiving needs. Parent/Caregiver needs assistance on a regular basis (weekly). Parent/Caregiver may have a physical limitation, and on a regular basis is not able to accommodate those physical limitations in order to take action.</td>
</tr>
<tr>
<td>D</td>
<td>Parent/Caregiver is not able to take action, be assertive and responsive, and/or physically respond to meeting caregiving needs of children. Parent/Caregiver requires assistance routinely (daily). Parent/Caregiver may have a physical limitation, and routinely is not able to accommodate that physical limitation in order to take action.</td>
</tr>
</tbody>
</table>
The parent/caregiver sets aside their own needs in favor of a child. This refers to people who can delay gratifying their own needs, who accept their children’s needs as a priority over their own.

A  Parent/Caregiver identifies their child’s needs as their number one priority. Parent/Caregiver has demonstrated through their actions that they place their child’s needs above their own by waiting to be satisfied, sacrificing for their children, and through seeking ways to satisfy their child’s needs as a priority. Parent/Caregiver does not need to be prompted by others to understand their needs as secondary to the child.

B  Parent/Caregiver views the child’s needs as a priority, however at times struggles to place their children’s needs before their own. The lack of understanding that the child’s needs as a priority does not result in the children being maltreated or exposed to danger.

C  Parent/Caregiver recognizes the need to place their child’s needs as a priority, however is not able to set aside their own needs in favor of their child’s needs, resulting in the child being maltreated and/or exposed to danger.

D  Parent/Caregiver does not recognize the need to place the child’s needs as a priority and does not set aside their own needs in favor of the child’s, resulting in the child being maltreated and/or exposed to danger on regular occasions.

The parent/caregiver demonstrates adequate skill to fulfill caregiving responsibilities. This refers the possession and use of skills that are related to being protective. Skills are used to ensure that basic needs are met for children, including food and shelter.

A  Parent/Caregiver is able to feed, care for, and supervise child. Parent/Caregiver has the skills necessary to cook, clean, maintain, guide and shelter child as related to protectiveness.

B  Parent/Caregiver is able to feed, care for, and supervise child, however at times requires assistance in fulfilling these duties. Parent/Caregiver is able to seek assistance in meeting child’s needs and the need for assistance does not result in the child’s needs being unmet and/or children being maltreated.

C  Parent/Caregiver has minimal skills related to providing for the basic needs of child. Parent/Caregiver lacks the ability to consistently feed, and/or care, and or/supervise child resulting in maltreatment and/or danger. Parent/Caregiver recognizes the need for assistance, however does not act to seek resources to assist in fulfilling caregiving responsibilities.

D  Parent/Caregiver has little to no skills related to providing for basic needs of child. Parent/Caregiver does not feed, and/or, care, and/or supervise child resulting in child being maltreated and/or in danger. Parent/Caregiver does not recognize the need to provide for basic needs of child and/or the parent/caregiver will not or cannot seek resources to assist in fulfilling caregiving responsibilities.
The parent/caregiver is adaptive as a caregiver. This parent/caregiver can adjust, is flexible and can make the best of whatever caregiving situation occurs.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
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<tbody>
<tr>
<td>A</td>
<td>Parent/Caregiver is flexible and adjustable, is able to accept things and move, is creative in their caregiving, and is able to come up with solutions and ways of behaving that may be new, needed and unfamiliar but are fitting to their child’s needs.</td>
</tr>
<tr>
<td>B</td>
<td>Parent/Caregiver is able to be flexible and adjustable in most situations, is able to accept most things and move forward, displays some creativity in their caregiving, and is able to come up with solutions and ways of behaving that are new, needed, and unfamiliar with some assistance. On occasion the parent/caregivers adaptation is not meeting their child’s needs, however this does not result in maltreatment and/or danger.</td>
</tr>
<tr>
<td>C</td>
<td>Parent/Caregiver lacks flexibility in most situations, including routine caregiving responsibilities. Parent/Caregiver struggles with adapting to meet child needs, including identifying solutions for ways of behaving or caretaking that does not result in maltreatment and/or danger to child. Parent/Caregiver acknowledges their struggle with flexibility and adaptation, however has not sought assistance in changing their behavior.</td>
</tr>
<tr>
<td>D</td>
<td>Parent/Caregiver is not flexible and/or adaptive in caregiving duties, resulting in children being maltreated and/or in danger. Parent/Caregiver cannot or will not acknowledge their lack of flexibility and/or adaptability in caregiving. Parent/Caregiver has not sought assistance in changing their behavior.</td>
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</table>

The parent/caregiver has a history of protecting. This refers to a person with many experiences and events in which they have demonstrated clear and reportable evidence of having been protective.

<table>
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<tr>
<th>Level</th>
<th>Description</th>
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<tbody>
<tr>
<td>A</td>
<td>Parent/Caregiver has raised children (older) with no evidence of maltreatment or exposure to danger, have demonstrated ways of protecting their children by separating them from danger, seeking assistance from others. Parent/Caregiver can describe events and experiences where they have protected children in the past.</td>
</tr>
<tr>
<td>B</td>
<td>Parent/Caregiver has raised children (older) with minimal exposure to danger or evidence of maltreatment. This may or may not include prior child welfare system involvement with the family. Parent/Caregiver is able to seek assistance from others and can describe events and experiences where they have protected their children in the past, as well as describe how they were not able to protect their children in past. Parent/Caregiver is able to differentiate between prior protective actions and lack of protective actions.</td>
</tr>
<tr>
<td>C</td>
<td>Parent/Caregiver has demonstrated minimal ability to raise children without exposure to danger or maltreatment. Parent/Caregiver has had frequent (three or more contacts with the child welfare system due to repeated exposure to maltreatment and parental conduct. Parent/Caregiver is not able to articulate how they have protected their children in the past and/or how they could take protective measures to ensure that their children are protected.</td>
</tr>
<tr>
<td>D</td>
<td>Parent/Caregiver has not been able to raise children without exposure to danger and/or maltreatment. Parent/Caregiver has had repeated contact with child welfare system (three or more reports within 1 year) due to repeated exposure to maltreatment and parental conduct.</td>
</tr>
</tbody>
</table>
**Cognitive protective capacities** are specific intellect, knowledge, understanding and perception that result in parenting and protective vigilance. The following parent/caregiver capacities are cognitive.

The parent/caregiver is self-aware as a caregiver. This refers to sensitivity in one’s thinking and actions and their effects on children.

<table>
<thead>
<tr>
<th></th>
<th>The parent/caregiver understands the cause-effect relationship between their own actions and effects on child. They are open to who they are and to what they do and the effects of what they do. They are able to think about themselves and judge the quality of their thoughts, emotions, and behaviors. They are able to view their role as a caregiver as being unique.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Parent/Caregiver understands the cause-effect relationship between their own actions and effects on child. They are open to who they are and to what they do and the effects of what they do. They are able to think about themselves and judge the quality of their thoughts, emotions, and behaviors. They are able to view their role as a caregiver as being unique.</td>
</tr>
<tr>
<td>B</td>
<td>Parent/Caregiver is able to understand the cause-effect relationship between their own actions and effects on children, however at times struggle to be open in regard to themselves and the quality of their thoughts, emotions, and behaviors in relation to providing for care of the child. The Parent/Caregiver struggles do not result in child being maltreated and/or being in dangerous situations.</td>
</tr>
<tr>
<td>C</td>
<td>Parent/Caregiver is able to understand the cause-effect relationship between their own actions, however are not able to relate their actions to the effects on their child. Parent/Caregiver is not open in reflecting their own thoughts, emotions, and/or behavior in relation to providing for care of their children, resulting in children being maltreated and/or in danger. Parent/Caregiver recognizes the need for understanding the causal relationship and the effects on child.</td>
</tr>
<tr>
<td>D</td>
<td>Parent/Caregiver is not able to understand the cause-effect relationship between their own actions and are not able to relate those actions to the effects on their child. Parent/Caregiver is not open in regard to their own thoughts, emotions, and/or behavior, resulting in child being maltreated and/or in danger. Parent/Caregiver does not recognize the need for understanding the causal relationship of their actions and the effects on child.</td>
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The parent/caregiver is intellectually able and/or capable. This refers to information and personal knowledge that is specific to caregiving that is associated with protection of children.

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<thead>
<tr>
<th></th>
<th>The parent/caregiver possesses essential knowledge regarding caregiving and child development. The parent/caregiver seeks to increase their knowledge in correlation with child’s needs and is able to recognize the need for increased knowledge as being essential to providing for child safety. Parent/caregiver may have cognitive limitations, however has supports and/or resources to assist in knowledge development.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Parent/caregiver possesses essential knowledge regarding caregiving and child development. The parent/caregiver seeks to increase their knowledge in correlation with child’s needs and is able to recognize the need for increased knowledge as being essential to providing for child safety. Parent/caregiver may have cognitive limitations, however has supports and/or resources to assist in knowledge development.</td>
</tr>
<tr>
<td>B</td>
<td>Parent/caregiver possesses essential knowledge regarding caregiving and child development, however at times struggles in recognizing the correlation with child’s needs and the need for increased/varied knowledge for providing for child safety. Parent/caregiver is open to seeking assistance and may or may not have a support network to assist in increasing their knowledge regarding child development. Maltreatment has not occurred as a result of the parent/caregiver’s knowledge capacity.</td>
</tr>
<tr>
<td>C</td>
<td>Parent/caregiver lacks essential knowledge regarding caregiving and child development and does not correlate the lack of knowledge to the responsibility for child safety and</td>
</tr>
</tbody>
</table>
Parent/caregiver may have a cognitive delay that affects their ability to increase their knowledge regarding caregiving and safety and the lack of resources or supports for their cognitive delay is a contributing factor to the parent/caregiver intellectual capacity. Parent/caregiver is not or will not seek assistance in increasing their knowledge. Maltreatment has occurred as a result of the parent/caregiver knowledge capacity.

**D** Parent/caregiver lacks essential and basic child development knowledge in regarding caregiving needs and child safety. Parent/caregiver may have a cognitive delay that is debilitating and is not being addressed through informal or formal supports. The parent/caregiver knowledge is such that it leaves children in danger and has resulted in maltreatment. Parent/caregiver is not or will not seek assistance in increasing their knowledge or accessing supports to develop knowledge regarding child development and child safety.

### The parent/caregiver recognizes and understands threats to the child.
This refers to mental awareness and accuracy about one’s surroundings, correct perceptions of what is happening and the viability and appropriateness of responses to what is real and factual.

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<tr>
<td><strong>A</strong></td>
<td>Parent/caregiver is attuned to their surroundings, in particular to their perceptions regarding life situations, recognizing dangerous and threatening situations and people. Parent/caregivers are reality orientated and consistently operate in realistic ways.</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Parent/caregiver is aware of their surroundings and life situations. Parent/caregiver is aware of dangerous and threatening situations and people, however at times struggles to correlate the impact of dangerous and threatening situations and people with their role as a parent/caregiver. Parent/caregiver ability does not result in children being maltreated and/or unsafe. Parent/caregiver is able to recognize the need for increased awareness and is able to access resources without assistance in increasing their mental awareness in regard to providing for safety of children.</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Parent/caregiver frequently is not aware of their surroundings and life situations. In particular this occurs when presented with dangerous and/or threatening situations. Parent/caregiver is not able to recognize the correlation with child safety and mental awareness, resulting in children being maltreated and/or unsafe. Parent/caregiver is not or will not access resources to increase their mental awareness without assistance.</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>Parent/caregiver is not aware of their surrounding and life situations, particularly when caring for children. Parent/caregiver does not recognize dangerous and/or threatening situations/people, resulting in children being maltreated and/or unsafe. Parent/caregiver may have an unmanaged mental health condition that affects their ability to be aware. The unmanaged mental health condition is known to the parent/caregiver and they have not or will not seek assistance to manage the mental health condition.</td>
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### The parent/caregiver recognizes the child's needs.
This refers to seeing and understanding a child’s capabilities, needs, and limitations accurately.

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<td><strong>A</strong></td>
<td>Parent/caregiver consistently recognizes the child’s needs, strengths and limitations. Parent/caregiver is able to appreciate the uniqueness and differences in children with</td>
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</table>
Parent/caregiver is sensitive to the child and their experiences.

B Parent/caregiver recognizes the child’s needs, strengths and limitations. Parent/caregiver is able to appreciate the uniqueness and differences in children, however at times struggles with understanding and accepting the child’s differences and uniqueness. At times the parent/caregiver struggles with identifying with the child and their experiences. Parent/caregiver is aware during these times and may have sought assistance in continuing to develop their parenting skills in regard to recognizing child’s needs and differences. The parent/caregiver has supports and/or resources available for assistance. Children have not been maltreated and/or unsafe due to the parent/caregiver capacity of being able to recognize child needs and strengths.

C Parent/caregiver does not identify with the child’s needs, strengths, and/or limitations resulting in the parent/caregiver acting in ways that have resulted in the child being maltreated and/or unsafe. The parent/caregiver is able to recognize their inability to identify with children and is open to assistance in increasing their parenting capacity.

D Parent/caregiver does not identify with the child’s needs, strengths, and/or limitations that have resulted in the child being maltreated and/or unsafe. The parent/caregiver does not see value in the capabilities of the child and are not sensitive to the child and their experiences. Parent/caregiver view of the child is incongruent to the child and how others view the child. Parent/caregiver is not able to recognize their inability to identify with child and the child’s needs and are not willing or able to seek assistance in increasing their parenting capacity.

The parent/caregiver understands their protective role. This refers to awareness, knowing that there are certain responsibilities and obligations that are specific to protecting children.

A Parent/caregiver values and believes that is their primary responsibility to protect the child. Parent/caregiver is committed to their beliefs and possesses an internal sense and appreciation for their protective role. Parent/caregiver is unwavering in their protective role and are able to articulate the significance of their role.

B Parent/caregiver believes that protecting their child is a primary responsibility, however at times struggles with their internal sense and appreciation for their protective role resulting in times where the parent/caregiver has abdicated their role for protectiveness to others without regard for the protectiveness of the alternate caregiver. Parent/caregiver recognizes their limitations in regard to protectiveness and their actions have not resulted in maltreatment and/or an unsafe child.

C Parent/caregiver does not value and/or believe that their primary responsibility is to protect the child. Parent/caregiver may have an internal sense for being protective, however does not or cannot internalize the primary responsibility for protection of the child. Parent/caregiver does not or cannot accept responsibility for child protection, resulting in children being maltreated and/or unsafe.

D Parent/caregiver does not recognize and/or value the responsibility to protect children as a primary role of a caregiver. Parent/caregiver does not have an internal sense for being protective and takes no responsibility for keeping children safe, resulting in children being maltreated and/or unsafe.
The parent/caregiver plans and is able to articulate a plan to protect children. This refers to the cognitive ability that is evidenced in a reasonable, well-thought-out plan to provide for protection of children.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Parent/caregiver has developed, either currently or in the past, plans to protect children. Parent/caregiver is realistic in their planning and arrangement about what is needed to ensure child safety. Parent/caregiver is aware of danger and is focused on their processing and development of a plan for safety.</td>
</tr>
<tr>
<td>B</td>
<td>Parent/caregiver is realistic in their plan for child safety and is able to make arrangements to ensure child safety, however may or may not have developed a plan for protection in the past. Parent/caregiver is able to articulate a plan and has the resources to execute the plan if needed.</td>
</tr>
<tr>
<td>C</td>
<td>Parent/caregiver does not recognize the need to plan for child safety and has not developed a plan in the past or has developed plans that were unrealistic to ensure safety, thus resulting in maltreatment and/or children being unsafe. Parent/caretaker may have cognitive limitations that affect their ability to conceptualize a plan for protection and are open to assistance in developing plans and/or accessing resources.</td>
</tr>
<tr>
<td>D</td>
<td>Parent/caregiver does not recognize the need to develop a plan to ensure child safety and has not developed a plan in the past or has developed plans that were unrealistic, resulting in children being maltreated and/or unsafe. Parent/caretaker does correlate the inaction of developing a plan and children being maltreated and/or unsafe. Parent/caretaker may have cognitive limitations that affect their ability to conceptualize a plan for protection. Parent/caregiver is unwilling or unable to seek assistance in developing plans and/or accessing resources to assure child safety. Parent/caregiver is unrealistic and unaware of the necessity as parents/caregivers to develop and execute plans for protection of children.</td>
</tr>
</tbody>
</table>
Emotional Protective Capacity refers to specific feelings, attitudes, and identification with a child and motivation that results in parenting protective vigilance. The following parent/protective capacities are emotional.

The parent/caregiver is able to meet their own emotional needs. This refers to the parent/caregiver satisfying their feelings in reasonable, appropriate ways that are not dependent on or take advantage of others, in particular children.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Parent/caregiver recognizes and understands their own emotional needs and effectively manages their needs in ways that do not interfere with their ability to parent and does not take advantage of others. Parent/caregiver makes choices to satisfy their feelings and emotional needs that are mature, acceptable, sensible, and practical.</td>
</tr>
<tr>
<td>B</td>
<td>Parent/caregiver recognizes their own emotional needs, however struggles to manage their needs in ways that do not interfere with their ability to parent and/or takes advantage of others. Parent/caregiver makes choices in regard to satisfying their emotional needs that at times are not mature and/or acceptable and/or sensible and/or practical. Parent/caregiver choices do not result in maltreatment and/or unsafe. Parent/caregiver has and uses resources necessary to ensure children are safe while ensuring their emotional needs are met.</td>
</tr>
<tr>
<td>C</td>
<td>Parent/caregiver shows limited understanding and recognition of their own emotional needs. Parent/caregiver often seeks to satisfy their own emotional needs through means that take advantage of others, primarily their children. Parent/caretaker uses avenues to satisfy their own emotional needs that are unacceptable, resulting in children being maltreated and/or unsafe.</td>
</tr>
<tr>
<td>D</td>
<td>Parent/caregiver does not recognize their own emotional needs, resulting in their needs being unmanaged and interfering with their ability to parent children. The unmanaged needs results in children being maltreated and/or unsafe.</td>
</tr>
</tbody>
</table>

The parent/caregiver is resilient as a caregiver. This refers to the parent/caregiver being responsive and able to take action.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Parent/caregiver has demonstrated that they are able to recover from or adjust easily to misfortune and/or change. Recovery and adjustment are focused on maintaining their role as a caregiver and providing for protection of their children. Parent/caregiver recognizes the need for resiliency as a caregiver and is effective at taking action and coping as a caregiver.</td>
</tr>
<tr>
<td>B</td>
<td>Parent/caregiver has demonstrated that they are able to recover from or adjust under most situations in regard to misfortune and/or change. Recovery and adjustment are mostly focused on their role as a caregiver and for providing protection. Parent/caregiver struggles with coping and taking action during these times. Children are not maltreated and/or unsafe due to the parents coping and/or taking action.</td>
</tr>
<tr>
<td>C</td>
<td>When faced with adversity/challenges parent/caregiver is not able to recover or adjust. Recovery and adjustment requires frequent interventions by support and resources. Parent/caregiver cannot focus their role during these times to caretaking, resulting in children being maltreated and/or unsafe.</td>
</tr>
</tbody>
</table>
**The parent/caregiver is tolerant as a caregiver.** This refers to Parent/Caregiver who is able to endure trying circumstances with even temper, be understanding and sympathetic of experiences, express forgiveness under provocation, broad-minded, and patient as a caregiver.

| A | Parent/caregiver maintains an even temper and patience under trying circumstances. Parent/caregiver recognizes the need for tolerance as a caregiver and works to ensure that they are open minded and understanding as a caregiver. |
| B | Parent/caregiver frequently maintains an even temper and displays patience under most situations. Parent/caregiver at times struggles with temper and patience, however does not impact their role as a caregiver or result in maltreatment and/or unsafe children. Parent/caregiver is aware of their challenges with tolerance and has the ability to access resources to assist in increasing their tolerance. |
| C | Parent/caregiver frequently cannot or will not maintain their temper and/or patience while providing care for children. Parent/caregiver are aware of their decreased tolerance however are not able to correlate the need for tolerance in parenting. Parent/caregivers lack of tolerance has resulted in children being maltreated and/or being unsafe. Parent/caregiver is willing to access resources and/or supports to increase their tolerance as a caregiver. |
| D | Parent/caregiver cannot or will not maintain their temper and/or patience while providing care for children. Parent/caregiver is not aware of their decreased tolerance and are not able to correlate the need for tolerance in parenting. Parent/caregiver lack of tolerance has resulted in children being maltreated and/or being unsafe. Parent/caregiver cannot or will not access resources and/or supports to increase their tolerance as a caregiver. |

**The parent/caregiver expresses love, empathy and sensitivity toward the child.** The parent/caregiver experiences specific empathy with the child’s perspective and feelings.

| A | Parent/caregiver is able to relate to their child and demonstrates actions that are reflective of expressing love, affection, compassion, warmth, and sympathy for the child and their experiences. Parent/caregiver is able to explain child feelings and emotions and is able to respond accordingly. |
| B | Parent/caregiver is able to relate to the child, however at times struggles to demonstrate either physically or verbally, love, affection, compassion, warmth, and sympathy. While the parent/caretaker acknowledges their love, compassion, warmth, and sympathy, they struggle with displaying affection to the child. This does not result in child being maltreated and/or unsafe. |
| C | Parent/caregiver frequently cannot or will not relate to their children’s feelings. Parent/caregiver does not express love, empathy, and/or sympathy for the child on a frequent or consistent basis. Parent/caregiver is able to recognize the absence of relating to the child’s feelings. The parent/caregiver’s feeling towards the child result in the child being maltreated and/or unsafe. |
D Parent/Caregiver is not able to relate to the child’s feelings. The parent/caregiver does not express any love, empathy, and/or sympathy for the child. The parent/caregiver’s lack of feelings towards the child results in the child being maltreated and/or unsafe.

The parent/caregiver is stable and able to intervene to protect children. This refers to the mental health, emotional energy, and emotional stability of the parent/caregiver in providing for protection of children.

A Parent/caregiver’s mental health, emotional stability, and energy are sufficient to meet the needs of the child. Feelings and emotions are not paralyzing to the parent/caregiver. Parent/caregivers are alert and reality orientated to their own emotions/feelings and actions. Parent/caregiver is motivated in ensuring their own mental, emotional stability and energy are sufficient to ensure that the child is safe.

B Parent/caregiver’s mental health, emotional stability, and energy are sufficient under most daily routines, however during times of adversity or challenges the parent/caregiver’s struggle to maintain their stability. Parent/caregiver seeks resources and supports during these times and accesses resources to ensure that child is safe.

C Parent/caregiver is frequently not able to maintain emotional stability during daily routines, resulting in the child’s needs not being met. Parent/caregiver is aware of instability, however is immobilized in taking action to access resources or supports to provide for child safety, resulting in child being maltreated and/or unsafe.

D Parent/caregiver is not able to maintain emotional stability during daily routines and challenging life events. Parent/caretaker is not aware of their instability and has taken no action to access resources and/or supports to ensure for child safety, resulting in child being maltreated and/or unsafe.

The parent/caregiver is positively attached to the child. This refers to a strong attachment that places a child’s interest above all else.

A Parent/caregiver demonstrates their attachment to the child through actions such as ordering their lives according to what is best for their child, displays affectionate regard for their child and the child’s experiences, and identifies their closeness with the child exceeds other personal relationships.

B Parent/caregiver demonstrates their attachment to the child through actions, however at times struggles with ordering their lives according to what is best for the child, displaying their affection for the child, and identifying the closeness of the relationship with the child. Parent/caregiver attachment struggle are not intentional and the parent/caregivers is aware of the struggle. Parent/caregiver has or has the ability to seek resources and/or supports for increasing their parenting capacity. Children have not been maltreated and/or unsafe due to the parental and child attachment.

C Parent/caregiver frequently does not demonstrate their attachment to the child. This is evidenced by the ordering of their lives, lack of affectionate regard for the child, and the parent identifying other relationships as being their primary relationship. Child has suffered maltreatment and/or is unsafe as a result of the parent/caregiver’s lack of attachment to the child.
<table>
<thead>
<tr>
<th>Part</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D</strong></td>
<td>Parent/caregiver has no attachment to the child, shows no regard for the child and the parent/caregiver relationship. Parent/caregivers do not identify them as a parent/caregiver. Parent/caregiver cannot or will not seek resources and/or supports to enhance their attachment and does not recognize the correlation between the lack of attachment and maltreatment.</td>
</tr>
</tbody>
</table>

**The parent/caregiver is supportive and aligned with the child.** This refers to encouraging and maintaining a child’s psychological, physical, and social well-being. Being aligned with the child refers to a mental state and/or identifying with the child. The parent/caregiver displays concern for the child through their sensitivity and sense of responsibility for the child and the child’s experiences.

<table>
<thead>
<tr>
<th>Part</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>Parent/caregiver demonstrates that they are strongly related and/or associated with the child, thus showing compassion for the child by calming, pacifying, and appeasing children as needed. Parent/caregiver is aligned with the child, as demonstrated by the actions and responses towards the child. Parent/caregiver identifies their relationship with the child as being the highest priority.</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Parent/caregiver frequently is aligned with the child through their actions, however at times struggles in demonstrating compassion for the child and/or being responsive. The parent/caregiver’s actions do not result in the child being maltreated and/or unsafe. The parent/caregiver acknowledges their struggle, and has the resources and/or supports to increase their responsiveness and compassion for the child.</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Parent/caregiver does not identify with the child through their actions and lacks compassion for the child. Parent/caregiver infrequently non-responsive to the child when the child needs to be calmed, pacified, and/or appeased. The parent/caregiver acknowledges their inability to align with the child however cannot or will not take actions to increase their alignment with the child. The parent/caregiver actions have resulted in children being maltreated and/or unsafe.</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>Parent/caregiver is not aligned with the child as demonstrated by their non-responsiveness to the child and the lack of compassion for the child. Parent/caregiver does not express concern and/or does not acknowledge their lack of alignment with the child. The lack of parent/caregiver actions has resulted in the child being maltreated and/or unsafe.</td>
</tr>
</tbody>
</table>
Definitions and Scaling Criteria: Child Strengths and Needs

Child strengths and needs measure the extent to which certain desired conditions are present in the life of the child within a recent timeframe. These indicators measure constructs related to a child’s well-being (e.g. emotion, behavior, relationships) and functioning (e.g. development, academic achievement, life skill attainment). An “A” or “B” rating for any indicator reflects that a child is doing well in that area; a “C” or “D” rating reflects that a child is not doing well and requires attention.

This assessment should be used to systematically identify critical child needs that should be the focus of thoughtful, case plan interventions. The information gathered from the case manager to complete this assessment will be gathered from the child, parent and other caregiver(s), and collateral sources such as a child care provider, teacher, and/or professional evaluator.

Organizing constructs:

A= EXCELLENT
Child demonstrates exceptional ability in this area

B=ACCEPTABLE
Child demonstrates average ability in this area

C=SOME ATTENTION NEEDED
Child demonstrates some need for increased support in this area

D=INTENSIVE SUPPORT NEEDED
Child demonstrates need for intensive support in this area

SPECIFIC CHILD STRENGTH AND NEED DEFINITIONS AND RATINGS

Emotion/trauma: The degree to which, consistent with age, ability and developmental level, the child is displaying an adequate pattern of appropriate self-management of emotions.

<table>
<thead>
<tr>
<th>A</th>
<th>Child is able to experience a wide range of emotions and can manage emotions to the best of developmental ability. Child recovers readily from experiences.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Child may have occasional brief periods of anger, sadness, worry, etc. that are temporarily disruptive but these periods do not interfere with building friendships with peers or adults in their social, educational or family life. Child may have occasional nightmares, but tolerates these without major disruption.</td>
</tr>
<tr>
<td>C</td>
<td>Child’s experience of anger, sadness, worry, etc. is frequent enough to cause some disruption in social, educational, or family life. OR Child has some symptoms of trauma such as a startle response, frequent difficulty sleeping or staying awake, bed-wetting, overeating or under-eating, and these symptoms are causing some distress for the child.</td>
</tr>
</tbody>
</table>
| D       | Child experiences out-of-control anger, profound sadness or worry so much that child is unable to maintain friendships, is falling behind academically. OR Child has pervasive trauma symptoms such as a startle response that is so severe child
cannot tolerate many environments; sleep disruption that is causing severe academic or health problems; bed wetting; eating patterns that are causing significant weight gain or loss; or child is experiencing despair or hopelessness to the point of thinking of self-harm.

**Behavior:** The degree to which, consistent with age, ability and developmental level, the child is displaying appropriate coping and adapting behavior.

| A | Child manages his/her own behavior above developmental expectations. Child is developing a sense of right and wrong and his/her approach is to seek to do what is right. He/she has an advanced awareness of the impact of behavior on others; keen empathy for others, and seeks to act in ways that promote the good and well-being of others. OR
|    | Child is not old enough to think about life choices and behaviors. (Children 0-3 would meet this criteria) |

| B | Child generally understands right and wrong and primarily seeks to do what is right. Motivation may still be more to please others or avoid punishment. Child will err, but not substantially more than would be expected for developmental level. |

| C | Child violates rules and expectations in ways that are disruptive to their normal routines or relationships. Child may be old enough to think about their behavior; however has frequent (weekly) struggles with making appropriate life choices. The child’s behaviors are difficult for parent/caregiver to manage. Child may run away on occasion. The child’s behavior may have resulted in childcare or school suspension, or involvement with juvenile justice. |

| D | Child consistently violates rules and expectations so that life around the child cannot be carried on. Child may be old enough to think about their behavior. Child may be frequently running away. Child’s behavior is harmful to self or others including self-injury, extreme risk-taking, persistent violence toward others, sexual violence, cruelty to animals, or fire setting. |

**Development /Early Learning (applies to children under the age of 6 years):** The child is achieving developmental milestones based on age and developmental capacities; child development in key domains is consistent with age and ability appropriate expectations.

| A | Child’s physical and cognitive skills are above age expectations in all domains based upon normal developmental milestones. OR
|    | Child with developmental delays is receiving special interventions and is demonstrating excellent progress. |

| B | Child’s physical and cognitive skills are at or near age expectations in most of the major domains. OR
|    | Child with developmental delays is receiving special interventions and is beginning to demonstrate some progress. |
### Module 1: Ongoing Safety and Services Management

| C | Child’s physical and cognitive skills are mixed, near expectations in some domains but showing significant delays in others.  
|   | OR  
|   | Child with developmental delays is or may be receiving special interventions and is demonstrating very slow gains that are below desired outcomes. |

| D | Child’s physical and cognitive skills show significant delays in most domains.  
|   | OR  
|   | Child with developmental delays is or may be receiving special interventions and is showing minimal to no improvement. |

**Academic Status (applies to children 6 years of age and older):** The child, according to age and ability, is actively engaged in instructional activities; reading at grade level or IEP expectation level; and meeting requirements for annual promotion and course completion leading to a high school diploma or equivalent or vocational program.

| A | Child is reading at or well above grade level and is meeting and exceeding all requirements for grade-level promotions.  
|   | OR  
|   | Child is exceeding outcomes set forth in an IEP or Section 504 plan. |

| B | Child is reading at or close to grade level and is adequately meeting all requirements for grade-level promotions.  
|   | OR  
|   | Child is adequately meeting outcomes set forth in an IEP or Section 504 plan. |

| C | Child is reading a year below grade level and is meeting some but not all requirements for grade-level promotions.  
|   | OR  
|   | Child is only meeting some of the outcomes set forth in an IEP or Section 504 plan. |

| D | Child is reading two years below grade level and is not meeting core requirements for grade-level promotions.  
|   | OR  
|   | Child is not meeting any of the outcomes set forth in an IEP or Section 504 plan. |

**Positive Peer/Adult Relationships:** The child, according to age and ability, demonstrates adequate positive social relationships.

| A | Child interacts with other children and with adults above expectations for developmental level. Child excels in making and keeping friends.  
|   | OR  
<p>|   | Child is not old enough to think about life choices and behaviors. (Children 0-3 would meet this criteria) |</p>
<table>
<thead>
<tr>
<th>B</th>
<th>Child interacts with other children and adults in ways that would be expected for developmental level.</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Child has some difficulty making or keeping friends and/or has some discomfort relating to adults. However, child has sufficient social interactions outside of the household.</td>
</tr>
<tr>
<td>D</td>
<td>Child has extreme difficulty making or maintaining friendships and experiences social isolation, ostracism, or bullying.</td>
</tr>
</tbody>
</table>

**Family Relationships:** Child demonstrates age and developmentally appropriate patterns of forming relationships with family members.

<table>
<thead>
<tr>
<th>A</th>
<th>Child experiences his/her family as a safe and supportive place and has a strong sense of belonging. Child does not express any concerns about safety nor shows any symptoms of fear or trauma.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Child is generally comfortable in his/her family. Child expresses some concerns or worries about family conflicts that appear to be normal. Child has a basic sense of safety and security.</td>
</tr>
<tr>
<td>C</td>
<td>Child has some conflicts with one or more family members that disrupt the child’s feeling of safety or belonging.</td>
</tr>
<tr>
<td>D</td>
<td>Child experiences no security or belonging with family; child experiences persistent conflict with one or more family members that makes it extremely uncomfortable to be present in the family.</td>
</tr>
</tbody>
</table>

**Physical Health:** Child is achieving and maintaining positive health status, which includes dental, audio and visual assessments and services. If the child has a serious or chronic health condition, the child is achieving the best attainable health status given the diagnosis and prognosis.

<table>
<thead>
<tr>
<th>A</th>
<th>Child is demonstrating excellent overall health.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>If child has a chronic condition is attaining the best possible health status that can be expected given the health condition.</td>
</tr>
<tr>
<td>B</td>
<td>Child is demonstrating an adequate level of overall physical health status.</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>If child has a chronic condition is responding adequately to medical treatment.</td>
</tr>
<tr>
<td>C</td>
<td>Child is demonstrating an inconsistent or inadequate level of overall physical health. The child’s physical health may be outside normal limits for age, growth and weight range.</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>If child has a chronic condition the symptoms are becoming problematic.</td>
</tr>
<tr>
<td>D</td>
<td>The child is demonstrating a consistently poor level of overall physical health. The child’s physical health is significantly outside normal limits for age, growth and weight range. Any chronic condition is becoming more uncontrolled, possibly with presentation of acute episodes.</td>
</tr>
</tbody>
</table>
Cultural Identity: Important cultural factors such as race, class, ethnicity, religion, LGBT, or other forms of culture are appropriately considered in the child’s life. (NOTE: the goal of responding to a C or D would not be to change the cultural identity or belonging, but to resolve the conflict or help the child cope with the conflict.)

A  Child identifies with his/her culture, has a sense of cultural awareness, and/or is motivated to explore his/her culture.  Child has an identified support network to assist in exploring and/or identifying with his/her culture.

OR

Child is of an age where they are not aware of their culture; however they have a support network that will cultivate the child’s sense of cultural identity.

B  Child identifies with his/her culture, has a sense of cultural awareness.  Child shows some motivation to explore his/her culture.

OR

Child is of an age where they are not aware of their culture; however their support network shows some motivation to cultivate the child’s sense of cultural identity.

C  Child does not identify with his/her culture, but does have a sense of cultural awareness.  Child does not have a support network to assist in exploring and/or identifying with his/her culture.

OR

Child is of an age where they are not aware of their culture and their support network shows little motivation to cultivate the child’s sense of cultural identity.

D  Child does not identify with his/her culture, lacks a sense of cultural awareness, and expresses no motivation in exploring and/or identifying their culture.  Child has minimal supports to assist with motivation, exploration, and/or identification of culture.

OR

Child is of an age where they are not aware of their culture and their support network shows no motivation and/or support for cultivation of the child’s cultural identity.

If C or D, what is the type of culture child identifies with?
(race/class/ethnicity/religion/LGBT/other:________)

Substance Awareness: The assessment of substance awareness is multi-dimensional. First, the assessment includes the child/youth’s awareness of alcohol and drugs, and their own use. Second, for children who have experienced substance misuse within their home, the assessment includes their awareness of alcohol and drugs and treatment/recovery for their parent(s).
### Core 122_CP_PG_July 2013

**Module 1: Ongoing Safety and Services Management**

### A
Child can voice the dangers of alcohol and drugs and the negative effects on daily life choices and makes conscious decisions to refrain from use of drugs and alcohol.

OR

Child is aware of the effects of drugs and alcohol within the family dynamic, including treatment and recovery for their parent(s), and makes daily life choices to refrain from the use of drugs and alcohol.

OR

Child is of an age where it is not reasonable to understand any of the family dynamics related to drug and alcohol use within the family.

### B
Child is somewhat aware of alcohol and drugs and their negative effects on daily life choices. Child has refrained from use of alcohol and drugs.

OR

Child is aware of the effect of drugs and alcohol with the family dynamic, and is aware of some basic information in regard to treatment and recovery for their parent(s).

### C
Child is aware of alcohol and drugs. Child chooses to use alcohol on limited occasions. Alcohol use has not resulted in disruption to school and/or relationships.

OR

Child is partially aware of the effect of alcohol and drugs within the family dynamic, and has no information in regard to treatment and recovery for their parent(s).

### D
Child uses drugs and/or alcohol on a regular basis and this has led to decreased school performance, disruption of social network, arrest, injury, or illness.

OR

Child is not aware of drugs or alcohol use within the family, including information regarding treatment and recovery for their parents.

### Preparation for Adult Living Skill Development (applies only to children 13 and over).

Child, according to age and ability, is gaining skills, education, work experience, long-term relationships and connections, income, housing and other capacities necessary for functioning upon adulthood.

### A
Child excels with developing long-term life skills, supportive relationships and connections. Child is motivated in their life skill development and recognizes the significance of developing life skills. Child has an identified support network to assist in achieving life skill development. According to age and ability, is developing necessary life skills for adult living.

### B
Child is making adequate progress with developing long-term life skills, relationships and connections. Child displays motivation, however requires assistance with maintain their motivation. Child has a support network in place to assist in achieving life skill development and motivation. According to age and ability has gained adequate for adult living.
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Child is making less than adequate progress with developing life skills, long-term supportive relationships and connections. Child is minimally engaged with life skill development, despite the level of support present. Child may or may not have a support network in place for life skill development. According to age and ability is beginning to gain life skill capacities that are not yet adequate.</td>
</tr>
</tbody>
</table>
| D | Child is making very limited progress with developing life skills, long-term supportive relationships and connections.  
   OR  
   Child is not aware of the need for developing life skills, long-term supportive relationships, and connections. Child may or may not have a support network in place for life skill development According to age and ability is not gaining necessary life skill capacities. |
Ongoing Family Functioning: Preparation Stage

Case Transfer Information Sufficiency Checklist

Determine the sufficiency of information in the Family Functioning Assessment (safety evaluation), Safety Planning Analysis and Safety Plan, including supporting documentation.

Does the documentation associated with the 6 assessment areas in the FFA sufficiently answer the 6 assessment questions?

Are there “gaps” in information?
Is there need for further clarification regarding documented information?
Are family, caregiver, and child functioning sufficiently understood?

Do you understand how impending danger is occurring in the family?

Does documentation in the FFA support the identification of impending danger?
Is it obvious how threats to child safety are operating in the family?
Is impending danger justified, clearly and precisely described in the FFA and safety analysis?
Is further information needed to understand the safety assessment decision?

Can the family adequately manage and control for the child’s safety without direct assistance from CPS?

Does documentation support the decision that the family can sufficiently manage safety on its own?
Is there an adequate basis for determining that a non-maltreating caregiver has the capacity and willingness to protect?
Is further clarification indicated?

Can an in-home safety plan sufficiently manage impending danger?

Does the safety planning analysis documentation clearly support the decision to use an in-home safety plan?
Do identified safety actions match up with how impending danger is manifested in the family?
Does the in-home safety plan provide a sufficient level of effort?
Is it clear who is responsible for providing what safety action?
Are there gaps in information that require immediate follow-up?
Is there a need for further clarification and supervisory consultation?

Does out-of-home placement appear to continue to be necessary?

Does the safety plan analysis documentation confirm the need for children to remain in placement outside of the home?
Is there a need for further clarification regarding the decision to place?

Identification of Caregiver Protective Capacities

Does documentation identify specific strengths associated with the caregiver role?
Is there need for clarification regarding caregiver protective capacities?
Consider what possibilities may exist for discussing and using caregiver protective capacities during the ongoing family functioning assessment process.

**Other Sources of Information for Consideration in Preparation:**
Case History and past interventions
Are there special circumstances that are impacting the family, such as
Domestic Violence
Parents’ own history of childhood abuse
Substance Use
Mental Illness
Criminal behaviors and other factors impacting the parents’ abilities to be protective
Results of criminal, delinquency and abuse/neglect history checks.
Are there legal interventions that must be known for children in out of home placement?
Are there additional professional evaluations that should be considered for information collection and assessment of the caregiver protective capacities based upon the information known?
Collaterals known, who would be contributing to the assessment process—including relatives, tribal members, parents not in the household, substitute care providers (for children out of home).

**Planning for Conducting the Ongoing Family Functioning Assessment and Implications for Immediate Response**
If it is unclear how impending danger is manifested, seek supervisor consultation and clarification from the previous worker.
If the safety response is unclear or not supported in the documentation, seek supervisor consultation and follow up with the previous worker.
Consider whether there is a need to immediately contact safety service providers (in-home safety plan) prior to the Introduction with the caregivers. Make immediate adjustments to safety plans as indicated.
Always consider if there is a need for immediate adjustments to safety plans prior to initiating the Introduction with caregivers.
If there are significant gaps in information related to impending danger and/or safety analysis and plans, attempts should be made to promptly make face-to-face contact with caregivers and children to verify that child safety is being sufficiently managed.
If impending danger is not well understood and cannot be clarified by the previous worker, seek to reconcile what information is unknown by the conclusion of the Introduction meeting(s), and make adjustments to the safety plan as indicated.
Consider how the caregivers’ reaction to intervention might influence how you introduce yourself and the ongoing family functioning assessment.
Prior to the Introduction meeting(s) with caregivers, make sure that you are clear about what you want to accomplish by the end of the meetings.
Given variation in family dynamics, consider carefully how best to initiate the ongoing process with caregivers.
Dutton-McAdams Documentation Review

Sufficiency Checklist for Preparation

FFA Information Sufficiency

Does Family Functioning Assessment documentation provide thorough information regarding maltreatment, nature of maltreatment, child functioning, adult functioning, discipline and parenting general, and family functioning?

☐ Yes ☐ No

What areas require additional information? What information can be gathered from CPI worker? What further information do you believe you may need in order to begin the ongoing family functioning assessment? What is your plan to gain information that is necessary for the ongoing family functioning assessment?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Impending Danger Summary

Can you clearly determine how impending danger is operating in the family?

☐ Yes ☐ No

What areas require additional information? What information can be gathered from CPI worker? What are the implications for promptly gathering safety related information as you think about beginning the ongoing family functioning assessment?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Safety Management

Does the response for controlling and managing impending danger appear to be appropriate?

☐ Yes ☐ No

Does the safety planning analysis support the decision to use the type of safety plan that was selected (i.e., an in-home safety plan or an out-of-home safety plan)?

☐ Yes ☐ No

If an in-home safety plan was used, is it clear how the plan is supposed to work? Do safety actions match up with how impending danger is operating in the home? Does there appear to be a sufficient level of effort in the safety plan to assure child safety?
Are there questions you have about the sufficiency of the safety plan? Areas of further study? Information that may still need to be gathered from either the CPI worker or family?

☐ Yes  ☐ No

Are there indications that the safety plan may need to be adjusted? Any implications of a need for immediate action?

☐ Yes  ☐ No

________________________________________

Ongoing Family Functioning Assessment Preparation

Are there areas that require an immediate intervention as you proceed with the ongoing family functioning assessment? What? And what are your immediate next steps?

________________________________________

What are the implications from the information gathered? Do you have preference about whom you would want to interview first? Would your introduction meeting be a joint interview with caregivers or separate?

________________________________________
**Introduction Stage: Working with Families to Begin to Build Trust and Gather Information**

To introduce and clarify the ongoing family functioning assessment process with caregivers and to make sure that all roles, responsibilities (expectations), agency-family issues and concerns are discussed and understood.

<table>
<thead>
<tr>
<th>Introduction to Ongoing Case Management</th>
<th>Reason for Involvement</th>
<th>Description of Ongoing Family Functioning Assessment Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage caregivers in assessment process.</td>
<td>Discuss impending danger threats.</td>
<td>Engage caregivers and seek partnership for completing the ongoing family functioning assessment.</td>
</tr>
<tr>
<td>Introduce ongoing worker.</td>
<td>Information identified during the CPI.</td>
<td>Discuss purpose for the ongoing family functioning assessment and Case Planning process.</td>
</tr>
<tr>
<td>Describe purpose of ongoing case management</td>
<td>Perception of caregiver regarding impending danger and intervention.</td>
<td>Describe the process for intervention</td>
</tr>
<tr>
<td>Clarify relationship between CPI and Ongoing case management</td>
<td>Address safety management issues (as indicated).</td>
<td>Seek commitment to participate in the assessment process.</td>
</tr>
<tr>
<td>Elicit caregiver perspective.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elicit concerns or worries about involvement.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Instructions for Demonstrating Introduction

The Dutton-McAdams Family

Purpose
The purpose of this exercise is to provide a practice opportunity that allows team members to perform the various aspects of the introduction concerned with working with Families to Begin to Build Trust and Gather Information.

Group Member Responsibilities
Each team member is expected to perform a portion of introduction. Group members can decide the order in which they wish to proceed. During each portion of this exercise, a group member will interview another group member serving as the chosen caregiver. The third and fourth group member will observe the interaction.

Interviews are expected to take 15 minutes.

Group members have the latitude to adjust client responses according to how the exploration is going and according to what feels natural.

The observer role will utilize the introduction section of the feedback instrument.

Any group member can put the interview on hold as needed to make adjustments and begin over.

Introduction Assignments
Set-up and Order

The approach to completing this exercise for all assignments is as follows:

Role assignments are selected: worker, caregiver, and observers – 2 minutes.

The exploration assignment is reviewed so expectations are clear to all team members – 5 minutes.

Worker and caregiver take moments to prepare themselves.

Worker conducts his or her exploration with parent – Up to 15 minutes.

Observers and group conduct debriefing – 5 minutes.

Short break before next round of interviews – 5 minutes.
**Exploration Stage: Explore with Parents what Must Change and Craft Danger Statement**

To identify and discuss with caregivers what must change with respect to diminished caregiver protective capacities associated with danger threats and to determine what caregivers are willing to work on in treatment.

<table>
<thead>
<tr>
<th>Overview of Exploration</th>
<th>Existing Caregiver Protective Capacities</th>
<th>Diminished Caregiver Protective Capacities</th>
<th>Determining What Must Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Status.</td>
<td>Discuss areas of effective parenting.</td>
<td>Broad discussion of any areas of concern related to adult/parent functioning.</td>
<td>Summarize diminished caregiver protective capacities associated with impending danger.</td>
</tr>
<tr>
<td>Review and clarify purpose.</td>
<td>Discuss areas of child needs and how parent is meeting needs.</td>
<td>Consider relationship between specific diminished caregiver protective capacities and impending danger.</td>
<td>Identify areas of agreement and disagreement.</td>
</tr>
<tr>
<td>Caregiver perception.</td>
<td>Consider difference or fluctuation in caregiver performance.</td>
<td>Create discrepancies and raise caregiver self-awareness.</td>
<td>Seek willingness to continue participation.</td>
</tr>
<tr>
<td>Engagement.</td>
<td>Consider how existing caregiver protective capacities can be used to promote change.</td>
<td>Seek mutuality.</td>
<td></td>
</tr>
<tr>
<td>Address safety management issues.</td>
<td></td>
<td>Reinforce self-determination.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Craft Danger Statement with Family</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify Family Strategy with Family</td>
<td></td>
</tr>
</tbody>
</table>
Instructions for Demonstrating Exploration

The Dutton-McAdams Family

Purpose

The purpose of this exercise is to provide a practice opportunity that allows team members to perform the various aspects of the exploration concerned with discovering what must change.

Group Member Responsibilities

Responsibilities remain the same as in the previous session role-play. Each team member is expected to perform a portion of exploration. Group members can decide the order in which they wish to proceed. During each portion of this exercise, a group member will interview another group member serving as the chosen caregiver. The third and fourth group member will observe the interaction.

Interviews are expected to take 15 minutes.

Group members have the latitude to adjust client responses according to how the exploration is going and according to what feels natural.

The observer role remains the same, utilizing the exploration section of the feedback instrument.

Any group member can put the interview on hold as needed to make adjustments and begin over.

Exploration Assignments

Set-up and Order

The approach to completing this exercise for all assignments is as follows:

Role assignments are selected: worker, caregiver, and observers – 2 minutes.

The exploration assignment is reviewed so expectations are clear to all team members – 5 minutes.

Worker and caregiver take moments to prepare themselves.

Worker conducts his or her exploration with parent – Up to 15 minutes.

Observers and group conduct debriefing – 5 minutes.

Short break before next round of interviews – 5 minutes.
Case Plan Timeframes

Statutory Requirements:
F.S. 39.603(1) – All case plans and amendments to case plans must be court approved.
F.S. 39.6011(2)(d) - The date the compliance period expires. The case plan must be limited to as short a period as possible for accomplishing its provisions. The plan’s compliance expires: no later 12 months after the date the child was initially removed from the home, or adjudicated dependent or the date the case plan was accepted by the court, whichever occurs first.
F.S. 39.6011(6)(b)(2) - When the child is placed in out-of-home care, a case plan must be prepared within 60 days after the removal of the child from the home and submitted to the court prior to the disposition hearing for review and approval.
F.S. 39.6011(6)(b)(3) - After jurisdiction attaches, all case plans must be filed with the court and a copy provided to all the parties whose whereabouts are known not less than 3 business days before the disposition hearing.
The agency must file with the court, and provide copies to the parties, all case plans prepared before jurisdiction of the court attached.

Case Plan Amendments
F.S. 39.6013(2) - The case plan may be amended at any time in order to change the goal of the plan employ the use of concurrent planning add or remove tasks the parent must complete to substantially comply provide appropriate services for the child update the child’s health, mental health, and education records required by s.39.6012.

F.S. 39.603(2) - When the court decides that any of the elements considered at the hearing related to the plan have not been met, the court will require the parties to make necessary amendments to the plan under 39.6013.
The amended plan must be submitted to the court for review/approval within 30 days after the hearing.
A copy of the amended plan must also be provided to each party, if the location of the party is known, at least 3 business days before filing with the court.
ASFA Requirements: Case Plan

The case plan for each child must:

Be a written document, part of the case record, in a format developed jointly with the parent(s),
child, if age appropriate, or guardian of the child in foster care; and

Be developed within a reasonable period, but no later than 60 days from the child’s removal
from the home;

Include a discussion of how the case plan is designed to achieve a safe placement for the child in:

- the least restrictive (most family-like) setting available
- close proximity to the home of the parent(s) when the case plan goal is reunification
- the best interests and special needs of the child

Reasonable Efforts

Include a description of the services offered and provided to prevent removal of the child from
the home and to reunify the family; and

Document the steps to finalize a placement when the case plan goal is or becomes adoption or
placement in another permanent home.

When the case plan goal is adoption, at a minimum, documentation must include:

- child-specific recruitment efforts, such as
- the use of state, regional, and national adoption exchanges including electronic exchange
  systems.

When a court decides that reasonable efforts to return the child home are NOT required,
a permanency hearing must be held within 30 days of the decision,
unless the requirements of the permanency hearing are fulfilled at the hearing when the court
decides reasonable efforts to reunify the child and family are not required.

Criminal Records Checks

Must provide documentation that criminal record checks have been conducted with respect to
prospective foster and adoptive parents.

The statute links the criminal records check requirements to Titles IV-B/IV-E eligibility.

All criminal background screenings must be completed and documented prior to issuance of
foster home license or approval of adoptive home.
What’s Missing?

Use the “Florida Statutes for Case Planning” section 39.6011, 39.6012, 39.6013, and “ASFA Requirements for Case Planning” to determine what is missing in each statement.

1. The case plan must be developed in conference with the ___________________ and ___________________ and, ___________________ and ___________________.

2. The case plan for each child must include a description of the _______________ offered and provided to prevent removal of the child from the home and to reunify the family.

3. The services described in the case plan must be designed to improve the ________________________________________________, or ________________________________________________.

4. The case plan must be written simply and clearly in ___________________ and, if _______________ is not the principle language of the child’s parent, to the extent possible in the _______________ principle language.

5. Who must inform the parent(s) of the right to receive assistance from any person or social service agency in the preparation of the case plan?
   ________________________________________________, ________________________________.
   ________________________________________________, ________________________________.

6. True or False: A copy of the amended case plan does not have to be given to the parents.
Rilya Wilson Act F.S.39.604

Overview
Requires coordination between CBC staff; Local School Readiness Coalitions and licensed early education or child care providers
Provides priority for childcare services for specified children who are at risk of maltreatment
Specifies certain requirements designed to ensure the safety and well-being of children age 3 to school entry who are:
under Judicial In-Home Services
in the custody of the community-based lead agency
are enrolled in a licensed early education or child care program
Each child who is subject must participate in licensed early education or childcare services at least 5 days a week, unless exempted by the court.

CBC Requirements to Notify Licensed Provider
CBC must notify the operator of a licensed early education or childcare program of any child who is subject to this law and enrolled in the program.
The program must be informed re: reporting requirements for child’s attendance per s.39.604, F.S.
Direct notification is encouraged.

Provider Requirements for Monitoring and Reporting Attendance
Providers of licensed early education or child care services must notify the CBC following EACH “unexcused absence” or SEVEN CONSECUTIVE “excused” absences for a child.
Absences must be reported by the end of the business day following an “unexcused” absence or a 7th consecutive “excused” absence.
Procedures regarding this notification are region/circuit specific.

Caregiver Requirement to Report Absences
The parent or caregiver must report the absence of the child to the program by the end of the business day for the absence to be considered “excused.”
Absence is considered “unexcused” if the parent or caregiver fails to timely report the absence.
Case Plans

Case plan and court order must specify the number of days per week that the child is to attend. An exemption for the required attendance of 5 days per week may be granted by the court. If the child is transferring from one program to another, court approval is not required unless the court order or case plan cites the specific program. Case plan and court order must not list a specific licensed early education or childcare program. • prevents multiple amendments

Requirements for Withdrawal or Reducing Attendance

Children cannot be withdrawn from the program without the prior written approval of the CBC lead agency. You must consult your supervisor prior to granting the approval. Court must approve an amended case plan or issue an order that recognizes the change in requirements prior to reducing and/or ceasing attendance. If the child is entering school, amend the case plan as soon as practical.

Case Manager Site Visits

Must make a site visit to the child’s residence to decide if the child is missing following:
2 CONSECUTIVE reports of UNEXCUSED absences or
a report of 7 CONSECUTIVE EXCUSED absences
Site visit must be made within one business day following receipt of the notification of the absences.
When a child is missing, you must notify local law enforcement and initiate established procedures for locating missing children.

Case Plan Compliance

When it is decided that the child is NOT MISSING, the parent or caregiver with whom the child resides must be informed that failure to ensure attendance is a violation of the case plan. When more than 2 site visits are conducted due to the requirements of this act, YOU MUST NOTIFY THE COURT of noncompliance with the case plan, whether or not the child is missing.
Rilya Wilson Activity Worksheet

Use PG51-52, Rilya Wilson Act, to record the key tasks for the assigned topics. Consider what tasks will facilitate implementation of the requirements.
Present key information and the tasks to the class during your presentation.
Record the remainder of the tasks on this worksheet as they are discussed.

CBC Requirements to Notify Licensed Provider

Provider Requirements for Monitoring and Reporting Attendance

Caregiver Requirement to Report Absences

Case Plans

Requirements for Withdrawal or Reducing Attendance

Case Manager Site Visits

Case Plan Compliance
“Zahid Jones, Jr., Give Grandparents and Other Relatives a Voice Act”

Zahid Jones was born in 2003 and murdered by his mother’s boyfriend in 2007. The family was known to DCF for prior allegations of physical abuse of Zahid and siblings. Zahid was removed from his mother and placed with a non-relative, rather than with his paternal grandmother, who had been a primary caretaker in the past. After the mother successfully passed drug screens, Zahid was returned home. The paternal grandmother attempted to alert investigators and service providers of imminent danger to Zahid. Zahid tragically died on May 29, 2007 at the hands of his mother’s boyfriend. Representatives pursued this legislation with a goal to establish a more effective protocol for engagement of relatives and assurance that their voice is heard during investigative and judicial process.

Child Protective Investigator Requirements:
Must provide contact information to reporter within twenty four hours. F.S. 39.301(6)
Must inform reporter of his/her right to provide written summary of report to CPI who must include it in master file. F.S. 39.301(6)
Must obtain collateral contact from a relative if a family is offered but refuses services, if the CPI has knowledge of and the ability, to contact a relative.

Child Protective Investigator and Case Managers Requirements:
Any photographs or reports on examinations made or X-rays taken pursuant to section 39.304, F.S. must be preserved in permanent form in child’s master records.
NOTE: “Open Records Law” requires a means for ensuring the extended maintenance of all dependency records, including medical content, until a child who received services from the Department reaches 30 years of age.
After commencement of the investigation, a relative may submit a request in writing to the CPI or CM to receive notification of all proceedings and hearings. F.S. 39.301(15)(b)
Request must include relative’s name, address, phone number, and relationship to the child. F.S. 39.301(15)(b).
Joint Action for CPI’s, Case Managers, Children’s Legal Services

It is the responsibility of the case manager to forward a relative’s request to receive notification of all proceedings and hearings submitted pursuant to. 39.301(14)(b) to the attorney for the department

CPI or CM must forward the request for notification to Children’s Legal Services

Children’s Legal Services Requirements

Children’s Legal Services must notify relative of all hearings either in writing or orally and must inform relative of their right to:

- attend all subsequent hearings
- submit written reports to the court
- speak to the court regarding the child. F.S. 39.502(19)

Court

Court may release attorney from this obligation if relative’s involvement is impeding the dependency process or detrimental to the child’s well-being. 39.402(19)

Failure to provide notice will not result in any previous action of the court being set aside, reversed, modified, or changed unless court makes a finding that a change is in the child’s best interest. F.S. 39.301(15)(b)

Court must provide notice of next hearing to relatives providing out-of-home care to the child F.S. 39.402(8)(b)(6), 39.506(9)

At shelter, court must notify the parents, legal custodian, and relatives providing out-of-home care of the importance of the active participation of the relative. F.S. 39.402(8)(b) 6

Court must notify relatives providing out-of-home care following a shelter petition being granted that relative has the right to:

- attend all subsequent hearings
- submit reports to the court
- speak to the court regarding the child F.S. 39.402(8)(b) 8
Criteria for Outcome Development

Introduction
The Ongoing Family Functioning results in the identification of specific Outcomes for Change. The Outcomes for change are precise and clearly worded statements that form a picture of what enhanced diminished caregiver protective capacities would look like for caregivers for each case that is opened for Ongoing Case Management. The Outcomes for change that emerge from the ongoing family functioning assessment process are the most important aspect of the case plan. The outcomes define for caregivers, workers, courts, and treatment providers what must change to achieve intervention success. The outcomes serve as the focus or target of all treatment intervention services throughout ongoing case management.

Developing Criteria Based Outcomes
All outcomes must focus on enhancing diminished caregiver protective capacities
When developing outcomes, ongoing workers and supervisors should always begin by referring to the Caregiver Protective Capacity Reference Guide.

All outcomes must target individual caregiver thinking, feeling, and behaving associated with caregiver performance and the ability to assure child protection.
Outcomes should always reflect how a caregiver’s thinking, feeling, and behaving are interrelated and influence caregiver performance. Outcomes should always be based on what has been identified as being diminished related to cognitive, emotional, and/or behavioral caregiver protective capacities.

All outcomes must be understandable.
The outcomes that are selected for the case plan (related to enhancing diminished caregiver protective capacities) should logically match up with the reason the case were opened (impending danger).

All outcomes must reflect specific behavioral change that must occur in order for a caregiver to have sufficient protective capacities to assure child safety and permanence.
Outcomes that are behavioral stated require that documentation describe in positive terms what it would look like (or how caregivers would specifically need to behave differently) in order for them to be protective.

All outcomes must be individualized based on the unique dynamics of the family, how impending danger is manifested, and which caregiver protective capacities are diminished.
Outcomes must be specific enough to accurately reflect diminished caregiver protective capacities and describe what must change for each individual caregiver. Outcomes for change are better when the outcome statements include a caregiver’s own perceptions and language.

All outcomes must be measurable in the sense of specifically defining what must change and/or exist related to caregiver thinking, feeling, and behaving.
The ability to effectively measure progress related to outcome achievement is based on the extent to which the outcome statement associated with caregiver protective capacities clearly describes what specifically must change related to caregiver thoughts, feelings, and behaviors.
Case Plan Outcome Examples for Evaluation

Angela is able to set her own needs aside in favor of meeting Angel’s needs and demonstrate that she is able to control herself, her impulses, and her personal habits including avoiding substances when she is in the presence of Angel or has responsibility for the care and protection of Angel and avoiding exposing Angel to inappropriate activities in the home or allowing the presence of people who cause Angel to be fearful of her home environment.

The caseworker will work with Ms. Kelly on developing short-term strategies for managing her household and providing for the basic needs of her children. Additionally, referral will be made to Home Again to assist Ms. Kelly in securing adequate and stable housing for her and her children.

Parenting Assistance will assist Sara Smith in continuing to grow as an effective and protective parent by providing direct information and knowledge about the stages of child development with specific relationship of each stage with the stage of development each of her children are in.

Rebecca can meet her own emotional needs. She feels self-confidence and is “able to express that she does not have to depend on other individuals to know that she is a good person”. She “feels positive about herself and she chooses friends and activities that support a positive attitude and behavior”.

Tara Deal demonstrates enhanced cognitive, emotional, and behavioral capacities that enable her to provide for the basic needs of her children, provide appropriate structure and guidance, and assure a secure and safe environment.
Case Planning Outcome Worksheet for Dutton-McAdams

OUTCOME #1:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Outcome applies to the following participants:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Outcome will be achieved when:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

<table>
<thead>
<tr>
<th>Who</th>
<th>Actions/Tasks</th>
<th>Estimated Completion Date</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
OUTCOME #2:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
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____________________________________________________________________________
____________________________________________________________________________
Outcome applies to the following participants:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Outcome will be achieved when:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Who | Actions/Tasks | Estimated Completion Date
---|--------------|------------------------


Module 2: Integrating the Child and Family Needs into the Case Plan

Implementation of the Guiding Principles of Care

Quality Assurance will review the case files of children placed in licensed care to decide the extent to which children in agency care and custody are receiving services listed in the Guiding Principles. The following data is collected:

**Screening**
- Percent of children screened for mental health and substance abuse needs.
- Percent of children with a potential need for services referred for further assessment.
- Percent of children with screenings completed in 30 days and percent of children with referrals completed in 30 days, or if not, reasons are documented.

**Assessment**
- Percent of assessments conducted or reviewed and approved by a licensed mental health professional or certified addictions counselor.
- Percent of assessments that include a comprehensive review of behavioral, educational, health, and home environment.

**Planning**
- Percent of children who have mental health or substance abuse needs who have a case plan.
- Percent of children whose mental health and substance abuse needs are included in the case plan.
- Percent of children with individualized case plans.
- Percent of case plans developed with involvement of family and/others important to the child.
- Percent of case plans that include a description of the mental health and substance abuse needs being addressed, services to be provided, including type, frequency, duration, location, and name of provider.
- Percent of case plans that are adjusted according to changes in treatment needs.
- Percent of children with mental health or substance needs not addressed by the case plan.

**Services**
- Percent of planned services implemented within 30 days of identification of need, or if not, reasons are documented.
- Percent of services consistent with child’s case plan.
- Percent of clients whose services are monitored by the Case Manager.
- Percent of children in the Independent Living Program who have appropriate outcomes and tasks to address the skills and needed services documented in their case plan.
Implementing the Guiding Principles

Screening
Refer children in care for 7 days for mental health assessments.
Refer children with potential need for services for further assessment.
Complete screenings and referrals within 30 days or document why not.

Assessment
Review assessments to ensure assessments are conducted/approved by a licensed mental health professional or certified addictions counselor.
Review assessment to ensure they include a comprehensive review of behavioral, educational, health, and home environment.

Planning
Develop a case plan that
Includes the behavioral health needs
Is individualized
Documents others input in case plan development
Describes needs being addressed, services to be provided, including type, frequency, duration, location, and name of provider
Is adjusted as treatment needs change

Services
Implement services within 30 days of identification of need, or document why not.
Identify services consistent with child’s case plan.
Monitor services, as appropriate.
Develop case plans with appropriate outcomes and tasks that address the skills and needed services for children in the Independent Living Program.
Principles for Service Provision

Mental Health Services

Mental health services must be provided in a system of care that:
is centered on the child and family, with their needs and strengths dictating the types and mix of services provided
engages children’s families and surrogate families as active participants in all aspects of planning, selecting, and delivering mental health services
is community based, with accountability, the location of services, and the responsibility for management and decision-making resting at the local level
provides timely access to a comprehensive array of cost-effective mental health treatment and support services
provides individualized services, guided by an individualized service plan, in accordance with the unique needs and strengths of each child and family
through an appropriate screening and assessment process, identifies as early as possible those children who are in need of mental health services
provides services in the least restrictive and most normal environment that is clinically appropriate for the service needs of the child
provides services that are integrated and linked with schools, child-caring agencies, and other agencies and programs
Community Mental Health Services  
(for children who are Medicaid eligible)

Goals
The goal of mental health services in the community is to:
provide individualized treatment and supports
enable the child to live in a home environment
reduce the number of unplanned moves
secure a permanent home for the child as soon as possible
To meet these goals, Medicaid funded services can be provided:
in the child’s home
foster and group care settings
schools
other community settings are available
Mental health service needs that are identified in the child’s case plan and that are not Medicaid funded may be purchased through Children Mental Health funds.

Children’s Mental Health Services

Behavioral Health Overlay Services, or BHOS
BHOS is a Medicaid program component that enables eligible children placed in designated agency contracted residential group care programs to receive medically necessary behavioral health services.
An eligible provider:
is an enrolled Medicaid Community Mental Health Services provider.
is under contract with the agency as a residential group care provider.
has the primary mission to provide an alternative living situation for children who have been adjudicated dependent.
is designated by the agency as an essential behavioral health care provider.
is certified as eligible by the district ADM program office and the AHCA regional office.
is under contract with the ADM program office as a provider.
Case Management

is provided primarily for children with more complex needs requiring coordinated services from two or more providers.

Case Managers

arrange for services for individual children and their families,

advocate on their behalf,

ensure that appropriate service plans are developed and implemented,

coordinate service delivery, and

review progress toward desired results.

Crisis Stabilization Units

provide short-term residential evaluation and crisis stabilization for persons experiencing an acute mental or emotional crisis.

Children admitted to these facilities are those who are believed to meet the criteria for involuntary treatment under Florida’s Baker Act (Chapter 394, Part 1, F.S.) and who

• require inpatient psychiatric care during a period of crisis.

The purpose of this service is to evaluate the child’s condition, stabilize the child, and provide recommendations for appropriate follow-up treatment upon release.

These facilities may be free-standing or may be hospital-based.

In some regions/circuits, crisis stabilization units serve both children and adults, but the facilities are in compliance with statutory requirements for keeping children separated from adults.

Day Treatment

An integrated program of academic, therapeutic, and family services, staffed by multi-disciplinary teams.

Educational services are usually delivered by local public school teachers and should be individualized.

Therapeutic services include individual and group counseling, interpersonal skill building, and therapeutic behavioral training.

Family services may include family counseling, parent training and assistance with specific family problems. The treatment team is expected to coordinate the services they provide for the child and family.

Day treatment programs may be school-based or provided at other community sites.

Individualized Wrap-Around Services

“Packages” of treatment and related services for the child and the family.

Enable the child to remain in the child’s own home, foster home, or other community setting.

May include both traditional and highly individualized services, including the purchase of needed goods and services identified in the service plan.
Outpatient Treatment/Outpatient Medical
Provision of individual, group or family therapy by mental health professionals, including psychiatrists, psychologists, and mental health counselors.
Treatment settings may include
community mental health centers
private offices
child’s home or school, and other settings
Non-Judicial In-Home behavioral services and supported community activities, such as therapeutic friends or community support aides, are also considered outpatient treatment.
Assessment of psychiatric mental status and medication administration can also be provided, to improve the functioning or prevent further deterioration of children with serious emotional disturbance.

Respite Care
Planned period of relief for parents caring for a child with serious emotional disturbance
May be used for any eligible child’s family, including biological, adoptive and foster parents
Respite care providers assume the duties of care-giving to relieve the family from the constant demands of parenting a child with often difficult behaviors and special needs.
several hours, overnight, several days in the child’s home or in the home of the respite care provider

Specialized Therapeutic Foster Care
Medicaid-funded program of intensive mental health treatment provided in specially recruited foster homes
Provides the supervision and intensity of programming required to support children with moderate to severe emotional and/or behavioral problems
Avoids the need for admission to an inpatient psychiatric hospital or residential treatment center
Specialized therapeutic foster homes must be licensed under Chapter 65M-6, F.A.C., and no more than two children requiring this level of care may be placed in a home except when a child has a sibling.

Therapeutic Foster Care
Provides mental health services for children with emotional and behavioral disturbances living in a foster family home. Each home:
is managed by trained foster parents who provide specialized care for children needing a therapeutic setting;
must be licensed under Chapter 65M-6, F.A.C, and supervision of the child’s treatment provided by mental health professionals;
is licensed to serve one or two children;
The child and family receive support services as necessary. In this program, the therapeutic foster parent is considered the key therapeutic agent.
Funding is through a combination of sources, usually a mixture of Child Protection Agency, Medicaid, and Children’s Mental Health.
Implementing CBHA Recommendations into the Case Plan

Consider the Johnson case study drafted by the class. Prior to the first JR hearing, another intake was received by the hotline. Following the investigation, the new allegation of substance abuse was verified. The children were removed due to risks associated with the mother’s substance abuse. A new case plan was drafted with a permanency goal of reunification. CBHA referrals were initiated and results for Marcus Johnson, the 10-year old child are included in the chart below.

Write an outcome for the new case plan to address the children's educational, physical, and mental health needs.

Write tasks for the mother, Case Manager, and caregiver to address the CBHA recommendations for Marcus.

Recommendations are from the therapist who completed the CBHA.

<table>
<thead>
<tr>
<th>(1) Problem/Issue</th>
<th>Marcus complains that he cannot see the board when his teacher writes on it and has trouble seeing movies and picture books from his seat in class. He also reports that he often has a runny nose and itchy eyes. There are medical records available, but the parent’s attorney advised her not to provide consent for release of information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal/Outcome</td>
<td>Marcus will receive any medical monitoring or treatment as recommended by his medical provider.</td>
</tr>
<tr>
<td>Intervention/Service recommended</td>
<td>Marcus may benefit from a pediatrician’s review of his medical records to decide if any medical treatment is necessary at this time. He may benefit from a referral to an eye doctor to assess his vision and to a primary care physician to assess his complaints.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(2) Problem/Issue</th>
<th>Marcus’s teacher stated that she is considering referring him for remedial reading services, and he is struggling to attain benchmark grade level achievements in reading, math, and science. School records indicate that his mother has missed multiple meetings at the school to discuss his progress. His attendance is adequate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal/Outcome</td>
<td>Marcus will receive educational testing to identify his intervention needs and will receive necessary services.</td>
</tr>
<tr>
<td>Intervention/Service recommended</td>
<td>Case Manager and caregiver consultation with school’s intervention team to request academic ability and achievement testing or to arrange for a psychological testing to rule out any learning disabilities and develop an appropriate intervention plan to assist Marcus in achieving success at school.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>(3)</strong></td>
<td><strong>Problem/Issue</strong></td>
</tr>
<tr>
<td></td>
<td>According to direct observation and verbal reports from others, Marcus has a tendency to engage in intense verbal arguments over minor issues, demonstrates difficulty in sharing, and is becoming physically aggressive with his classmates when they touch his belongings or do something he does not want them to do.</td>
</tr>
<tr>
<td><strong>Goal/Outcome</strong></td>
<td>Marcus will demonstrate non-disruptive behaviors for problem solving, sharing, and expressions of anger.</td>
</tr>
<tr>
<td><strong>Intervention/Service recommended</strong></td>
<td>Marcus may benefit from participating in an anger management group or counseling to support him in developing age appropriate behaviors in expressing anger. He and his parent and/or caregivers may benefit from joint counseling.</td>
</tr>
</tbody>
</table>
Children Jointly Served: CBC and DJJ

F.A.C. 65C-30.017 - Coordination of Services for Youth Involved with the Department of Juvenile Justice

Who Are They?
Children who are in the legal or physical custody of CBC in paid out-of-home care and are
Children in secure detention facilities and residential programs through commitment to a DJJ program OR
Children on probation in lieu of commitment to a DJJ program.

Overview of Agency Relationships
You must share information regarding the child’s background, family history, service history and participate with DJJ when initial plans are being developed and when the child is being transitioned back into the community.
DJJ must provide you with monthly progress reports regarding services and sanctions.
Failure of either department to work together will result in notification of respective agencies district administrators.

Secure Detention
The assessment for and provision of mental health services for children in secured detention (long-term basis) are the primary responsibility of the DJJ counselor.
The assessment for and provision of mental health services for children who remain in CBC licensed care or who are in temporary, short-term secured detention are your responsibility.
Rules of DJJ do not supersede provisions in Chapter 39 governing consent to treatment and services for DCF children in DJJ's custody including the provisions of psychotropic medications.
Visitation by you is allowed according to the regulations of facility; by caregivers during regular facility visitation hours; by parents when you approve.
Within 5 days of any change in legal and/or physical custody between CBC and DJJ (or vice versa) you must meet with the DJJ counselors to transition case responsibilities and ensure continued service provision.

Probationary Status
The assessment for and provision of mental health services for children on probationary status is your responsibility.
You and the DJJ counselors jointly decide how to handle the notification of probationary compliance and coordination of efforts.
Day Treatment
CBC retains responsibility for treatment provision and monitoring.
DJJ retains responsibility for monitoring progress at day treatment program.

Commitment
You will participate in commitment hearing for the purpose of transitioning services.
You/DJJ/Child/Family/Others meet to develop case plan.
DJJ responsible for coordinating services with you and providing monthly progress reports.
DJJ to provide information to you for ongoing judicial review report development.
You will continue visitation planning in accordance with DJJ facility visitation policy.
Domestic Violence Service Planning Activities

The primary goal of service planning with battered victims and their children is to protect the children by protecting their battered parent and have batterers take responsibility for stopping their violence.

Case Plan Tasks for Victims and Children

The parent participates in safety planning for them and the children.
The parent participates in empowerment counseling to address personal safety issues in order to increase protections for them and their children.
The parent self-educates regarding the effects of domestic violence on children through involvement with local domestic violence programs.
The parent does not use physical discipline with the children.
The children have a safety plan that is consistent with their willingness to use it, their age, and their developmental level.

Services

individual/group counseling through battered women’s program or other community programs
legal, housing, welfare advocacy
shelter and transitional services
visitation services
specialized assessment services focusing on issues of domestic violence
day care
parent support groups

Case Plan Tasks for Batterers

appropriate batterer intervention programs (certified by the state)
visitation center services
specialized assessment services focusing on issues of domestic violence
cooperation with police, probation, and parole when involved
substance abuse and mental health services, if needed

Inappropriate Services and interventions for Domestic Violence

options for protection for the adult victim that in their estimation increases the level of danger
couples or family therapy
court mediation/divorce mediation
anger management groups or other batterer’s treatment options that do not meet the requirements for domestic violence perpetrator rehabilitation programs
visitation arrangements that endanger victim and/or children
Domestic Violence Criteria for Effective Perpetrator Rehabilitation Programs

The Program:

Goal is for the batterer to stop all tactics of control, rather than striving to keep the couple together or resolve the couple’s issues.

Defines domestic violence as a pattern of coercive behaviors that includes physical, sexual, and psychological assaults, as well as economic coercion.

Holds the batterer accountable for the abusive conduct and for making the necessary changes to stop the abuse. The program also uses strategies that do not blame the victim for the batterer’s violence.

Follows clear policies regarding victim confidentiality and safety.

Provides information to adult victims and/or victim advocates about issues related to victim safety.

Provides initial and on-going assessments of the danger posed to the victim or children by the batterer and notifies the victim and the appropriate authorities should the victim or children are in danger.

Conducts an initial assessment to assess if there are significant factors that may influence the batterer’s ability to benefit from treatment (e.g., organic impairments, psychosis, and motivation to change).

Is a minimum of one year of batterer accountability to an intervention program within which there are a minimum of 26 group sessions.

Have clear completion or termination criteria.

Has clear consequence for noncompliance by the batterer.

Staff have demonstrated ability to work cooperatively with victim advocacy programs, the courts, and other agencies.

This material was adapted from the Family Violence Prevention Fund’s publication Domestic Violence: A National Curriculum for Child Protective Services, by Dr. Anne Ganley and Susan Schechter and was made possible by support from the Edna McConnel Clark Foundation. Used with permission of the Family Violence Prevention Fund.
Module 3: Concurrent Case Planning

Concurrent Case Planning Terminology

Alternate Goal
Refers to a permanent placement for the child other than the child’s own home or reunification with the child’s parents.
Alternate permanency goals are adoption, relative/non-relative custody.

Attachment
The psychological connection between people that permits them to have significance to each other.
Attachment has also been defined as an affectionate bond between two individuals that endures through space and time and serves to join them emotionally.

Concurrent Planning
A process that supports family reunification efforts and
Simultaneously supports all the preparation necessary to quickly implement an identified alternate goal for the child(ren) if a safe, timely reunification is not successful.

Early Decision-Making
Means reaching the point without delay when case documentation clearly supports either the primary goal of family reunification or
An alternate permanency goal for the child(ren) such as adoption or legal guardianship.

Frontloading
Immediate, early provision of rehabilitative services
Intensive follow-up until such services are successful or proven unsuccessful

Full Disclosure
A situation in which you candidly and thoroughly inform the birth family and appropriate others from the beginning about the potentially negative consequences of out-of-home care, the need for a concurrent plan, parental rights, and responsibilities, and the consequences of not achieving the outcomes in the case plan.
Full disclosure also includes informing the parents of how others view the parents’ progress and what the full range of parental options are at each stage of process.
Primary Goal
The agreed upon goal, usually reunification, to be supported as long as progress toward the goal is consistent with the agreed-upon time frames.
If the child is receiving Non-Judicial In-Home Services, the primary goal is to maintain or strengthen the current placement.
For the agency, when the term primary goal or reunification is used, it may also refer to the goal of maintaining or strengthening the current placement.

Resource Family
A family related to the child or a foster/adoptive family who is willing and able to assist the agency in working toward reunification.
Considers themselves a permanent placement for the child if the reunification efforts are unsuccessful.

Target Population
The age group of children whose parents are screened to determine if a concurrent plan is appropriate.
If a child who falls in the target age group has older siblings and the case is appropriate for a concurrent plan, the older child(ren) are included in the concurrent plan.
Is Concurrent Case Planning Appropriate?

Directions: Read each of the scenarios and decide if concurrent case planning is appropriate.

Scenario 1: Tanya and Derrick

Toddler Left with Neighbors

Derrick was 20 months old when his mother left him with a neighbor while she “went to work to pick up her check.” Three days later, the neighbor called the Hotline and Derrick was placed in emergency shelter care while PI searched for the mother. The mother finally returned in five days. Two weeks later a maternal aunt was located who agreed to care for Derrick temporarily. The following information was gathered for the intake:

According to the closed case file

Derrick was born addicted to crack-cocaine and was reported to be difficult to calm and soothe in the first three months of his life, when the maternal aunt often cared for him. Following Derrick’s birth, services, which included substance abuse treatment, were court ordered and successfully completed in 18 months.

Tanya, 28 years old, has been abusing crack-cocaine for three years. Tanya participated unsuccessfully in a substance abuse program when she was pregnant with Derrick.

She has one older son who lives with his paternal grandmother who was asked by Tanya to provide care when Tanya didn’t have food or shelter.

Tanya is separated from Derrick’s father, Derrick Sr. He is not the father of the oldest child, and abuses alcohol and does not maintain sobriety despite support from his mother and his sister.

According to an interview with the maternal aunt

Since the termination of court ordered services, Tanya often disappeared for several days, and sometimes up to a week’s time; the maternal aunt finally became too frustrated by Tanya’s erratic behavior and refused to take Derrick just prior to his being left with the neighbor.

The maternal aunt is open to consideration of long term relative placement if necessary.

According to Tanya

At the time of the intake, Tanya admitted that she ran into old friends and relapsed. Derrick, Sr. does not work, and lives on and off with his mother and his sister who has recently said he could not stay with her any longer.

Tanya told the PI that she loves Derrick and wants him to be returned to her.
Scenario 2: Jordan Rogers

PI responded to an intake alleging that Cindy Rogers had been using cocaine and marijuana, sometimes in the presence of her six year old son, Jordan. When PI arrived at the apartment of Ms. Rogers, she admitted that she had a drug problem and desperately needed help. Jordan also spoke to PI and said that his mom smokes funny cigarettes and does drugs with her friends. The apartment had very little furniture and no food. Cindy told PI that she had sold the furniture to buy drugs.

Cindy has a sister, named Mary who lives in the area. Mary agreed to help support Cindy and agreed to take custody of Jordan provided she had a court order that gave her temporary custody. Jordan was placed with his Aunt Mary at a shelter hearing held the following day.

At the time of the case plan conference, Cindy was already enrolled in a residential drug treatment program. She has been having and attending at least one supervised visit a week with Jordan. She calls him regularly on the telephone.

Scenario 3: Ricky Fernandez

An intake called in to the Abuse Hotline indicated that the local fire rescue squad was called to the home of Alex Fernandez. They were met by Mr. Fernandez, who was holding a limp nine-month-old boy, his son, Ricky. There were scratch marks on the left side of the chest and bruising on both sides of the neck. After administering emergency treatment, Ricky was transported to the hospital. He was diagnosed with a severe bleed in his cranium. Mr. Fernandez stated that he had put Ricky down for a nap and had gone outside for ten minutes. When he returned, he found the side of the crib lowered, and said that the baby had rolled onto the tile floor. He said he must have forgotten to raise the other side of the crib after he put the baby down for his nap.

Mr. Fernandez is the primary caregiver for Ricky since his wife, Maria died in a car accident six months ago. He is not employed at the present time, and his income is from a life insurance policy he had on Maria.

The child protection team was consulted, and the physician determined that the injuries to Ricky were a subdural hematoma and acute retinal hemorrhaging, consistent with “Abusive Head Trauma.” X-rays revealed that Ricky had two fractured ribs, plus evidence of two older fractured ribs. There was also a partially healed spiral fracture of the long bone of the baby’s right leg. The father denies causing any of the injuries to the baby. When asked about the fractured ribs and leg, he says he has no idea how that could have happened.
Reunification Prognosis Assessment for Concurrent Planning

Based on “Foster Care Drift: A Risk Assessment Matrix,” Child Welfare by Linda Katz and Chris Robinson

Section A: Grounds for TPR

voluntarily executed a written surrender
abandonment as defined in s. 39.01(1) or when the identity or location of the parent or parents is unknown and cannot be ascertained by diligent search within 60 days
severe or continuing maltreatment
parent who has materially breached the case plan making it unlikely that he or she will be able to substantially comply with the case plan before the time for compliance expires
when the parent of a child is incarcerated and either:
The period of for which the parent is expected to be incarcerated will constitute a significant portion of the child’s minority. When determining whether the period of time is significant, the court shall consider the child’s age and the child’s need for a permanent and stable home. The period of time begins on the date that the parent enters into incarceration.
The incarcerated parent has been determined by the court to be a violent career criminal as defined in s. 775.21;
the court determines by clear and convincing evidence that continuing the parental relationship with the incarcerated parent would be harmful to the child, and for this reason, that termination of the parental rights of the incarcerated parent is in the best interest of the child.
egregious, bad conduct or failure to prevent egregious conduct
aggravated child abuse, sexual battery, sexual abuse, or chronic abuse

Expedited TPR

A petition for termination of parental rights may also be filed when a child has been adjudicated dependent, a case plan has been filed with the court, and the child continues to be abused, neglected, or abandoned by the parents.
Parent(s) have engaged in egregious conduct or had the opportunity and capability to prevent and knowingly failed to prevent egregious conduct that threatens the life, safety, or physical, mental or emotional health of the child or the child’s sibling.
Parent(s) have subjected the child to aggravated child abuse as defined in s.827.03, sexual battery or sexual abuse as defined in s.39.01, or chronic abuse.
Parent(s) have committed murder or voluntary manslaughter of another child, or a felony assault that results in serious bodily injury to the child or another child, or aided or abetted, attempted, conspired, or solicited to commit such a murder or voluntary manslaughter or felony assault. Parental rights of the parent to a sibling have been involuntarily terminated.
The parent or parents have a history of extensive abusive, and chronic use of alcohol or a controlled substance which render them incapable of caring for the child, and have refused or failed to complete available treatment for such use during the 3-year period immediately preceding the filing of the petition for termination of parental rights.

A test administered at birth that indicated that the child’s blood, urine, or meconium contained any amount of alcohol or a controlled substance or metabolites of such substances, the presence of which was not the result of medical treatment administered to the mother or the newborn infant, and the biological mother of the child is the biological mother of at least one other child who was adjudicated dependent after a finding of harm to the child’s health or welfare due to exposure to a controlled substance or alcohol as defined in s. 39.01(31), after which the biological mother had the opportunity to participate in substance abuse treatment.

On three or more occasions the child or another child of the parent or parents has been placed in out-of-home care pursuant to this chapter, and the conditions that led to the child’s out-of-home placement were caused by the parent or parents.

**Section B: Good Prognosis Indicators**

**Parent-Child Relationship**
- Parent shows empathy for the child.
- Parent responds appropriately to the child’s verbal and non-verbal signals.
- Parent has an ability to put the child’s needs ahead of his/her own.
- When they are together, the child shows comfort in the parent’s presence.
- The parent has raised the child for a significant period of time.
- In the past, the parent has met the child’s basic physical and emotional needs.
- Parent accepts some responsibility for the problems that brought the child into care or to the attention of the authorities.

**Parental Support System**
- The parent has positive, significant relationships with other adults who seem free of overt pathology (spouse, parents, friends, relatives).
- The parent has a meaningful support system that can help him/her now (church, job, and counselor).
- Extended family is nearby and capable of providing support.

**Past Support System**
- Extended family history shows family members able to help appropriately when one member is not functioning well.
- Relatives came forward to offer help when the child needed placement.
- Relatives have followed through on commitments in the past.
- There are significant other adults, not blood relatives, who have helped in the past.
- Significant other adults have followed through on commitments in the past.
Family History
The family’s ethnic, cultural, or religious heritage includes emphasis on mutual caretaking and shared parenting in times of crisis.
The parent’s own history shows consistency of parental caretaker.
The parent’s history shows evidence of his/her childhood needs being met adequately.

Parent’s Self-Care and Maturity
Parent’s general health is good.
Parent uses medical care for self appropriately.
Parent’s hygiene and grooming are consistently adequate.
Parent has a history of stability in housing.
Parent has a solid employment history.
Parent has graduated from high school or possesses a GED.
Parent has employable skills.

Child’s Development
Child shows age-appropriate cognitive abilities.
Child is able to attend to tasks at an age-appropriate level.
Child shows evidence of conscience development.
Child has appropriate social skills.
Major behavioral problems are absent.

Section C: Poor Prognosis Indicators
Child experienced physical or sexual abuse in infancy.
Treatment of offending parent may be so difficult and lengthy that child would spend years in foster care.

Dangerous Lifestyle
**Parent’s only visible support system and only visible means of financial support is found in illegal drugs, prostitution and street life.
Parent is addicted to debilitating illegal drugs or to alcohol.
Pattern of documented domestic violence between the spouses of one year or longer and they refuse to separate.
Parent has a recent history of serious criminal activity and jail.
Mother abused drugs/alcohol during pregnancy, disregarding medical advice to the contrary.
**Significant CPS History**

The agency and or law enforcement has intervened regarding three or more serious separate incidents, indicating chronic pattern of maltreatment.  
In addition to emotional trauma, the child has suffered more than one form of maltreatment.  
Parent’s other child(ren) have been placed in foster care or with relatives for periods of time over six months duration or have had repeated placements with agency intervention.  
This child has been abandoned with friends, relatives, hospital, or in foster care, or once the child is placed in subsequent care, the parent does not visit of his or her own accord.  
Agency preventive or family preservation measures have failed to keep the child with parent.  (Intensive Crisis Intervention, Family Builders, homemakers, therapeutic child care) 
Parent is under the age of 16 with no parenting support system, and placement of the child and parent together has failed due to parent’s behavior.  
Parent has asked to relinquish or place the child on more than one occasion following initial intervention. (Child may suffer repeated voluntary placements)

**Inherent Deficits**

**Parent diagnosed with severe mental illness (psychosis, schizophrenia, borderline personality disorder, sociopathy), which has not responded to previously delivered mental health services.** 
Parent’s symptoms continue, rendering parent unable to protect and nurture child.  
Parent has a diagnosis of chronic and debilitating mental illness; psychosis, schizophrenia, borderline personality disorder, sociopathy or other illness that responds slowly or not at all to current treatment modalities.  
Parent is intellectually impaired, has shown significant self-care deficits, and has no support system of relatives able to share parenting.  
Parent grew up in foster care or group care, or in a family of intergenerational abuse.  (Unfamiliarity with normal family life can severely limit parent’s ability to overcome other problems in life)  
Lack of prenatal care for other than financial reasons.  (May indicate parent is unlikely to bond with child)

**Important: See Instructions and Signature/Date lines below and on next page.**
Instructions

Use of Section A
If any one of the grounds for expedited TPR grounds 6-9 from PG105-106, a reunification case plan is not required. In rare instances, if good prognosis indicators offset one of the grounds (e.g., item 9) the ground may then become a poor prognosis indicator and trigger a concurrent plan. Consult with legal staff immediately if any of the grounds are present to determine whether a TPR petition is the appropriate course of action.

Use of Section B
Good prognosis indicators are used as strengths on which to build, in a traditional or concurrent case plan in which reunification is the goal or the primary goal.

Use of Section C
Asterisked items are EXTREME conditions that make reunification a very low probability. Only one indicator is necessary to classify the prognosis as poor. Non-asterisked items are SERIOUS conditions that make reunification a low probability. Two or more SERIOUS conditions have the same weight as one EXTREME condition. Two SERIOUS conditions are necessary to classify the prognosis as poor. The more SERIOUS conditions that are present, the less likely it is that safe reunification will occur. A determination that a particular EXTREME or SERIOUS condition is present must be based on accurate verified information that, if challenged, can be proven in court. Attach verification to the Reunification Prognosis Assessment and consult immediately with legal staff to discuss a concurrent plan.

Recommended Course of Action:
Expedited TPR Petition
Engage family in a traditional case plan
Engage family in a concurrent case plan

Permanency Goals
Reunification
Adoption
Permanent Guardianship
Permanent Placement with a Fit and Willing Relative
Placement in Another Planned Permanent Living Arrangement

Signature  Date

Case Manager
Supervisor
Attorney
Module One: Learning Objectives

Participants are able to:
• Recognize dual, sometimes conflicting roles of case management.
• Define and illustrate the actions and tasks associated with ongoing family functioning assessment.
• Define the assessment of caregiver protective capacities and child needs to inform case plan outcomes;
• Describe decisions related to family needs, services and child placement.
• Identify statutory requirements for the case plan.
• Apply case planning methodology and statutory requirements to draft a case plan.
• Able to evaluate case information to develop case plan outcomes.

Foundational Knowledge

Introduction to Ongoing Safety and Services Management
Slide 4

Creating a Frame of Reference
- What should be the primary reason for deciding a family should have a case opened for ongoing case management?
- What is the ideal success in ongoing case management?
- What is the intervention focus of the case plan?
- What is the ongoing case manager role in working with caregivers?

Slide 5

From Great Wall of China to the Panama Canal
- CPI
  - Safety
  - Danger Threats
  - Caregiver Protective Capacities
  - Safety Plans
- Case Management
  - Safety
  - Danger Threats
  - Caregiver Protective Capacities
  - Treatment-Change

Slide 6

[Diagram not transcribed]
Slide 7

Ongoing FFA Engage Raise Awareness Focus Treatment Caregiver Protective Capacities

Slide 8

Ongoing Family Functioning Decisions
✓ Are danger threats being managed?
✓ How can existing protective capacities — STRENGTHS — be built upon to make changes?
✓ What is the relationship between danger threats and the diminished caregiver protective capacities — What must change?
✓ What is the parent’s perspective or awareness of their caregiver protective capacities?
✓ What are the child’s needs and how are the parents meeting or not meeting those needs?

Slide 9

Ongoing Family Functioning Decisions
✓ What are the parents ready and willing to work on in the case plan?
✓ What are the areas of disagreement with what needs to change?
✓ What change strategy (case plan) will be used to assist in enhancing diminished caregiver protective capacities?
Slide 10

Philosophy: Ongoing Family Functioning Assessment

• Safety is paramount and the basis for intervention.
• Case planning process and interventions can be more clearly defined through the use of safety concepts.
• Case planning processes can be structured in a way to encourage and direct parent’s involvement and establish consistent intervention decisions and objectives.

Slide 11

Knowledge and Essential Skill Associated with the Family Functioning Assessment: Case Manager

Core Concepts of Safety
• Ongoing Safety Management Focused

Engagement of Families
• Change Focused

Child Needs and Caregiver Protective Capacities Assessment

Slide 12

FSDMM: Motivation for Change

– Pre-Contemplation
– Contemplation
– Preparation
– Action
– Maintenance
– Relapse
Slide 13

Hotline/CPI
Intervention Protocol
Danger Threats
Safety Plans
Caregiver
Protective Capacities

Intervention Standards
Managing Safety
Reconciling
Caregiver
Protective Capacities and Danger
Developing Change Strategies

Ongoing Case Management
Intervention Standards
Managing Safety
Reconciling
Caregiver
Protective Capacities and Danger
Developing Change Strategies

Slide 14

Four Stages of Intervention

Preparation
Introduction
Exploration
Case Planning

Slide 15

Preparation

? What does it mean to be prepared?
? What does preparation in ongoing case management look like?
? What is the purpose of preparation—for the worker? For the Supervisor?
Preparation

Preparation is the act of getting ready, being prepared. In ongoing case management and services this entails key actions and tasks:
- Review of the family functioning assessment
- Review and analysis of the safety plan
- Review of case information and content
- Contact with collaterals
- Response to any immediate safety management needs
- Consultation with the supervisor to reconcile information and prepare for family contact.

When reviewing information, the ongoing worker and supervisor are working towards reconciling information and identifying strategies for involvement with the family.

Small Group Exercise

What is the purpose of preparation?
What does preparation look like in practice and tasks are typically associated with preparation?
What is the role of the supervisor in preparation?

Introduction

What does it mean to be introduced?
What does introduction in ongoing case management look like?
What is the role of the case manager in introduction? Supervisor in introduction?
Introduction

Introduction is the act of introducing you as the worker, clarifying the agency’s role, describing what ongoing case management is and is not, and providing clarification as to the role of the ongoing worker.

Small Group Exercise

? What is the purpose of introduction?
? What does introduction look like in practice, what tasks are associated with introductions?
? How does preparation assist the worker and supervisor in their introduction?

Exploration

? What does it mean to explore?
? What does exploration in ongoing case management look like?
? What is the purpose of exploration—for the worker? For the Supervisor?
**Slide 22**

**Exploration**

Exploration is the act of exploring with families how they are functioning in relationship to the protective capacities, understanding how danger threats or negative family conditions have manifested, exploring motivation for change, resistance, or ambivalence, identifying family strengths, creating danger statements, and finding mutuality for continued work.

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**Slide 23**

**Small Group Exercise**

- What is the purpose of exploration?
- What does exploration look like in practice? What tasks are associated with exploration in this context?
- How does preparation and introduction assist the worker in their exploration work with families?

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**Slide 24**

**Case Planning**

- In what context do you view case planning?
- What tasks are associated with case planning?
Slide 25

Case Planning
Case planning with families is the act of establishing outcomes and motivation for change.

Slide 26

Small Group Exercise

? What is the purpose of case planning?
? What does case planning look like in practice, actions and associated interactions?
? How do preparation, introduction, and exploration assist the worker and supervisor with case planning?

Slide 27

Ongoing Family Functioning Assessment
Application of Intervention Standards

Preparation
Caregiver Protective Capacities
Child's Needs Assessment
Sufficiency of Information
Introduction

Discovery
Obtaining and Analyzing Information for Caregiver Protective Capacities and Child's Needs
Danger Statements and Family Strategy
Case Planning
Developing Outcomes for Change
Slide 28

Ongoing Family Functioning Assessment
Actions/Tasks Through the Lens of Intervention Standards

Slide 29

Commencing Preparation
To know what is necessary to adequately prepare for conducting the ongoing family functioning assessment.

Slide 30

5 Primary Areas of Critical Evaluation for Intervention Standards: Preparation
• Sufficiency of information known—identify information gaps;
• Sufficiency of safety plans to control for danger;
• Identify information that is relevant;
• Baseline information regarding Caregiver Protective Capacities from CPI;
• Information that must be known—what information is needed to inform the Caregiver Protective Capacity and Child Needs Assessment.
Preparation
Knowing How and What Informs the Caregiver
Protective Capacities Assessment

Preparation
Knowing How and What Informs the Child Needs Assessment

Preparation Sufficiency Checklist
Ensuring the next steps are well guided and reconciliation of known information
Slide 34

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Preparation Exercise

Slide 35

Intervention Standards: Introduction

Objectives of Introduction for Case Manager

• Begin to establish rapport with family;
• Establish a working relationship with the family;
• Provide clarification and process with family for ongoing case management.

Slide 36

What Would YOU Want to Know?

• You are a parent who has been transferred to ongoing case management.
• You have had a child removed from your home.
• You have been told “you have been opened to ongoing services.”
• You are meeting your new worker today.
• As your new worker introduces herself and what she is going to do, identify something that you would like to know from her.
• Write the things that you would like to know on a piece of paper or in your participant guide.
Introduction Stage: Working with Families to Build Trust and Gather Information

Handout and Discussion

Dutton-McAdams Ongoing Family Functioning Assessment Intro:
Engagement and Explanation of the Ongoing Family Functioning Assessment

Group Exercise

Exploration

Discussion
Slide 40

**Exploration Seeks to....**
- Identify and reach agreement about diminished caregiver protective capacities.
- Reach agreement about what must change for children to be safe through discussions about impending danger and caregiver protective role and responsibilities.
- Encourage caregivers to invest themselves to participate and work toward changes.
- Reach agreement about how to enhance diminished caregiver protective capacities.
- Join with caregivers in all efforts to enhance diminished protective capacities.
- Focus services and activities and support on enhancing diminished protective capacities.
- Measure progress toward enhancement and restoration of the protective role and responsibilities.
- With the ultimate goal of identifying what must change.

Slide 41


Slide 42

**Family Strategy and Danger Statement**

The Process of What, not Why
THE "WHAT" QUESTIONS THAT FORMULATE THE DANGER STATEMENT and FAMILY STRATEGY

• What is happening that requires CPS involvement?
  • What is the threat?
  • What have you been doing?
• What must be different?
  • What must you do?
  • What can you do?
• What are you willing to do?
• What will be necessary for you to do what you must do?

Crafting the Danger Statement and Family Strategies

Large Group Exercise

Demonstrating: Exploration

Small Group Exercise
Slide 46

Concluding Exploration
Identifying Caregiver Protective Capacities, Child Needs, and Creating the Danger Statement

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Slide 47

Statutory Requirements for Case Planning

Slide 48

Case Plan Defined

FS 39.01(11)

- document prepared with input from all parties
- follows the child from voluntary services through any dependency, foster care, termination of parental rights proceeding or related activity or process F.S. 39.01(11)
Slide 49

Rilya Wilson Act F.S. 39.604

Requires coordination between CBC, Local School Readiness, and licensed early education programs.

Slide 50

Zahid’s Law HB 381

“Zahid Jones, Jr., Give Grandparents and other Relatives a Voice Act”

• Goal: To establish a more effective protocol for engagement of relatives and assurance that their voice will be heard during investigative and judicial processes.

Slide 51

Case Planning

Purpose and Creation of Outcomes
Slide 52

Case Plan

Agreement
Communication
Responsibility
Outcomes
Organized
Focused
Communication

___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________

Slide 53

Greatest Impact
Areas of Least Resistance
Most Urgent
Mutuality

___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________

Slide 54

6 Criteria for Developing Outcomes

Precise-Specific
Clearly Worded
Measurable
Attainable
Reasonable
Timely

___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
___________________________________
Module 2: Integrating Child & Family Needs into Case Plan

Objectives:

- Describe how to integrate child’s mental health needs w/other interventions & case plan services.
- Name case planning issues related to domestic violence.
**Slide 58**

**Problem/Need Statement**

**Problem:**
- Marcus is acting out aggressively with classmates.

**Need:**
- Marcus needs to demonstrate positive methods for dealing with his aggression.

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**Slide 59**

**Outcome**

- Marcus will attend counseling sessions to learn to deal with his aggression until the LCSW determines that substantial progress has been made.

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**Slide 60**

**Task Statement**

- Marcus’s caregivers will arrange for him to be transported to the Community Mental Health Clinic for counseling on Thursday afternoons until his therapist ends the treatment.
- Case Manager will call the clinic at least monthly to ensure attendance.
Children Jointly Served by CBC and DJJ

Children in DCF’s legal or physical custody in paid out-of-home care, &

- in secure detention facilities & residential programs through commitment to DJJ program, or
- on probation in lieu of commitment to a DJJ program

CBC/DJJ Relationship

You must

• Share information with DJJ regarding child’s background, family history, service history
• Participate with DJJ during initial planning and during transition back into the community

DJJ must

• Provide monthly progress reports to you regarding services and sanctions

Responsibilities for Assessment & Provision of Mental Health Services

DJJ Counselor:

• children in secured detention on a long-term basis
• children in licensed care
• children in temporary, short-term secured detention
• (Within 5 days of any placement change between agencies, must meet with DJJ counselor to transition services)

You:

• children in licensed care
• children in temporary, short-term secured detention
• (Within 5 days of any placement change between agencies, must meet with DJJ counselor to transition services)
Day Treatment

You
- retain responsibility for treatment provision and monitoring

DJJ
- retains responsibility for monitoring progress at day treatment program

Commitment

You participate in commitment hearing for service transition

You/ DJJ/Child/Family/Others meet to develop case plan

DJJ coordinates services w/ you & provides monthly progress reports & ongoing JRSS/CPU information

You continue visitation planning in accordance with DJJ facility visitation policy

Principles of Intervention

Protect children
Increase children’s well-being by increasing their mother’s safety
Increase children’s safety by supporting the autonomy of the adult victim
Hold the batterer, not the victim, responsible for the abusive behavior
Supportive Services Network

- Social Services
- Counseling
- Al-Anon meetings
- Church
- School

Module 3: Concurrent Case Planning

Objectives:

- Identify basis for concurrent case planning.
- Describe key concepts of concurrent case planning.
- Identify when to use concurrent case planning.

What is concurrent case planning?

- Establish case plan permanency goal using reasonable efforts to reunify the child with the parent, while at the same time establishing another goal.
- Concurrent efforts to more quickly move children from foster care to a permanent family.
Slide 70

**Good Prognosis Indicators**
- Parent-child relationship
- Parental support systems
- Past support systems
- Family history
- Parent’s self-care and maturity
- Child’s development

Slide 71

**Poor Prognosis Indicators**
- Dangerous lifestyle
- Significant child welfare history
- Inherent deficits