TENNESSEE CENTER FOR CHILD WELFARE

PRE-SERVICE CORE TRAINING FOR WORKERS

PARTICIPANT GUIDE

December 2009 TCCW 1021

Tennessee Center for Child Welfare
MIDDLE TENNESSEE STATE UNIVERSITY

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DCS

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Middle Tennessee State University
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Making a measurable difference in child welfare management, practice, and outcomes!

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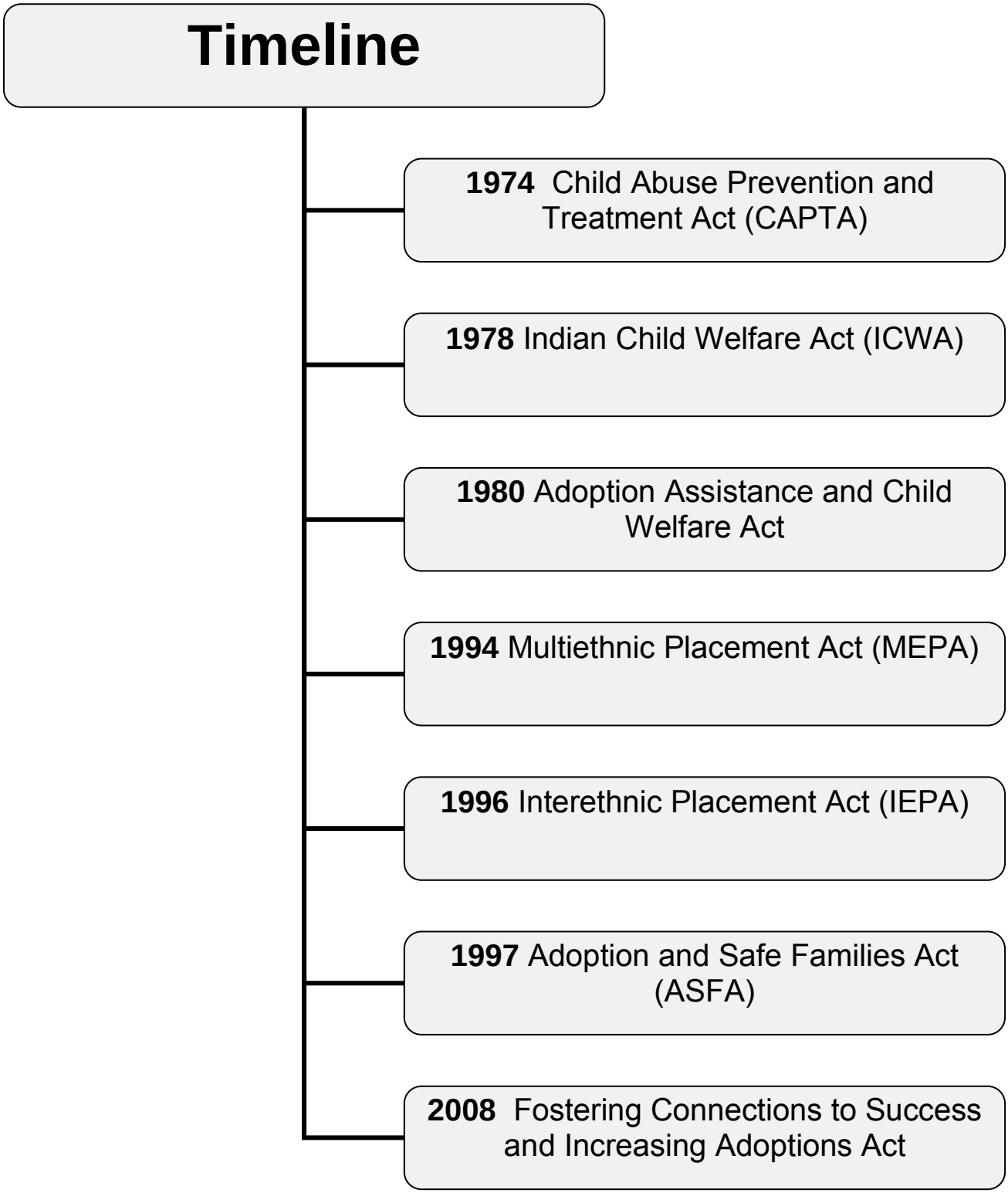
Major Child Welfare Federal Legislation



Child Abuse Prevention and Treatment Act (CAPTA) of 1974

P.L. 93-247

Enacted January 31, 1974

Purpose: To provide financial assistance for a demonstration program for the prevention, identification, and treatment of child abuse and neglect

Major Provisions of the Act:

√ Provided assistance to States to develop child abuse and neglect identification and prevention programs

√ Authorized limited government research into child abuse prevention and treatment

√ Created the National Center on Child Abuse and Neglect (NCCAN) within the Department of Health, Education, and Welfare to:

- Administer grant programs
- Identify issues and areas needing special focus for new research and demonstration project activities

√ Serve as the focal point for the collection of information, improvement of programs, dissemination of materials, and information on best practices to States and localities

√ Created the National Clearinghouse on Child Abuse and Neglect Information

√ Established Basic State Grants and Demonstration Grants for training personnel and to support innovative programs aimed at preventing and treating child maltreatment

1978 Reforms:

√ Established the Adoption Opportunities Program to facilitate placement of children with special needs in permanent adoptive homes and promote quality standards.

Indian Child Welfare Act (ICWA) of 1978

P.L. 95-608

Enacted November 11, 1978

Purpose: To establish standards for the placement of Indian children in foster and adoptive homes and to prevent the breakup of Indian families.

Major Provisions of the Act:

√ Established minimum Federal standards for the removal of Indian children from their families

√ Required Indian children to be placed in foster or adoptive homes that reflect Indian culture

√ Provided for assistance to Tribes in the operation of child and family service programs

√ Created exclusive Tribal jurisdiction over all Indian child custody proceedings when requested by the Tribe, parent, or Indian ‘’custodian’’

- √ Granted preference to Indian family environments in adoptive or foster care placement
- √ Provided funds to Tribes or nonprofit off-reservation Indian organizations or multiservice centers for purpose of improving child welfare services to Indian children and families
- √ Required State and Federal courts to give full faith and credit to Tribal court decrees
- √ Set standard of proof for terminating Indian parents' parental rights that required the proof to be beyond a reasonable doubt

Adoption Assistance and Child Welfare Act of 1980

P.L. 96-272
Enacted June 17, 1980
Purpose: To establish a program of adoption assistance, strengthen the program of foster care assistance for needy and dependent children, and improve the child welfare, social services, and aid to families with dependent children programs. This act amended titles IV-B and XX of the Social Security Act.

Major Provisions of the Act

- √ Required States to make adoption assistance payments, which take into account the circumstances of the adopting parents and the child, to parents who adopt a child who is AFDC-eligible and is a child with special needs
- √ Defined a child with special needs as a child who:
    - Cannot be returned to the parent's home
    - Has a special condition such that the child cannot be placed without providing assistance
    - Has not been able to be placed without assistance
- √ Required, as a condition of receiving Federal foster care matching funds, that States make ''reasonable efforts'' to prevent removal of the child from the home and return those who have been removed as soon as possible
- √ Required participating States to establish reunification and preventive programs for all in foster care
- √ Required the State to place a child in the least restrictive setting and, if the child will benefit, one that is close to the parent's home
- √ Required the court or agency to review the status of a child in any nonpermanent setting every 6 months to determine what is in the best interest of the child, with most emphasis placed on returning the child home as soon as possible
- √ Required the court or administrative body to determine the child's future status, whether it is a return to parents, adoption, or continued foster care, within 18 months after initial placement into foster care

Multiethnic Placement Act of 1994

P.L. 103-382
Enacted October 20, 1994

Major Provisions of the Act:

- √ Prohibited State agencies and other entities that receive Federal funding and were involved in foster care or adoption placements from delaying, denying, or otherwise discriminating when making a foster care or adoption placement decision on the basis of the parent or child's race, color, or national origin
- √ Prohibited State agencies and other entities that received Federal funds and were involved in foster care or adoption placements from categorically denying any person the opportunity to become a foster or adoptive parent solely on the basis of race, color, or national origin of the parent or the child
- √ Required States to develop plans for the recruitment of foster and adoptive families that reflect the ethnic and racial diversity of children in the State for whom families are needed
- √ Allowed an agency or entity to consider the cultural, ethnic, or racial background of a child and the capacity of an adoptive or foster parent to meet the needs of a child with that background when making a placement
- √ Had no effect on the provisions of the Indian Child Welfare Act of 1978
- √ Made failure to comply with MEPA a violation of title VI of the Civil Rights Act

The Interethnic Provisions of 1996

P.L. 104-188
Enacted August 20, 1996

Major Provisions of the Act:

- √ Established the title IV-E State Plan requirement that States and other entities that receive funds from the Federal Government and are involved in foster care or adoption placements may not deny any individual the opportunity to become a foster or adoptive parent based upon the race, color, or national origin of the parent or the child
- √ Established the title IV-E State Plan requirement that States and other entities that receive funds from the Federal Government and involved in foster care or adoption placements may not delay or deny a child's foster care or adoptive placement based upon the race, color, or national origin of the parent or the child
- √ Strengthened MEPA's diligent recruitment requirement by making it a title IV-B State Plan requirement
- √ Established a system of graduated financial penalties for States that do not comply with the title IV-E State Plan requirement established under this law

√ Repealed language in MEPA that allowed States and other entities to consider the cultural, ethnic, or racial background of a child, as well as the capacity of the prospective parent to meet the needs of such a child

Adoption and Safe Families Act of 1997

P.L. 105-89
Enacted November 19, 1997
Purpose: To promote the adoption of children in foster care
Major Provisions of the Act:

√ Reauthorized the Family Preservation and Support Services Program:
- Renamed it the Safe and Stable Families Program
- Extended categories of services to include time-limited reunification services and adoption promotion and support services

√ Ensured safety for abused and neglected children:
- Ensured health and safety concerns are addressed when a State determines placement for abused and neglected children
- Required HHS to report on the scope of substance abuse in the child welfare population, and the outcomes of services provided to that population
- Added ''safety of the child'' to every step of the case plan and review process
- Required criminal records checks for foster/adoptive parents who receive Federal funds on behalf of a child, unless a State opted out of this requirement

√ Accelerated permanent placement:
- Required States to initiate court proceedings to free a child for adoption once that child had been waiting in foster care for at least 15 of the most recent 22 months, unless there was an exception
- Allowed children to be freed for adoption more quickly in extreme cases

√ Promoted adoptions:
- Rewarded States that increased adoptions with incentive funds
- Required States to use reasonable efforts to move eligible foster care children towards permanent placements
- Promoted adoptions of all special needs children and ensured health coverage for adopted special needs children
- Prohibited States from delaying/denying placements of children based on the geographic location of the prospective adoptive families
- Required States to document and report child-specific adoption efforts

√ Increased accountability:
- Required HHS to establish new outcome measures to monitor and improve State performance

- Required States to document child-specific efforts to move children into adoptive homes

√ Clarified ‘’reasonable efforts’’:

- Emphasized children’s health and safety
- Required States to specify situations when services to prevent foster placement and reunification of families are not required

√ • Required shorter time limits for making decisions about permanent placements:

- Required permanency hearings to be held no later than 12 months after entering foster care
- Required States to initiate termination of parental rights proceedings after the child has been in foster care 15 of the previous 22 months, except if not in the best interest of the child, or if the child is in the care of a relative

Fostering Connections to Success and Increasing Adoptions Act of 2008

P.L. 110-351
Enacted October 7, 2008

Purpose: To amend parts B and E of title IV of the Social Security Act to connect and support relative caregivers, improve outcomes for children in foster care, provide for tribal foster care and adoption access, improve incentives for adoptions, and for other purposes.

Major Provisions of the Act:

√ Created a new plan option for States and Tribes to provide kinship guardianship assistance payments under title IV-E on behalf of children who have been in foster care of whom a relative is taking legal guardianship

√ Extended eligibility for Medicaid to children receiving kinship guardianship assistance payments

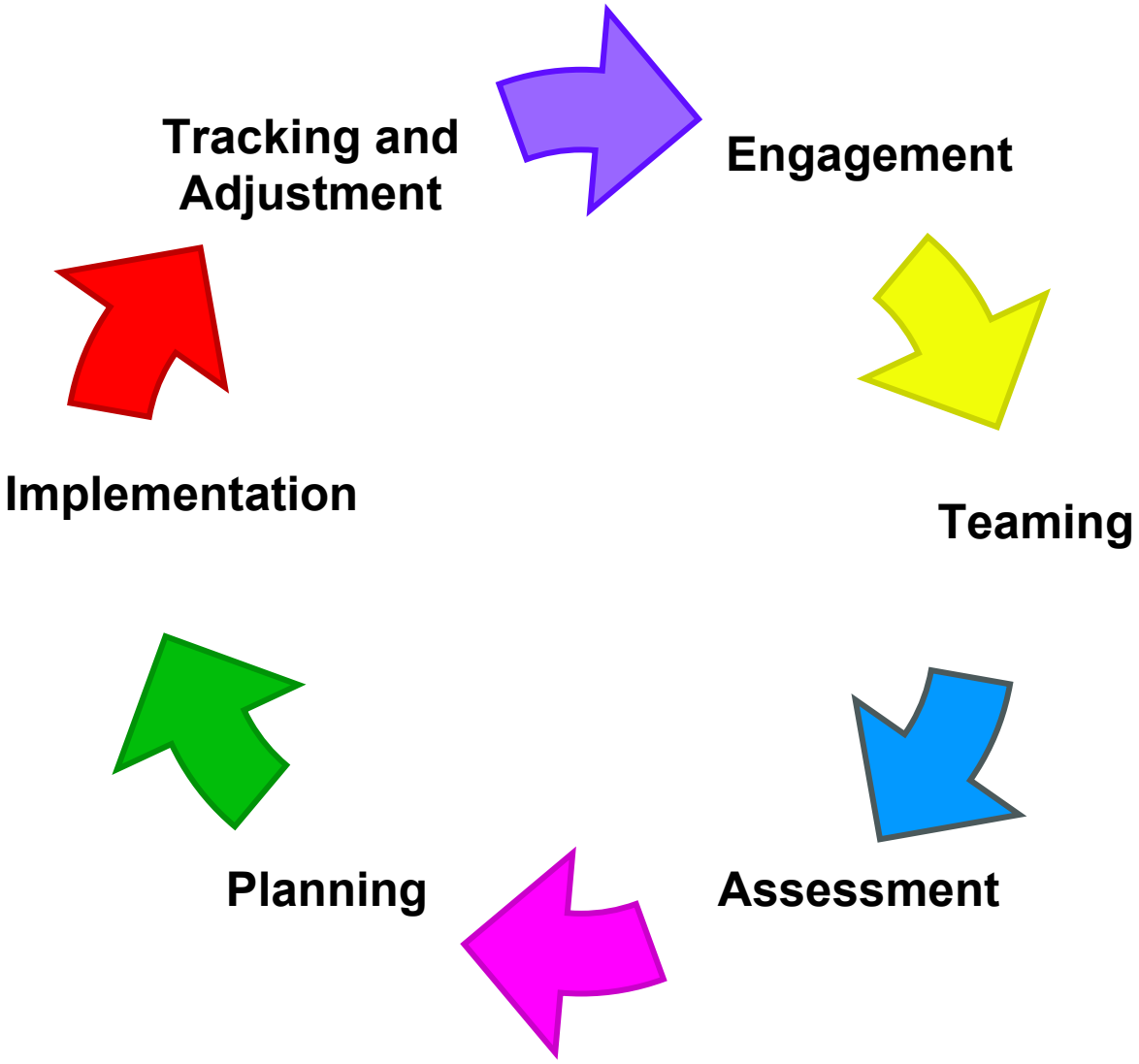
√ Required fingerprint-based criminal records checks of relative guardians, and child abuse and neglect registry checks of relative guardians and adults living in the guardian’s home, before a relative guardian may receive title IV-E kinship guardianship assistance payments on behalf of a child

√ Amended the Chafee Foster Care Independence Program to allow services to youth who leave foster care for kinship guardianship or adoption after age 16

- √ Authorized grants to State, local, or Tribal child welfare agencies and private nonprofit organizations for the purpose of helping children who are in or at-risk of foster care reconnect with family members through:
    - Kinship navigator programs
    - Efforts to find biological family and reestablish relationships
    - Family group decision-making meetings
    - Residential family treatment programs
- √ Required title IV-E agencies to identify and notify all adult relatives of a child, within 30 days of the child's removal, of the relatives' options to become a placement resource for the child
- √ Required each child receiving a title IV-E foster care, adoption, or guardianship payment to be a full-time student unless he or she is incapable of attending school due to a documented medical condition
- √ Required title IV-E agencies to make reasonable efforts to place siblings removed from their home in the same foster care, adoption, or guardianship placement
- √ Required States to ensure coordination of health care services, including mental health and dental services, for children in foster care
- √ Required that, 90 days prior to a youth's emancipation, the caseworker develop a personalized transition plan as directed by the youth
- √ Required that a case plan include a plan for ensuring the educational stability of the child in foster care

Adapted from: Major Federal Legislation Concerned with Child Protection, Child Welfare and Adoption. Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/otherpubs/majorfedlegis.cfm

DCS Practice Wheel



THE FUNCTIONAL PRACTICE WHEEL

Philosophical Tenets of Child Welfare

- Prevention programs are necessary to strengthen families and reduce the likelihood of child abuse and neglect.
- The responsibility for addressing child maltreatment is shared among community professionals and citizens.
- A safe and permanent home is the best place for a child to grow up.
- When parents (or caregivers) are unable or unwilling to fulfill their responsibilities to provide adequate care and to keep their children safe, child welfare has the mandate to intervene.
- Most parents want to be good parents and have the strength and capacity, when adequately supported, to care for their children and keep them safe.
- To help families protect their children and meet their basic needs, the community's response must demonstrate respect for every person involved.
- Services must be individualized and tailored.
- Child protection and service delivery approaches should be family centered.
- Interventions need to be sensitive to the cultures, belief, and customs of all families.
- To best protect a child's overall well-being, agencies must assure that children move to permanency as quickly as possible.

(From: Goldman, J., Salus, M.K., Wolcott, D. & Kennedy, K.Y. (2003) *A Coordinated Response to Child Abuse and Neglect: Foundation for Practice.* U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (Washington, DC: U.S. Government Printing Office).

DCS Guiding Principles for Professional Practice

Guiding Principle 1: Unified Purpose

DCS' primary responsibilities are to prevent child maltreatment, promote child and family well-being, and aid and prepare youthful offenders in becoming constructive members of their communities.

Guiding Principle 2: Urgency of Child's Needs

DCS practice will be driven by a sense of urgency related to each child's unique needs for safety, permanence, stability and well-being.

Guiding Principle 3: Individualized Planning for Permanency

DCS will provide flexible, intensive and individualized services to children and families in order to preserve, reunify or create families.

Guiding Principle 4: Family-Centered Casework and Case Planning

DCS will utilize a family-centered case planning model that encourages, respects and incorporates input from the children and families it serves.

Guiding Principle 5: Systemic Continuity of Care

DCS will work with communities, organizations, and institutions to build and maintain a seamless and effective system of service delivery that produces measurable, positive outcomes for children and families.

Guiding Principle 6: Constructive Organizational Culture

DCS will model a constructive organizational culture that is culturally competent and will attract and sustain qualified, trained and competent staff.

Guiding Principle 7: Equal Access to Services

DCS will provide the best available and appropriate services to all children in care, without regard to age, race, religion, gender, disability, sexual orientation or legal classification.

Guiding Principle 8: Reduction of Trauma to Child

DCS will strive to recognize and minimize the trauma children experience while in Departmental care.

Guiding Principle 9: Best Interests of Child as Paramount

DCS will consider the totality of circumstances to make decisions that are in the best interests of each child and will not apply any single principle or standard of practice if in so doing a negative outcome for the child would result.

Principles of the Brian A. Settlement Agreement

1. All children should have the best possible opportunity to grow up within a safe, nurturing family, either their biological family or, if that is not possible, within an adoptive family.

2. The state should make reasonable efforts to avoid foster care placement by providing services to preserve the biological family whenever that is reasonably possible. However, child welfare decision-makers must have the professional capacity to make determinations as to when making efforts to preserve the biological family, or leaving the child with that family, is neither safe for the child nor likely to lead to an appropriate result for the child.

3. After children enter placement, all non-destructive family ties should be maintained and nurtured. Children should be placed with relatives who are able to provide a safe, nurturing home for them, and should be placed with siblings, and relationships with relatives and siblings should be facilitated and maintained by the child welfare agency.

4. Foster care should be as temporary an arrangement as possible, with its goal being to provide a permanent home for the child as quickly as possible. In making the determination about what plans and services will best meet this goal, the child's interests must be paramount.

5. The state has primary responsibility for the care and protection of children who enter the foster care system. Insofar as it relies on private contractors to assist in meeting this responsibility, it should only do so according to standards set by and rigorously monitored by the state.

6. All children in need of child welfare services should receive full and equal access to the best available services, regardless of race, religion, ethnicity, or disabilities.

7. Children in foster care placement should be in the least restrictive, most family-like setting possible, and the state should make all efforts to avoid the use of non-family settings for children, particularly young children.

8. Children in foster care placement should have stable placements that meet their needs and the services necessary to address both the trauma of foster care placement and the problems surrounding their removal from their family.

9. Children in out-of-home placement must have timely decision-making about where and with whom they will spend their childhood, and timely implementation of whatever decisions have been made.

10. Families of children in foster care should be significant participants in the planning and decision-making concerning their children.

11. The state should achieve these goals in a family environment whenever possible, separating the child from the child's parents only when necessary for the child's welfare or in the interest of the child's safety, keeping a child as close to home as possible.

12. All parties in judicial proceedings involving neglect, abuse, unruly and delinquency should be provided a fair hearing and their constitutional and other legal rights should be enforced and recognized.

13. Except where a particular provision of this Settlement Agreement establishes a specific limit on the resources required to be allocated, defendants shall commit all necessary resources (administrative, personnel, financial and otherwise) to implement all provisions of the Settlement Agreement.

14. All actions required for plaintiff class members under the Settlement Agreement shall be documented within the individual case file of each member of the plaintiff class. DCS shall have the ability to produce aggregate data requested by the Monitor concerning compliance with the provisions of this Settlement Agreement.

Values Inherent in the Practice Model

- Human beings have inherent dignity and worth.
- Everyone deserves to be treated with respect.
- Each person is unique.
- People have the right to make choices.
- People can change.
- Family plays an essential role in child development.
- A family's culture influences how its members behave.
- The family is part of a system.
- Family members are colleagues, not "clients."
- Every family has strengths and resiliencies.
- Relationships are important vehicles for change.
- The family's needs determine services.
- Families have the knowledge, expertise and abilities to be responsible for the safety, well being and permanence of their children.

Family Centered Practice

- Seeing the family team as a *system*
- Viewing the situation from the family team's *perspective*
- Respecting the unique *culture* of a family team
- Treating family team members with *respect and genuineness*
- Considering services as *family supportive and family strengthening* rather than "child-saving"
- Viewing the family in the context of its environment
- *Involving* the family team in assessment and planning
- Identifying and accessing the family team's *strengths*

Family-Systems Concepts

Interactions
Family members interact with one another. As family members interact over time, they learn more about how other family members will react to what they say or do and adjust their behavior accordingly.

Interdependence
Each family member's behavior affects the behavior of every other family member. Interdependence refers to the repeated patterns of interactions that develop within a family. As the various parts of a family system interact with one another, the family members resemble dancers who cooperate in dancing a familiar dance. One family member could not perform the "dance" without the other family members. They are dependent on one another.

Balance
All families develop a kind of balance. Whether this balance is healthy or unhealthy, it is what the family becomes used to. By finding a balance, families attempt to maintain their family system in a stable and predictable way, to keep things the same. Even if the family's balance is based on hurtful patterns, this balance becomes for them the consistent norm around which they build their lives. For example, a single mother of two children ages 6 years and 12 months is isolated from other family members and has minimal contact with friends. This mother has little to no energy to take care of the house or to provide much supervision for the children. The mother spends most of her time in bed with the shades drawn and sleeping. Both children have come to expect that their mom is sleeping or too tired to do anything. In response to the mother, the six-year-old has become a "little mom" to her baby sister. The baby has learned to turn to her sister when she is hungry or unhappy. This pattern happens over and over again. Even though this pattern is unhealthy, the family balances their lives around it. It may be impossible for the family to find a better balance or lifestyle without seeking outside help.

The family system has five major characteristics:

1. Boundaries
2. Rules
3. Roles
4. Decision-making and power distribution
5. Communication styles

Strengths-Based Approach to Practice

- People, regardless of difficulties, can change and grow.
- Healing occurs when a family's strengths, not its weaknesses, are engaged.
- It is just as important to identify family strengths as it is to identify weaknesses or problems.
- Communities and support systems are potential resources.
- The family is the agent of its own change.

Solution Focused vs. Traditional Approach

Strength-Based, Solution-Focused Approach	**Traditional Approach**
Identify what the client wants	Diagnose the problem
Let the client tell you who he or she is	Gather all available information in order to classify the client
The client is the "expert" about his or her life.	The professional is the expert
Identify client strengths that can be used to promote client goals	Identify the web of causality that is supporting the client problem.
The professional collaborates with the client to help the client identify ways to accomplish goals.	The professional develops a service plan that the client is expected to follow in order to achieve the case goals.
The unfolding of the plan may not be step-by-step, but may emerge in ways best suited to client needs and style.	The plan is expected to be implemented in a logical, step-by-step way.

(From: Pennsylvania Child Welfare Training Program (2007). Module Two: Introduction to Pennsylvania's Child Welfare Practice. University of Pittsburg, School of Social Work. Available at: http://www.pacwcbt.pitt.edu/Curriculum/CTC.html)

WHAT ARE STRENGTHS?

Saleeby defines strengths in six categories:

- What people have learned about themselves, others, and the world.
- Personal qualities, traits, and virtues that people possess.
- What people know about the world around them.
- The talents that people have.
- Cultural and personal stories and lore from their cultural orientation.
- The resources of the community in which they live.

CHAPTER 2
What Are the Philosophical Tenets of Child Protection?

The importance of the family in U.S. society is central to the Nation's history and tradition. Parents have a fundamental right to raise their children as they see fit, and society presumes that parents will act in their children's best interest. When parents do not protect their children from harm and meet their basic needs—as with cases of child abuse and neglect—society has a responsibility to intervene to protect the health and welfare of these children. Any intervention into family life on behalf of children must be guided by State and Federal laws, sound professional standards for practice, and strong philosophical underpinnings. This chapter presents key principles underscored in Federal legislation and the philosophical tenets on which the community's responsibility for child protection is based.

Key Principles of Child Protection

The key principles guiding child protection are largely based on Federal statutes, primarily delineated in the Child Abuse Prevention and Treatment Act (CAPTA) and the Adoption and Safe Families Act (ASFA). CAPTA, in its original inception, was signed into law in 1974 (P.L. 93-247) and is reauthorized by Congress every 5 years. As of the publication of this manual, CAPTA is in the process of its latest reauthorization. ASFA was signed into law in 1997 (P.L. 105-89) and built upon earlier laws and reforms to promote the safety and well-being of maltreated children. These laws and other guiding legislation are referenced throughout this publication and are specifically discussed in "Federal Legislation and Programs" in Chapter 8. ASFA promotes three national goals for child protection:

- **Safety.** All children have the right to live in an environment free from abuse and neglect. The safety of children is the paramount concern that must guide child protection efforts.
- **Permanency.** Children need a family and a permanent place to call home. A sense of continuity and connectedness is central to a child's healthy development.
- **Child and family well-being.** Children deserve nurturing environments in which their physical, emotional, educational, and social needs are met. Child protection practices must take into account each child's needs and should promote healthy development.

In addition, ASFA underscored the importance of accountability of service delivery systems in achieving positive outcomes for children related to each of these goals.

Philosophical Tenets

The following philosophical tenets expand upon the principles set forth in ASFA and the values that underlie sound practices in community responses to child abuse and neglect:

- **Prevention programs are necessary to strengthen families and reduce the likelihood of child abuse and neglect.** Child maltreatment results from a combination of factors: psychological, social, situational, and societal. Factors that may contribute to an increased risk for child abuse and neglect include, for example, family structure, poverty, substance abuse, poor housing conditions, teenage pregnancy, domestic and community violence, mental illness, and lack of support from extended families and community members. To reduce the occurrence of maltreatment, communities should develop and implement prevention programs that support children and families.

- **The responsibility for addressing child maltreatment is shared among community professionals and citizens.** No single agency, individual, or discipline has all the necessary knowledge, skills, or resources to provide the assistance needed by abused and neglected children and their families. While public child protective services (CPS) agencies, law enforcement, and courts have legal mandates and primary responsibility for responding to child maltreatment, other service providers working with children and families—along with community members—play important roles in supporting families and protecting children. To be effective in addressing this complex problem, the combined expertise and resources of interdisciplinary agencies and professionals are needed.

- **A safe and permanent home is the best place for a child to grow up.** Most children are best cared for in their own families. Children naturally develop a strong attachment to their families and when removed from them, they typically experience loss, confusion, and other negative emotions. Maintaining the family as a unit preserves important relationships with parents, siblings, and extended family members and allows children to grow and develop within their own culture and environment.

- **When parents (or caregivers) are unable or unwilling to fulfill their responsibilities to provide adequate care and to keep their children safe, CPS has the mandate to intervene.** Both laws and good practice maintain that interventions should be designed to help parents protect their children in the least intrusive manner possible. Interventions should build on the family's strengths and address the factors that contribute to the risk of maltreatment. Reasonable efforts must be made to maintain child safety and keep the children with their families except when there is significant risk to child safety. Referral to court and removal of children from their families should only be done when it is determined that children cannot be kept safely in their own homes.

- **Most parents want to be good parents and have the strength and capacity, when adequately supported, to care for their children and keep them safe.** Underlying CPS intervention is the belief that people have the strength and potential to change their lives. Professionals must search for and identify the strengths and the inner resiliencies in families that provide the foundation for change.

- **To help families protect their children and meet their basic needs, the community's response must demonstrate respect for every person involved.** All people deserve to be treated with respect and dignity. This means showing respect for a person, while not necessarily approving or condoning his or her

actions. In addition to caregivers and children, service providers should demonstrate respect for mothers, fathers, grandparents, other family members, and the family's support network.

- **Services must be individualized and tailored.** While people may have similar problems, there are elements that will vary from family to family. In addition, each family's strengths and resources are different. The community's response, therefore, must be customized to reflect the particular circumstances, strengths, and needs of each family.

- **Child protection and service delivery approaches should be family centered.** Parents, children, their extended families, and support networks (e.g., the faith community, teachers, health care providers, substitute caregivers) should be actively involved as partners in developing and implementing appropriate plans and services to reduce or eliminate the risk of maltreatment. Tapping into the strengths and resources of a family's natural support network is fundamental to enhancing family functioning.

- **Interventions need to be sensitive to the cultures, beliefs, and customs of all families.** Professionals must acknowledge and show respect for the values and traditions of families from diverse cultural, ethnic, and religious backgrounds. To become culturally competent, professionals must first understand themselves and the effects of their own background on their values, behaviors, and judgments about others.[1] In working with children and families different from themselves, professionals need to be aware of the context of the family's culture and background in order to help provide access to culturally relevant services and solutions.

- **To best protect a child's overall well-being, agencies must assure that children move to permanency as quickly as possible.** Along with developing plans to facilitate reunification of children, agencies must develop alternative plans for permanence from the time the child enters care. For those children who cannot be safely reunified with their families, timely efforts must be made to ensure a stable, secure, and permanent home for the child through adoption or other permanent living arrangements.

Department of Children's Services

Vision

Leading the way for safety and permanency in the lives of children and families by championing excellence in service.

Mission

Our mission is to empower families and support community safety and partnerships to help ensure safety, permanency and well-being for children.

Values

Integrity - *The Department values honor, respect, trustworthiness and principled action.*

Commitment to Excellence - *The Department expects peak performance from all levels of staff, every day, in every degree.*

Diversity - *The Department respects, celebrates and seeks to maintain the integrity of all cultures.*

People - *The Department values all people, promoting partnerships between staff, families and community partners in order to create a comprehensive network of services.*

Family-Focused - *The Department takes a strengths-based service approach, coordinating with family members as well as professionals and others to form an all-inclusive team promoting stability and permanence for children.*

Community Partnerships - *The Department actively engages community stakeholders.*

Safety - *The Department makes every effort to ensure the safety of children, families, staff and the community.*

Employees - *The Department strives to create a work environment that allows for personal and professional growth, affording each employee a high quality of life. The Department will also respect and promote each staff member's personal family interests recognizing that we must have the opportunity for safety and stability in our own lives before we can adequately and appropriately serve others.*

Tennessee Department of Children's Services Guiding Principles for Professional Practice *

Guiding Principle 1: Unified Purpose

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Guiding Principle 2: Urgency of Child's Needs

DCS practice will be driven by a sense of urgency related to each child's unique needs for safety, permanence, stability and well-being.

Guiding Principle 3: Individualized Planning for Permanency

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Guiding Principle 4: Family-Centered Casework and Case Planning

DCS will utilize a family-centered case planning model that encourages, respects and incorporates input from the children and families it serves.

Guiding Principle 5: Systemic Continuity of Care

DCS will work with communities, organizations, and institutions to build and maintain a seamless and effective system of service delivery that produces measurable, positive outcomes for children and families.

Guiding Principle 6: Constructive Organizational Culture

DCS will model a constructive organizational culture that is culturally competent and will attract and sustain qualified, trained and competent staff.

Guiding Principle 7: Equal Access to Services

DCS will provide the best available and appropriate services to all children in care, without regard to age, race, religion, gender, disability, sexual orientation or legal classification.

* Developed by M & B Consulting.

Guiding Principle 8: Reduction of Trauma to Child

DCS will strive to recognize and minimize the trauma children experience while in Departmental care.

Guiding Principle 9: Best Interests of Child as Paramount

DCS will consider the totality of circumstances to make decisions that are in the best interests of each child and will not apply any single principle or standard of practice if in so doing a negative outcome for the child would result.

Tennessee Department of Children's Services (TDCS) Standards of Professional Practice for Serving Children and Families (Practice Model) encapsulates the Department's ambitions for best practices in serving children and families in Tennessee. These ambitions are based on the fundamental beliefs that all children served by DCS deserve to be safe from harm, nurtured by life-long families and provided with the same protections and supports that any loving parents would expect for their children. The Practice Model provides *guiding principles* and *standards of professional practice* for how DCS will work in partnership with children and families, service providers, State departments, and all other community stakeholders to achieve the *desired outcomes* of *child safety, permanency* and *well being*.

Child Safety

DCS becomes involved in the lives of children and their families when there are child safety concerns and/or child actions that result in serious violations of the law. Achieving the *desired outcome* of *child safety* means that the child is safe from abuse or neglect and/or the community is safe from delinquent transgressions.

Child Permanency

It is not enough for the Department to address safety issues for children who experience maltreatment or who have committed delinquent acts. In order to thrive, all children need families committed to permanent relationships and stable home environments. From the first contact with a child and family in crisis, the Department begins the process of identifying the child and family's strengths, risks, needs, and wants related to child permanence. *Child permanency* is successfully achieved when the Department expediously facilitates the preservation, reunification or creation of lifelong, healthy families that provide safe, nurturing and stable relationships and home environments for the child.

Child Well Being

The Department, while maintaining a primary commitment to safety and permanency, has a broader commitment to the well being of children in its care. *Child well-being* is successfully achieved when a child's current and future physical, emotional, intellectual,

and developmental needs are being met within a familial environment providing consistent nurture, support and stimulation.

The *standards of professional practice* in the Practice Model are grounded in the vision contained in the *guiding principles*. This vision seeks to achieve *child safety*, *permanency* and *well being* by utilizing a holistic approach to Departmental reform. This approach requires:

Employing Family-Centered Practices

Family-centered practices are those that encourage and support children and their families in actively participating in the casework process. These practices are founded on the belief that the best way to aid and protect children over time is to strengthen and support families in understanding and carrying out their responsibilities. The intent of family-centered casework and case planning is to ensure the long-term well-being of children through the provision of resources and supports that complement the family unit's unique strengths, needs, and goals. A strengths-based approach requires the artful uncovering and effective leveraging of resiliencies and resources. This intentional search for and conscious use of strengths is based on the assumption that, in the end, strengths are the primary tools that individuals possess to create real change. Deficits may provide information necessary to diagnose problems, but it is through building upon and helping children and families transfer strengths that challenges are surmounted. The belief in possibility increases both family and case manager engagement in the process and provides fuel through hope. Effective family-centered practice requires genuine engagement and relationship building with children and families. In order to build trusting relationships with families, casework practitioners must have a working knowledge of and sensitivity to the dynamics of ethnic and cultural differences and similarities. Culturally competent practice acknowledges that an individual's culture is an integral part of overall development and selfhood and strives to use concepts of culture in a manner that enhances individual and family functioning. Casework practitioners must be keenly aware of how their personal values, behaviors, and attitudes may affect serving children and families who have different cultural orientations. Given the increasingly diverse service population in Tennessee, developing cultural competency and understanding the cultural norms are casework necessities to authentic engagement with children and families. The family-centered approach to practice is reflected in *guiding principles* 2, 4, and 9 of the Practice Model.

Related Guiding Principles

#2: DCS practice will be driven by a sense of urgency related to each child's unique needs for safety, permanence, stability and well being.

#4: DCS will utilize a family-centered case planning model that encourages, respects, and incorporates input from the children and families it serves.

Providing Service Delivery within a Seamless System of Care

Delivering services and supports to children and families within a seamless system of care minimizes the experienced trauma and disruption by providing comprehensive, accessible, timely, and sequentially appropriate services and supports. A seamless system of care promotes child safety, permanency and well being while engaging individuals, community organizations and governmental institutions in developing and maintaining a range of flexible and effective services. Focused collaboration both on individual cases and on systemic issues and barriers will ensure a responsive and cohesive system that meets the unique needs demonstrated by children and families. Maintaining one case manager throughout the life of a case is the key to achieving the goals of seamless service delivery - expediting permanency, reducing transitions and trauma, building effective relationships, and maintaining continuity. The case manager is the fulcrum for case activity, ensuring that children and families are connected to appropriate services, that the Child and Family Team is functioning effectively, that the supervisor is aware of significant case events, and that safety, permanency and well-being are core priorities. The One Worker/One Child model provides necessary continuity and forward movement that keeps pace with the evolution of children and families as they learn, heal, and change. To successfully achieve permanency and healing, children and families must be invested in resolving their underlying issues and building upon their strengths and resources. Meaningful and stable connections encourage children and families to openly participate in and own their assessment processes, development and alteration of their permanency plans, and the ongoing evolution of their cases. Along with the One Worker/One Child model, a seamless system of care requires the ability to provide timely and individualized services. This requires flexible funding pools and access mechanisms. It also requires careful analysis of local needs and available services in order to recognize patterns of and build capacity for needed services. This seamless approach to service delivery flows from *guiding principles* 3, 5, 7 and 8 of the Practice Model.

Related Guiding Principles

#3: DCS will provide flexible, intensive and individualized services to children and families in order to preserve, reunify or create families.

#5: DCS will work with communities, organizations, and institutions to build and maintain a seamless and effective system of service delivery that produces measurable, positive outcomes for children and families.

Embracing and Modeling a Constructive Organizational Culture

A constructive organizational culture supports a system of care that encourages self-expression, innovation, open dialogue, genuine decision-making, shared leadership, and personal and collaborative responsibility and accountability at all levels. A constructive organization promotes positive functioning in its staff, administration, children and families, and community partners. Like a healthy organism, it actively recognizes and fights dis-ease and dysfunction, recognizing them as potential enemies to wellness and hardiness. A constructive organization – which allows for diversity, promotes cultural competence, supports effective collaboration, seeks community partnership, and values children, their families and organizational staff – actively works to attain and maintain strong functioning as a cornerstone of success. The purpose of building a constructive organizational culture is to ensure that organizational functioning furthers, rather than acts as a barrier to, achieving desired outcomes with children and families and recruiting and retaining qualified staff. The Practice Model envisions a constructive organizational culture as one of the core components involved in assuring that the necessary tools, supports and environment exist to prevent child maltreatment, promote family well-being, and aid and prepare youthful offenders in becoming constructive members of the community. This vision is most clearly defined in *guiding principles* 1 and 6 of the Practice Model.

Related Guiding Principles

#1: DCS's primary responsibilities are to prevent child maltreatment, promote child and family well-being, and aid and prepare youthful offenders in becoming constructive members of their communities.

#6: DCS will model a constructive organizational culture that is culturally competent and will attract and sustain qualified, trained and competent staff.

The *guiding principles* and the *standards of professional practice* direct the selection of the *key indicators* used to measure progress in achieving the *desired outcomes* of *child safety*, *permanency* and *well-being*. The Practice Model requires that Departmental progress is measured, in large part, by the outcomes experienced by children and families. Currently, the initial *key indicators* that measure progress in achieving the *desired outcomes* are:

- Reduction in the number of children in placement
- Reduction in the number of children in institutional care
- Increase in the number of children placed in their home counties
- Increase in the number of children experiencing placement stability
- Increase in the number of children who are reunified with their families
- Reduction in the time to permanency for children with permanency goals of reunification

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April 2008

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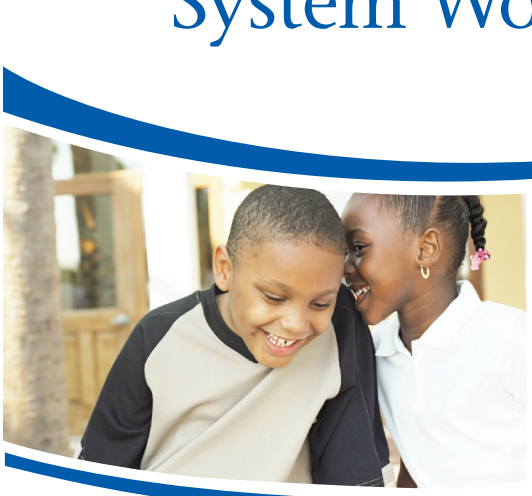
How the Child Welfare System Works



The child welfare system is a group of services designed to promote the well-being of children by ensuring safety, achieving permanency, and strengthening families to successfully care for their children. While the primary responsibility for child welfare services rests with the States, the Federal Government plays a major role in supporting States in the delivery of services through funding of programs and legislative initiatives.

What's Inside:

- What happens when possible abuse or neglect is reported?
- What happens after a report is "screened in"?
- What happens in substantiated (founded) cases?
- What happens to people who abuse children?
- What happens to children who enter foster care?
- Resources

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

Child Welfare Information Gateway
Children's Bureau/ACYF
1250 Maryland Avenue, SW
Eighth Floor
Washington, DC 20024
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www.childwelfare.gov

The primary responsibility for implementing Federal child and family legislative mandates rests with the Children's Bureau within the Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. The Children's Bureau works with State and local agencies to develop programs that focus on preventing the abuse of children in troubled families, protecting children from abuse, and finding permanent families for those who cannot safely return to their parents.

THE CHILD ABUSE PREVENTION AND TREATMENT ACT

The Child Abuse Prevention and Treatment Act (CAPTA), originally passed in 1974, brought national attention to the need to protect vulnerable children in the United States. CAPTA provides Federal funding to States in support of prevention, assessment, investigation, prosecution, and treatment activities as well as grants to public agencies and nonprofit organizations for demonstration programs and projects. Additionally, CAPTA identifies the Federal role in supporting research, evaluation, technical assistance, and data collection activities. CAPTA also sets forth a minimum definition of child abuse and neglect. Since it was signed into law, CAPTA has been amended several times. It was most recently amended and reauthorized on June 25, 2003, by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36). To see the 2003 amendment to CAPTA, visit: www.acf.hhs.gov/programs/cb/laws_policies/cblaws/capta03/index.htm

Most families first become involved with their local child welfare system due to a report of suspected child abuse or neglect (sometimes called "child maltreatment"). Child maltreatment is defined by CAPTA as serious harm (neglect, physical abuse, sexual abuse, and emotional abuse or neglect) caused to children by parents or primary caregivers, such as extended family members or babysitters.[1] Child maltreatment also can include harm that a caregiver allows to happen or does not prevent from happening to a child. In general, child welfare agencies do not intervene in cases of harm to children caused by acquaintances or strangers. These cases are the responsibility of law enforcement.[2]

The child welfare system is not a single entity. Many organizations in each community work together to strengthen families and keep children safe. Public agencies, such as departments of social services or child and family services, often contract and collaborate with private child welfare agencies and community-based organizations to provide services to families, such as in-home family preservation services, foster care, residential treatment, mental health care, substance abuse treatment, parenting skills classes, employment assistance, and financial or housing assistance.

[1] Each State has its own laws that define child abuse and neglect for purposes of stating the reporting obligations of individuals and describing required State/local child protective services agency interventions. For State-by-State information about civil laws related to child abuse and neglect, visit the Child Welfare Information Gateway website at www.childwelfare.gov/systemwide/laws_policies/state

[2] While some States authorize child protective services agencies to respond to all reports of alleged child maltreatment, other States authorize law enforcement to respond to certain types of maltreatment, such as sexual or physical abuse.

Child welfare systems are complex, and their specific procedures vary widely by State. The purpose of this factsheet is to give a brief overview of the purposes and functions of child welfare from a national perspective. Child welfare systems typically:

- Receive and investigate reports of possible child abuse and neglect
- Provide services to families who need assistance in the protection and care of their children
- Arrange for children to live with foster families when they are not safe at home
- Arrange for adoption or other permanent family connections for children leaving foster care

Appendix A provides a graphic overview of the process described in the following sections.

What happens when possible abuse or neglect is reported?

Any concerned person can report suspicions of child abuse or neglect. Most reports are made by people who are required by State law to report suspicions of child abuse and neglect—mandatory reporters.[3] As of January 2008, statutes in approximately 18 States and Puerto Rico require any person who suspects child abuse or neglect to report it.[4] Reports of possible child abuse and neglect are generally received by child protective services (CPS) workers and either "screened in" or "screened out." A report is screened in if there is sufficient information to suggest an investigation is warranted. A report may be screened out if there is not enough information on which to follow up or if the situation reported does not meet the State's legal definition of abuse or neglect.[5] In these instances, the worker may refer the person reporting the incident to other community services or law enforcement for additional help.

In 2006, an estimated total of 3.3 million referrals involving 6 million children were made to CPS agencies. Approximately 61.7 percent were screened in, and 38.3 percent were screened out (U.S. Department of Health and Human Services [HHS], 2008).

What happens after a report is "screened in"?

CPS workers, often called investigators, respond within a particular time period, which may be anywhere from a few hours to a few days, depending on the type of maltreatment alleged, the potential severity of the situation, and requirements

[3] See *Mandatory Reporters of Child Abuse and Neglect* (www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm) and Making and Screening Reports of Child Abuse and Neglect (www.childwelfare.gov/systemwide/laws_policies/statutes/repproc.cfm), available from Child Welfare Information Gateway.

[4] The word *approximately* is used to stress the fact that States frequently amend their laws.

[5] See *Definitions of Child Abuse and Neglect* (www.childwelfare.gov/systemwide/laws_policies/statutes/define.cfm), available from Child Welfare Information Gateway.

under State law. They may speak with the parents and other people in contact with the child, such as doctors, teachers, or childcare providers. They also may speak with the child, alone or in the presence of caregivers, depending on the child's age and level of risk. Children who are believed to be in immediate danger may be moved to a shelter, foster care placement, or a relative's home during the investigation and while court proceedings are pending. An investigator's primary purpose is to determine if the child is safe, if abuse or neglect has occurred, and if there is a risk of it occurring again.

Some jurisdictions now employ an alternative response system. In these jurisdictions, when risk to the children involved is considered to be low, the CPS caseworker may focus on assessing family strengths, resources, and difficulties and identifying supports and services needed, rather than on gathering evidence to confirm the occurrence of abuse or neglect.

At the end of an investigation, CPS workers typically make one of two findings—"unsubstantiated" ("unfounded") or "substantiated" ("founded"). These terms vary from State to State. Typically, a finding of "unsubstantiated" means there is insufficient evidence for the worker to conclude that a child was abused or neglected, or what happened does not meet the legal definition of child abuse or neglect. A finding of "substantiated" typically means an incident of child abuse or neglect, as defined by State law, is believed to have occurred. Some States have additional categories, such as "unable to determine," that suggest there was not enough evidence to either confirm or refute that abuse or neglect occurred.

The agency will initiate a court action if it determines that the authority of the juvenile court (through a child protection or dependency proceeding) is necessary to keep the child safe. To protect the child, the court can issue temporary orders placing the child in shelter care during the investigation, ordering services, or ordering certain individuals to have no contact with the child. At an adjudicatory hearing, the court hears evidence and decides whether maltreatment occurred and whether the child should be under the continuing jurisdiction of the court. The court then enters a disposition, either at that hearing or at a separate hearing, which may result in the court ordering a parent to comply with services necessary to ameliorate the abuse or neglect. Orders can also contain provisions regarding visitation between the parent and the child, agency obligations to provide the parent with services, and services needed by the child.

In 2006, approximately 905,000 children were found to be victims of child abuse or neglect (HHS, 2008).

What happens in substantiated (founded) cases?

If a child has been abused or neglected, the course of action depends on State policy, the

severity of the maltreatment, an assessment of the child's immediate safety, the risk of continued or future maltreatment, the services available to address the family's needs, and whether the child was removed from the home and a court action to protect the child was initiated. The following general options are available:

- **No or low risk**—The family's case may be closed with no services if the maltreatment was a one-time incident, the child is considered to be safe, there is no or low risk of future incidents, and any services the family needs will not be provided through the child welfare agency but through other community-based resources and service systems.
- **Low to moderate risk**—Referrals may be made to community-based or voluntary in-home CPS services if the CPS worker believes the family would benefit from these services and the child's present and future safety would be enhanced. This may happen even when no abuse or neglect is found, if the family needs and is willing to participate in services.
- **Moderate to high risk**—The family may again be offered voluntary in-home CPS services to address safety concerns and help ameliorate the risks. If these are refused, the agency may seek intervention by the juvenile dependency court. Once there is a judicial determination that abuse or neglect occurred, juvenile dependency court may require the family to cooperate with in-home CPS services if it is believed that the child can remain safely at home while the family addresses the issues contributing to the risk of future maltreatment. If the child has been seriously harmed, is considered to be at high risk of serious harm, or the child's safety is threatened, the court may order the child's removal from the home or affirm the agency's prior removal of the child. The child may be placed with a relative or in foster care.

In 2006, an estimated 312,000 children were removed from their homes as a result of a child abuse investigation or assessment. Nearly two-thirds (63.6 percent) of the victims who were removed from their homes suffered from neglect; 8.6 percent from physical abuse; 3.2 percent from sexual abuse; and 16.8 percent from multiple types of maltreatment (HHS, 2008).

What happens to people who abuse children?

People who are found to have abused or neglected a child are generally offered support and treatment services or are required by a juvenile dependency court to participate in services that will help keep their children safe. In more severe cases or fatalities, police are called upon to investigate and may file charges in criminal court against the perpetrators of child maltreatment. In many States certain types of abuse, such as sexual abuse and serious physical abuse, are routinely referred to law enforcement.

Whether or not criminal charges are filed, the perpetrator's name may be placed on a State child maltreatment registry if abuse

or neglect is confirmed. A registry is a central database that collects information about maltreated children and individuals who are found to have abused or neglected those children.[6] These registries are usually confidential and used for internal child protective purposes only. However, they may be used in background checks for certain professions, such as those working with children, so children will be protected from contact with individuals who may mistreat them.

What happens to children who enter foster care?

Most children in foster care are placed with relatives or foster families, but some may be placed in group homes. While a child is in foster care, he or she attends school and should receive medical care and other services as needed. The child's family also receives services to support their efforts to reduce the risk of future maltreatment and to help them, in most cases, be reunited with their child. Parents may visit their children on a predetermined basis. Visits also are arranged between siblings, if they cannot be placed together.

Every child in foster care should have a permanency plan that describes where the child will live after he or she leaves foster care. Families typically participate in developing a permanency plan for the child and a service plan for the family. These plans guide the agency's work. Except in unusual and extreme circumstances, every child's plan is first focused on reunification with parents. If the efforts toward reunification are not successful, the plan may be changed to another permanent arrangement, such as adoption or transfer of custody to a relative.[7] Whether or not they are adopted, older youth in foster care should receive support in developing some form of permanent family connection, in addition to transitional or independent living services to assist them in being self-sufficient when they leave foster care between the ages of 18 and 21.

Federal law requires the court to hold a permanency hearing, which determines the permanent plan for the child, within 12 months after the child enters foster care and every 12 months thereafter. Many courts review each case more frequently to ensure that the agency is actively pursuing permanency for the child.

In fiscal year 2003, 55 percent of children leaving foster care were returned to their parents. The median length of stay in foster care was 12 months. The average age of a child exiting foster care was 10 years old (HHS, 2006).

[6] For more information about these databases, see *Establishment and Maintenance of Central Registries for Child Abuse Reports* (www.childwelfare.gov/systemwide/laws_policies/statutes/centreg.cfm), available from Child Welfare Information Gateway.

[7] Under the Adoption and Safe Families Act (ASFA), while reasonable efforts to preserve and reunify families are still required, State agencies are required to seek termination of the parent-child relationship when a child has been in foster care for 15 of the most recent 22 months. This requirement does not apply (at the State's option) if a child is cared for by a relative, if the termination is not in the best interest of the child, or if the State has not provided adequate services for the family.

Summary

The goal of the child welfare system is to promote the safety, permanency, and well-being of children and families. Even among children who enter foster care, most children will leave the child welfare system safely to the care of their birth family, a relative, or an adoptive home.

For more detailed information about the child welfare system, please refer to the resources listed below. For more information about the child welfare system in your State or local jurisdiction, contact your local public child welfare agency.

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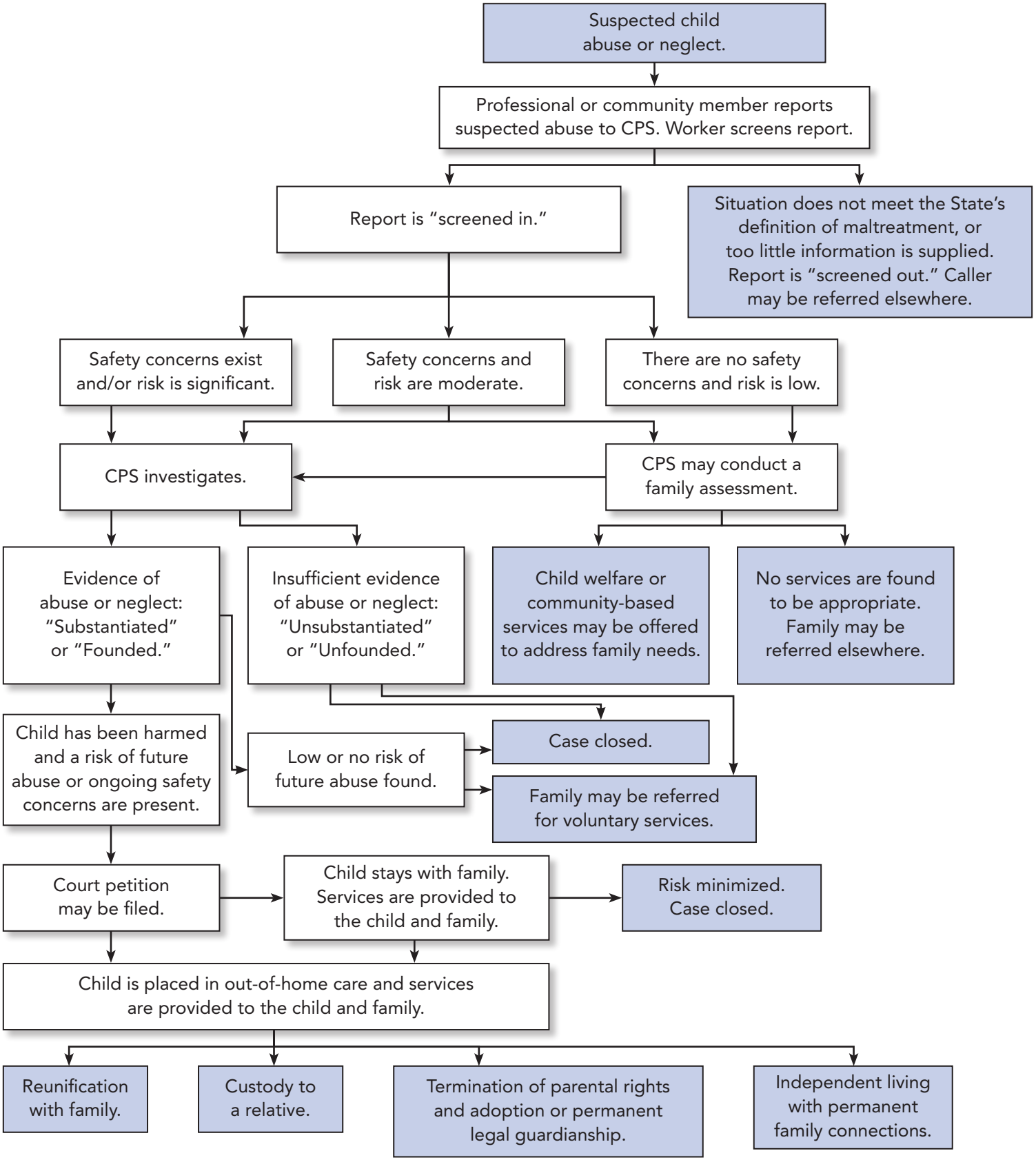
Appendix A: The Child Welfare System



Publication Survey

Publication Title: How the Child Welfare System Works

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Or mail to: Child Welfare Information Gateway; ATTN: Publications Survey; 10530 Rosehaven St., Suite 400; Fairfax, VA 22030

1. Please rate your agreement with the following statements using this scale:

   SD — Strongly disagree
   D — Disagree
   N — Neither agree nor disagree
   A — Agree
   SA — Strongly agree
   NA —Not applicable

I am satisfied with the content of this publication.	SD	D	N	A	SA	NA
This publication is useful.	SD	D	N	A	SA	NA
This publication was easy to read and understand.	SD	D	N	A	SA	NA
This publication met my needs.	SD	D	N	A	SA	NA
I can apply what I learned from this publication to my work, school, or personal situation.	SD	D	N	A	SA	NA
I would recommend this publication to others.	SD	D	N	A	SA	NA

2. How are you using or do you intend to use the information in this publication? *(Check one.)*
   - ☐ Personal use (personal situation, school report)
   - ☐ Provide information for families
   - ☐ Research
   - ☐ Service delivery
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3. What would have made this publication more helpful to you?

   _____

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   - ☐ Child Welfare Information Gateway *E-lert! (email/listserv notification)*
   - ☐ Child Welfare Information Gateway website
   - ☐ Child Welfare Information Gateway staff
   - ☐ Conference
   - ☐ Other organization's website or publication
   - ☐ Referred by a colleague/friend
   - ☐ Other: _____

5. Which of the following best describes your professional background or role in the child welfare field? *(Check one.)*
   - ☐ CPS/Foster care professional
   - ☐ Child abuse prevention/Family support professional
   - ☐ Adoption professional
   - ☐ Other professional: _____
   - ☐ Student (e.g., K-12 or University)
   - ☐ None of the above — I contacted Information Gateway for personal and NOT professional reasons.

6. Do you have suggestions or recommendations to make future publications more useful (e.g., different format, more interactive, specific topics)?

   _____

Client Relationships and Ethical Boundaries for Social Workers in Child Welfare

Written by Rose M. Handon, BSW, MSA, LSW

Many professionals enter into the field of social work to help others grow and improve their life circumstances. Yet, when working with clients, social workers must maintain clear boundaries to assure professional integrity and responsibility. On any given social work credentialing board Web site, one will see frequent cases in which there have been complaints filed against social workers resulting in imposed fines, penalties, licensure sanction, suspension, or revocation. In some instances, workers have been imprisoned for misconduct for violation of confidentiality, falsification in record-keeping, malfeasance, and so forth. However, this article will explore the issue of client relationships and ethical boundaries for those working in social work, with a particular focus for those in child welfare.

Dietz & Thompson (2004) offered, “The concern about appropriate boundaries is, at least in part, a concern about the effects of the power differential between client and professional. It is primarily a concern about boundary violations” (p. 2). Boundaries are “the limits that allow for a safe connection based on the client’s needs” (Peterson, 1992, p. 74). Yet, in retrospect, Reamer (2003) suggested that boundary violations and boundary crossings have to be examined in the context of the behavioral effects the behavior has caused for either the social worker or client. He posited a typology of five central themes in which boundary issues may arise: 1) intimate relationships, 2) pursuit of personal benefit, 3) emotional and dependency needs, 4) altruistic gestures, and 5) responses to unanticipated circumstances.

In addition, the clinical issues of managing dual relationships and management of transference and countertransference are factors that cannot be ignored in this discussion. Workers in child welfare are often found in dual client relationships. According to the NASW Code of Ethics (1999), dual relationships occur “when social workers relate to clients in more than one relationship, whether professional, social, or business” (p. 9). Social workers must be knowledgeable and mindful of the NASW Code of Ethics (http://www.socialworkers.org/pubs/Code/code.asp), which provides a comprehensive and strategic outline of one’s professional standards and conduct in meeting the needs of those we serve.

Throughout one’s career, the question is often asked, “Why did you go into social work?” The answer invariably centers on an interest in wanting to help or improve the lives of others. In child welfare, we are often described as helpers, resource/change agents, do-gooders, motivators of change, child-snatchers, and other stereotypes. Inside our respective roles and responsibilities, to move a client forward, we must engage a client in the process of change.

When working with clients, a major skill that social workers must utilize in facilitating the client's growth or change process is to earn their trust, confidence, and respect. This is an integral part of the client engagement strategy, which must be established in the early phase of the relationship. For those in child welfare, this poses a great challenge, since there is an inherent right and governmental authority to remove children from their own homes, while continuing to work with families toward improved functioning, stabilization, and or family reunification. Unfortunately, many professionals in our field have difficulties in the area of client rapport building. In an effort to meet the clients' needs, workers may find themselves "befriending the client," under the guise of helping.

Throughout our profession, thousands of men and women work with vulnerable families and children. In the scope of delivering social services, we often hear stories that can "break one's heart," or cause one to be inadvertently "sympathetic vs. empathetic" to the clients' experiences and/or pain. Many of our clients have been subjected to abuse, neglect, or other forms of violence or maltreatment. Some report stories of abandonment, domestic violence, emotional abuse, or other wrenching experiences. Some even report having difficulty with intimacy as a result of their reported pain. When social workers have not clearly identified and/or managed their emotional issues and baggage that they brought into the profession, the scope and nature of client/worker relationships can become quite blurry. Subsequently, instead of helping, the social worker may start the path of hurting the client while disclosing or sharing his or her own personal experiences.

In child welfare, immediate supervisors must play a vital role in modeling, coaching, and engaging in frequent discussions with workers on topical issues of client engagement, rapport building, and assurance of proper boundaries in the worker and client relationship. Social work schools, child welfare training, and other continuing education programs also have a responsibility in providing education and information on the management of client relationships and examination of ongoing ethical issues.

The following behavioral factors may warrant or signal violations in the worker/client relationship:

Worker has given the client his/her personal e-mail, cell, home address or phone number, or may even disclose his/her MySpace or FaceBook account.

Worker and client communicate with each other via texting via cell on the worker's personal and/or company cell phone.

Worker is warm-natured and enjoys physical connectedness with clients, such as hugging or embracing upon contact, kissing, rubbing the shoulder, hands, or face to provide comfort and support to the client.

Worker spends lengthy phone hours with the client during the work day or even on personal time.

Worker may tend to dress provocatively on days when scheduled to see the client(s)

Worker tends to spend an inordinate amount of time with the client, both scheduled and unscheduled visits, in comparison to other clients.

Worker talks frequently about the client, and may even openly share how much he or she likes, fantasizes, or can relate to the client.

Worker may begin to spend frequent time with client at various restaurants, movie theaters, or other public places outside of the client's home, or even at worker's home, under the guise of a client visit.

Worker freely shares and discusses his/her own personal experiences with the client Worker spends his/her own personal funds to support clients' needs, particularly if agency won't pay for clients' needs, while worker chooses to assume cost on his/her own.

Worker engages in the use of drugs and/or alcohol with the client.

Co-workers begin to talk about the worker and his/her relationship(s) with specific clients.

Client's own family and/or personal friends begin to talk about the amount of time worker spends with the client, and may even share such information with the agency.

The above is not an exhaustive list, but signals that the worker's involvement with the client warrants further probe and attention. If the supervisor has a suspicion or concern, it's important to document and confer with others in authority. In some instances, it may be a labor relations matter, or a training or coaching issue between the worker and supervisor.

There have been two distinct incidents in my career in which it was determined, following an internal investigation, that two different workers had grossly violated boundaries in the client/worker relationship. One case involved a worker being intimate with a parent during a weekend home visit, and a four-year-old child reported "daddy and caseworker" were kissing in father's bedroom. The other involved a caseworker who had called off sick, and one of the caseworker's clients called to report to the supervisor that the worker was not sick, but was instead at a client's home getting "high." In both instances, the workers were terminated from their jobs.

Why might a caseworker risk contamination of the client engagement process or actual working relationship? There is no definitive or even easy answer. Erickson's developmental stage of young adulthood, when there is a concentration on intimacy and expansion of one's interpersonal relationships, might suggest that social workers between 22 and 25 years of age are vulnerable to such violations occurring while finding their personal and/or professional selves. Others may suggest that social workers' use and/or abuse of power and authority may be a contributing factor while

working with vulnerable clients who lack decision-making or empowerment skills. From others, it may be suggested there are always persons in any given profession who will violate the code of conduct rules and standards, despite any degree of training, supervision, or administrative oversight.

As social workers, we have a responsibility to examine the issues of client relationships and ethical boundaries. This conversation merits discussion among our peers and other related professionals. In the age of increased litigation and constituent complaints, it is not a topic to be ignored. The personal and corporate costs and liabilities associated with claims of unethical behaviors have long lasting impact to those in the profession and for those who are served.

Fortunately, ethics training for social workers must be taken in accordance with state licensure standards. This provides an opportunity to be mindful of our ethical obligations and boundaries in serving others throughout the field. Non-licensed employees are not exempt from the risk of assumed liabilities in child welfare or other social work settings. Both public and private organizations generally have ascribed core principles, ethical procedures, and guidance with regard to policy safeguards that govern the scope of responsibilities of employees in providing client services. This is intended to keep all safe.

As individuals, let's take the time to examine our own behaviors and interactions in the way we communicate with and relate to our clients. This includes verbal and nonverbal communication. Explore and determine whether your client engagement skills are healthy or unhealthy. Revisit the signals and warning list of possible risk factors provided earlier in this article. If you find yourself or others on the list, take any necessary action to correct the area(s) of concern.

Always remain focused on meeting the needs of the client versus your own personal needs. Evaluate and pursue other avenues of support, which may include professional counseling, clinical supervision, and training. Finally, critically evaluate whether a career change might be necessary for the protection of self, clients, and agency employer.

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DEVELOPING SELF-AWARENESS

The following list outlines some of the factors that can interfere with the formation of a professional helping relationship and client service; use it as an aid in self-examination.

1. *Personal hang-ups and emotional problems.* To a considerable degree, our believers and behavior have been shaped by our childhood and early family experiences. Most people carry a certain amount of emotional "baggage" into their adult lives, including unresolved parent-child conflicts, prejudice, after-effects of traumatic events, and so on. Sometimes this "baggage" is carried to the workplace, where it has a negative impact on clients and work performances. For example:
   - Preoccupation with personal problems, resulting in an inability to give one's full attention to the client.
   - Inability to control one's reactions or exercise self-disciple when in an emotionally charged situation or when under the ordinary pressure associated with direct social work practice.
   - Inability to demonstrate warmth, empathy, and genuine caring for clients served by the agency.
   - Inability or unwillingness to work cooperatively with persons in positions of authority(e.g., judges, physicians, administrators, supervisors, etc.)
   - Difficulty separating personal experience (e.g., having been a victim of child abuse, growing up with alcoholic parents, etc.) from the concerns and problems presented by clients.
   - Extreme defensiveness that prevents a critical examination of one's own job performance.
   - Avoiding certain clients or difficult tasks.
   - Personalization of client anger and frustrations (i.e., inability to maintain an appropriate level of objectivity).
   - Imposing one's values, political beliefs, religious beliefs or life-style on clients.
   - Inability to respect the religious beliefs and cultural values of a client.
   - Alcohol or drug abuse.
   - Misuse or abuse of one's authority over clients.
   - Extreme level of shyness or non-assertiveness resulting in an inability to express one's opinion and engage in the give-and-take of client work, peer supervision, and team decision making.

2. *Appearance, clothing and grooming.* To a large extent, people form impressions of others – especially the powerful first impression – on the basis of physical appearance. Thus, the social worker must pay attention to his or her clothing and grooming because it matters to clients and will affect how they respond to the worker and their utilization of agency services. Of course, what is offensive to one client may be acceptable to another, and what is appropriate dress in one agency setting may be inappropriate to another. The staff in a particular setting must make decisions on what is acceptable. Many agencies and most hospitals establish dress codes as way of providing guidance to staff. When examining your appearance and its possible impact on clients, remember the following:
   - Some choices of clothing, hairstyle, makeup, perfume, or jewelry may offend or distract clients served by the agency.
   - Deficiencies in grooming and personal hygiene may offend clients.
   - Uncovered infections, skin irritations, and similar conditions may distract the client or cause him or her worry and anxiety.

3. *Behaviors that devalue or degrade others.* Social work values dictate that every client should be treated with respect. The social worker must avoid behaviors that are disrespectful, including the following:
   - Using words, phrases, or gestures that are in bad taste or known to offend clients and staff (e.g., cursing, sexual overtones, etc.)
   - Telling sexist, off-color, or ethnic jokes.
   - Telling disrespectful or disparaging stories about clients.
   - Demonstrating prejudice against particular client groups.
   - Making sarcastic, insulting, cruel, or disrespectful comments about clients.

4. *Distracting personal habits.* Most people have some undesirable mannerisms and habits that their friends and families have learned to accept. However, the social worker must be willing to modify habits that annoy clients, including the following:
   - Fidgeting, pencil tapping, knuckle cracking, nail biting, and the like.
   - Scratching, pulling, or twisting hair.
   - Chewing gum or tobacco and smoking.
   - Scowling, frowning, or other facial gesture that seem to express scorn, contempt.
   - Excessive nervous laughter, frequent clearing of throat, or other distracting mannerisms.

5. *Difficulties in cognitive functioning.* A social worker must absorb information quickly and apply complex principles. A capacity for abstract thinking is essential. The following examples illustrate insufficient cognitive functioning.
   - Difficulty processing new information, drawing logical inferences, and solving problems.
   - Lack of reading speed and comprehension needed to understand records and reports, agency policy, and professional books and journals.
   - Cognitive deficits that interfere with attention, memory, and judgment.
   - Inability to explain the assumptions and inferences behind one's professional judgments, conclusions, and decisions.

6. *Difficulties in verbal communication.* The social worker's verbal communication must be understandable to clients and other professional persons. The following problems could hamper work with clients:
   - Mumbling, speaking inaudibly, loud or penetrating voice tones, halting or hesitant speech, rapid speech.
   - Frequent use of slang not understood by or offensive to clients.
   - Errors of grammar or awkward sentence construction that confuse clients.
   - Inability or unwillingness to adjust vocabulary to client's age or educational level.
   - Uncorrected vision or hearing problems.

7. *Problems in written communication.* Because so much of the social worker's service to a client involves the exchange of information with other professionals, the worker must be able to communicate in writing. If letters, reports, and agency records are carelessly written and difficult to understand, those attempting to red them will conclude either that the worker does not care enough to communicate clearly or is incompetent. The worker's effectiveness is seriously damaged if the client or other professional persons form such negative impressions. Serious writing problems that merit correction include the following:
   - Inability to prepare letters, reports, and records that are understandable to clients, agency staff, and other professionals.
   - Problems recognizing and correcting errors of spelling, grammar, and syntax.
   - Difficulty selecting words that adequately express thought.
   - Inability to write at a speed sufficient to manage required paperwork.

8. *Poor work habits.* Poor work habits may have a direct or indirect impact on the clients served by an agency. Some of the commonly observed problems are:
   - Being late for client appointments, team meetings, case conferences, and other scheduled events.
   - Missing deadlines for the completion of written reports that are important to clients or other agencies and professionals serving the client.
   - Incomplete or sloppy recordkeeping.
   - Lack of preparation for meetings with clients and other professionals.
   - Not following thorough on assignments or tasks.
   - Distracting other staff members or keeping them from their work.
   - Unwillingness to seek and utilize direction and guidance from the supervisor.
   - Blaming clients or others for one's own ineffectiveness; inability or unwillingness to acknowledge mistakes or limitations or knowledge and skill.
   - Being more interesting in diagnostic labels and theoretical issues than with the clients as real people.
   - Unwillingness to follow established agency policies and procedures.
   - Behaviors occurring outside work hours that draw negative attention to the social worker and thereby lessen client and public respect for the social agency and/or the worker.
   - Unwillingness to share information and preoccupation with protection of professional or agency turf.

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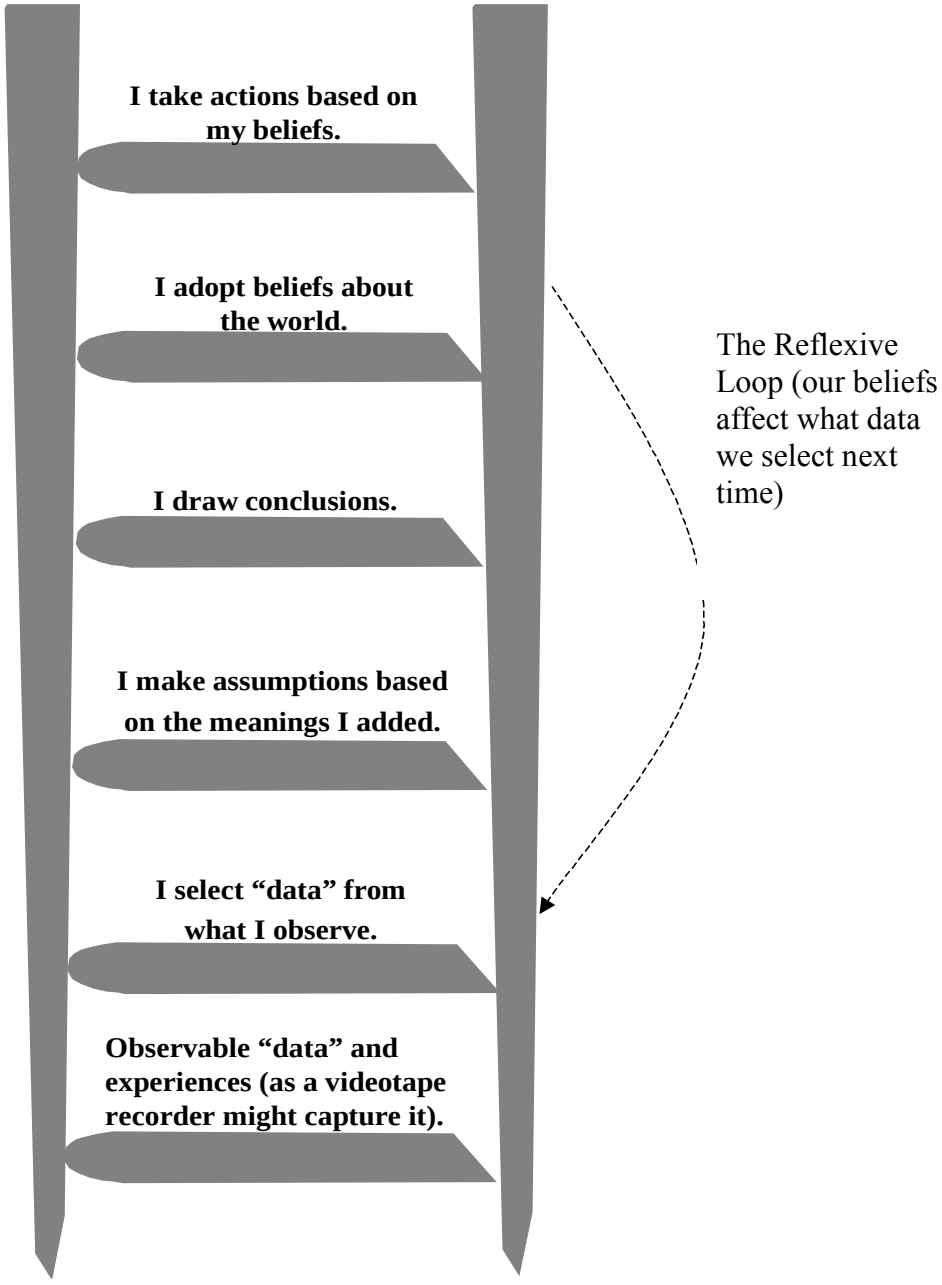
Ladder of Inference



Source: Adapted from Peter M. Senge, et al., *The Fifth Discipline Fieldbook: Strategies and Tools for Building a Learning Organization* (New York: Currency, 1994). Ladder of Inference originally developed by Chris Argyris. Permission pending.

12

Practice Principles That Build Partnership

1. Respecting service recipients as people worth doing business with.
2. Cooperate with the person, not the abuse.
3. Recognize that cooperation is possible even where coercion is required.
4. Recognize that all families have signs of safety.
5. Maintain the focus on safety.
6. Learn what the service recipient wants.
7. Always search for detail.
8. Focus on creating small change.
9. Don't confuse case details with judgments.
10. Offer choices.
11. Treat the interview as a forum for change.
12. Treat these practice principles as aspirations, not assumptions.

(From: Turnell, A., & Edwards, S. (1999). Signs of safety: A solution and safety oriented approach to child protection. New York: Norton.)

INTERPERSONAL HELPING SKILLS

Attending: Communicating respect, interest and acceptance for the families by actively attending to them at both the physical and psychological levels.

Elements of Attending

Physical Attending

Use of Environment
- ✪ Comfortable
- ✪ Minimize barriers
- ✪ Minimize distractions

Use of Body
- ✪ Gestures
- ✪ Eye contact
- ✪ Voice quality
- ✪ Body posture
- ✪ Facial expression

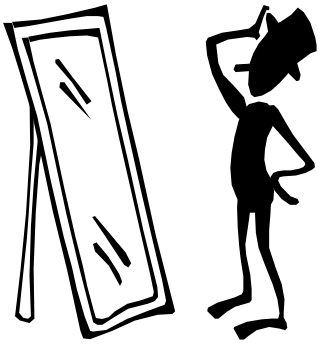
Psychological Attending

Observing
- ✪ Client's congruence
- ✪ Client's use of voice
- ✪ Client's nonverbal behavior

Responding
- ✪ Verbal following
- ✪ Minimal encouragers
- ✪ Congruence with client

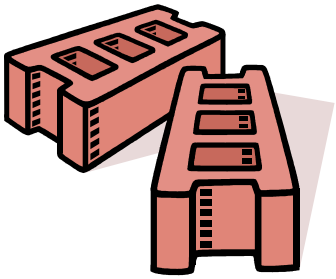
Reflections: *Concise* restatements of the person's immediate past message, or some part of the person's past message that result from careful, selective and/or psychological attending to both verbal messages and non-verbal cues.

√ Reflections of *content* involve attending to, then stating the beliefs, opinions, events and facts of the person's message.



√ Reflections of *feeling* involve attending to, then stating the emotions or emotional aspects of the person's message. *Combined* reflections involve mirroring both the content and feeling aspects of the message.

Summarization: Using multiple statements of feeling or content expressed over a period of time. Summarizations can be used for opening and closing an interview as well as in the middle of an interview or as a transition.



Concreteness: Asking the person for additional information when vague terms are used. For example, if a parent states: "*Johnny's foster mother acts like she doesn't like it when I have visitation.*" The worker should ask the parent to explain what the foster mother is doing when she "*acts like…*"

Reframing: Reframing is both a skill and a tool used to seek out additional meaning or explanations for family's behaviors. It can focus on the *positive intent, trait or characteristic being expressed through family members' behavior, feelings, or statements.* In reframing, the "lens" with which we view a behavior or statement is changed in order to get at the underlying positive intent or characteristic of the family member. We want to see the behavior from behind the person's eyes.

Use of Questions: The way in which we ask questions plays an important role in determining the type of answer we are likely to receive. There are several types of questions:

Closed Ended: questions that can be answered with one or two words, *i.e. "When do your parenting classes start?*"

Open Ended: questions that encourage the person to use his or her own words to elaborate on a topic, *i.e. "Can you tell me more about what happened right before your child was injured."* Sometimes, an open ended question follows a closed ended question to ask the person to elaborate on their previous answer.

Indirect: questions that are statements made for the purpose of seeking information, *i.e. "It sounds like you have worked really hard at not losing your temper."* Notice that this type of question can also serve as a reflection or a reframe, but it clearly invites the person to share additional information.

Solution-focused: questions designed to seek strengths and possible solutions. For a more thorough explanation of solution-focused questions, see the assignment box.

Guidelines for Giving and Receiving Feedback

Qualities of Effective Feedback

- Concrete
- Helpful
- Timely
- Behaviorally specific
- Useful
- Clear (using an "I" message)

Conditions for Effective Feedback

- Trusting relationship
- Honesty and openness
- Linked to performance

Process for Effective Feedback

- Utilize the Up/Down/Up technique

  - Identify successes and specific strengths
    - ✓ Self-Assessment
    - ✓ Other (peer, family)
    - ✓ Trainer/ Coach/Supervisor

  - Identify areas for growth
    - ✓ Self-Assessment
    - ✓ Other (peer, family)
    - ✓ Trainer/OJT Coach/Supervisor

  - Refocus on strengths
    - ✓ Self-Assessment
    - ✓ Other
    - ✓ Trainer/Coach/Supervisor

  - Reach mutual understanding of the situation/performance

Receiving Feedback

- Agree with the feedback if you think it is accurate and helpful.
- Maintain good eye contact.
- Tell the observer how her or his feedback is helpful to you.
- If you disagree with the feedback, accept it as an accurate indication of how the observer perceived what occurred.
- Ask for specifics if the feedback is too general.

The Solution-Focused Approach To Practice

HISTORY & VALUES

History of Solution-Focused/Solution-Building Model

The Solution-Focused/Building Approach was pioneered through the work of Steve de Shazer ad Insoo Kim Berg. Beginning in the mid-1970s, de Shazer, Berg, and their colleagues, through an inductive process of observing clients in therapy, sought to determine what activities were most helpful to clients. In 1982, de Shazer hit upon the idea that there is not a necessary connection between problem and solution –namely, that helpful solutions could emerge from the client/therapist interaction that were not directly connected to the presenting problem. This was a significant shift from the medical model, which requires a detailed examination of the problem, a more formal diagnosis, and treatment specifically connected to the problem and diagnosis.

Influenced by the research of others in the field of communications, and their own research, de Shazer and Berg recognized that the way in which the practitioner phrases and uses questions has a discernable relationship to the way in which the client responds and how the helping process unfolds. From this research and practice, they developed the Solution-Focused model. Effective use of questions to help clients recognize, explore, and use strengths is a key feature of the Solution-Focused Approach.

Value Base for Solution-Focused Intervention (Saleebey, 1992)

1. Despite life's struggles, all persons possess strengths that can be marshaled to improve the quality of their lives. Practitioners need to respect these strengths and the direction clients wish to apply them.
2. Client motivation is increased by a consistent emphasis on client-defined strengths.
3. Discovering strengths requires a process of cooperative exploration between clients and helpers.
4. Focusing on strengths turns practitioners away from the temptation to judge or blame clients for their difficulties and toward discovering how clients have managed to survive.
5. All environments – even the most bleak – contain resources.

Solution-Focused Approach Core Principle

If what you are doing doesn't work, stop doing it and do something else.

If what you are doing is working, do more of it.

Solution-Focused Techniques

Building Solutions in Child Welfare
(Partnerships for Safety)
Insoo Kim Berg

We face an increasing number of complex situations that challenge our skills, compassion and sense of mission, and our desire to make a difference. "Multi-problems" cases, substance abuses, repeated crises in children and families test our limits. Along with shrinking resources, changing demands on client-worker relationships demand innovative, client-driven, and cost-effective interventions.

Based on Solution-Focused Therapy, this training will challenge you in thinking about effective interventions and provide you with innovative techniques you can use immediately. Through lecture, videotape examples of child protective services investigations, foster care cases, handouts, exercises, and discussions, you will learn skills that you can use immediately in the following areas:

- Thinking from out of the box in child welfare
- Working assumptions about child welfare – Where did it come from?
- Evidence-based child welfare practice – Common sense approach
- Investigation for abuse vs. Assessment for safety
- Strategies for engaging clients quickly and respectfully
- How to turn "investigation" into a collaborative, joint effort
- Negotiation of what the client wants
- What do we (agency, community) want?
- Useful and frequently used tools
- Ways to get there fast by going slow
- When to close a case
- Multiple investigation cases
- "Removing" children respectfully and with hope

About Insoo Kim Berg

Insoo is the co-developer of the popular Solution-Focused Brief Therapy model. She lectures extensively around the world. Many of her seven books and 30 papers have been translated in 10 languages. Most recent books include: *Family Based Services* (94); *Solutions Step by Step* (with Reuss, 97); *Interviewing for Solutions* (with DeJong, 98); *Building Solutions in Child Protective Services* (with Kelly, 2000); and *Tales of Solutions* (with Dolan, 2001) and she is currently working on a book on working with children.

Solution-Focused Techniques

Building Solutions with Mandated Clients
Insoo Kim Berg

Self Check:

Make sure to set aside your personal biases against the client, if any.
Make sure your personal attitude is positive and hopeful.
Set aside whatever you might have heard about the client from others. Be open to hearing the client's view.
Find a way to maintain a "not-knowing" position.

I. Assess the Person first, Not the Problem.

A. Connect with the person by:
- Find out what is important to the client
- Find out the person's aspirations and dreams
- Find out who is important to the client

B. Find out how to face the problem together with the client by:
- Putting yourself one-step behind the client (at least side-by-side)
- Find out what the client is able to do toward what he wants (exception)

II. Assess for Sustainable Solution

A. Find out the details of what the client wants (not what he doesn't want)
B. Past successes, recent successes in different social contexts
C. What does the client need to do to repeat the exception?
- Ask: "How did you know to do that"
- Useful questions – open-ended questions, miracle question, exception finding question.
- Always ask questions (open-ended), not tell them what to do.

III. Help the Client to Assess his/her own Progress Toward the Goal

A. Ask many variations of scaling questions
B. Ask what is the next small step to achieve the desirable small level
C. Find out how significant others would rate the client's progress
D. Ask client what it will take to get there (to 10, for example)
E. Ask relationship questions (What would _____ say where you are?)

Solution-Focused Techniques

Questions Lead-In

The most difficult part of mastering a new concept is how to get started. The following are some suggestions for beginning to feel comfortable using Solution-Building conversations.

Stay with WH questions (What, When, Who, Where, And How. Avoid using Why).
What does ____ expect to come out of your coming to this meeting?
What part do you agree with and what part do you disagree with?
What needs to come out of this meeting today so that you can say this is helpful?
What tells you that you are at 5?
Tell me about the time when you were more productive? What was different then?
How do you know what to do next?
What do you know about him that tells you that he can do this?
How would that be helpful?
What has been changed, even a little, since you made this appointment?

Tentative Language (Perhaps, it seems, suppose, it appears, it sounds like, could it be…)
I am not sure about this. What do you suppose…?
Do you suppose…?
It sounds like what you really want is…?
Suppose your son (boss, etc) changed, what difference would that make (between you and him)?
How will things be different then?

Relationship Questions
What would your best friend (boss, mother, etc) say what you are like when you are calmer?
What would ____ notice different about you that will tell her things are better for you?
What would ____ (your best friend) say how you are different when you are successful?

Personal Meaning and Language
You are clear about not doing it. What does it mean to you? What about it is so important?
So, how would that be helpful to you to (drink more, stay in bed, not go to work, etc.)?
Can you explain that again, what different would it make for you?
You must have a good reason to…"

What Else? (For more and more details from the client – up to 4 or 5 times)
What else would it take for you to stop drinking and stay stopped?
What would it take for you to…? What would ____ say it would take for you to …?
How can you tell it will work? Good, what else tells you that it will work?

Solution-Focused Techniques

Avoiding "WHY" Questions

- So, how do you decide to come back? **NOT** Why did you come back?
- What is it about living there that is good for you? **NOT** Why do you like living there?
- So, what would you do instead of losing your temper? **NOT** Why would you lose your temper.
- So, how would you react? **NOT** Why would you react that way?
- How come? **NOT** Why?
- How come you don't do that with your boss? **NOT** Why don't you do that with your boss?
- Where (or How) did you learn that? **NOT** Why did you learn that?

Useful Language Skills

- Building a "yes set" and ways to maintain it
- "Not-Knowing" skills
- The other person's key words
- Tentative language (collaborative, negotiation)
- Use of HOW questions
- Suppose…(pause)
- Instead (goal negotiation)
- "Difference" or "different" questions
- Self-complimenting vs. praise
- "How did (do) you do it?" (Admiring commiseration)
- How come? Instead of "why" question
- How helpful is that? How would that be helpful?
- What difference would it make?
- You must have a good reason for…?
- Relationship question

Focusing on Exceptions

- Exceptions shrink problems. (Ask about details.)
- Exceptions demonstrate client abilities. (How do you suppose you did this?)
- Exceptions point toward solutions. (What would it take to repeat this?)
- Exceptions focus on what is possible. (You already know what to do.)

Solution-Focused Techniques

Scaling Questions

- What tells you that you are at 8?
- How long did it take you to get to 8?
- How is 8 different than say, when you were at 5?
- What do you need to do to keep your 8?
- How come it's not -1?
- Suppose I ask your best friend (son, mother, etc) what would ____ say you are at on the same scale?
- What would it take to move 1 point higher?
- When you move up 1 point higher, what would be different in your life? With your child?
- How would your (family life, safety, health, depression, etc) be a little bit better?

Working Assumptions About Children

We believe all children want to:

- Have their parents be proud of them
- Please their parents and other adults
- Be accepted as a part of a social group
- Be active and involved in activities with others
- Learn new things
- Be surprised and surprise others
- Voice their opinions and choices
- Make choices when given an opportunity

Working Assumptions About Parents

We believe all parents want to:

- Be proud of their children
- Have a positive influence on their child
- Hear good news about their child and what the child is good at
- Give their child a good education and a chance to succeed
- See their child's future is better than theirs
- Have a good relationship with their child
- Be hopeful about their child
- Feel they are good parents

Solution-Focused Questions

Solution-focused questions are actually open, closed, and indirect questions that are sequenced in such a way as to move the client and family from problem identification to problem resolution. Solution-focused questions provide an opportunity for individuals and families to identify solutions that were effective in the past, to explore situations in which the problem could have occurred but did not, and to articulate their vision of success once the problem is resolved. The use of solution-focused questions can offer hope and empower families to resolve the issues that brought them to the agency. The following describes the five types of solution-focused questions:

Solution-defining questions help individuals and families clarify the "who, what, why, where, when, and how" of the problem, determine the circumstances under which the problem is likely to occur, and identify potential resources for solving the problem.

1. Examples include:

"How often does this usually happen?"

"Who else was there when it happened?"

"Under what circumstances is this likely to happen again?"

"Who else is concerned about this problem?"

"How might they help us in finding a solution to the problem?"

Past-success questions also acknowledge the individual/family's ability to cope and function effectively in the past and empower families to utilize these same strengths and resources in resolving the current problem.

2. Examples include:

"Losing both of your parents at such a young age must've been really tough. How were you able to get through it?"

"It's not easy being a single mom. Tell me how you have managed over the years."

"What would help you regain the sense of control over your life that you've felt in the past?"

Exception-finding questions focus on situations in which problems could have occurred but didn't and help families explore the reasons why. This information is then used to develop strategies with the family that will help them deal with similar problems in the future.

3. Examples include:

"I know the breakup with your boyfriend last week really upset you. Usually this would've led to a drinking binge, but this time you maintained your sobriety. How did you cope with the disappointment?"

"Your foster mother said that you were pretty angry with her for enforcing the curfew the other night, but you didn't lash out at her. How did you manage to keep your temper under control?"

"You're usually somewhat depressed after a visit with the children, but today you seem more upbeat. What was different about this visit?"

Miracle questions allow clients to consider how their life might be different if the problem that brought them to the agency was resolved. This "what if" approach encourages clients to visualize positive outcomes for themselves and their families.

4. Examples include:

"I'd like for you to imagine yourself in the morning, waking up and discovering that the problem that brought you to this agency has miraculously been solved. You're not aware of how it was solved or even that it has been solved. You just notice that things are very different. What is the first thing you notice that is different? In what ways are you different? In what ways are your children different?"

"If this problem were solved and your family was transformed into the ideal family, what would it look like?"

"If you found a magic lamp on your way home today and were granted three wishes, what would they be?"

Scaling questions usually involve asking clients to assess a given situation by determining where they are currently or where they want to be using a ten-point scale (with ten representing the most positive response).

5. Examples include:

"On a scale of 1 to 10 (with 10 meaning 'exceptionally well' and 1 meaning 'not well at all'), how would you say your visit with Susan went last week?"

"On a scale of 1 to 10 (with 10 meaning 'extremely hopeful' and 1 meaning 'totally hopeless'), how hopeful are you that this problem will be resolved and your family will be reunited?"

A Positive Approach to Resistance
The S.H.E.R. Model

- **Surface**

- **Honor**

- **Explore**

- **Rechecking**

CHAPTER 3
The Helping Relationship

Developing a helping relationship with abused and neglected children and their families is critical to changing the conditions or patterns of behavior that contributed to the risk of maltreatment. Experience has demonstrated that successful intervention and treatment depend heavily on the quality of the caseworker's relationship with the children and family.

Developing helping alliances with families and children at risk for child maltreatment is challenging because they may have a history of difficulties in forming and sustaining mutually supportive, interpersonal relationships, and they may not have had positive relationships with formal systems, such as schools, social services, or counseling services.[16] Whether one's role is interviewing family members as part of the initial assessment or investigation, or determining what must change to reduce the risk of maltreatment and improve outcomes for risk reduction, the quality of the caseworker's effort is directly dependent on his or her ability to develop a collaborative relationship.[17]

This relationship begins with the very first contact and continues to develop with ongoing caseworker and client communication and interaction. By definition, relationships have a strong emotional component. Good relationships do not just happen; they must be built. The relationship does not result from a caseworker's charismatic personality or a mystical connection between people. Rather, it is a product of the caseworker's commitment to helping the children and family, his or her ability to relate effectively on an interpersonal level, and the children and the family's willingness to be open and risk "relating" to the caseworker. Caseworkers' behavior can significantly increase the chances that a positive relationship will develop.[18]

Core Conditions of the Helping Relationship

Researchers have defined three core conditions that are essential to the helping relationship:

- Empathy
- Respect
- Genuineness[19]

A caseworker's ability to communicate these three core conditions will strongly influence whether they will build a relationship with the children and family that is characterized by cooperation or a relationship that is hostile and distrustful. Each of the conditions is described below.

Empathy

Empathy is the ability to perceive and communicate with sensitivity the feelings and experiences of

another person by being an active responder rather than a passive listener. Empathy is a process of attempting to experience another person's world and then communicating an understanding of, and compassion for, the other's experience. The caseworker should focus on the verbal and nonverbal cues, such as smiling or eye-rolling, presented by the children and family and frequently share his or her understanding of what the client has communicated. The content of the message is never ignored, but empathy goes beyond the facts, circumstances, and events of the children's and family's life and conveys an understanding of how those circumstances uniquely affect them.

Empathy builds trust and openness and helps to establish rapport between the children and family and the caseworker. Caseworkers can demonstrate empathy by:

- Paying attention to verbal and nonverbal cues;
- Communicating an understanding of the children's and family's message;
- Showing a desire to understand;
- Discussing what is important to the children and family;
- Referring to the children's and family's feelings.

In their effort to be empathetic, some new caseworkers may lose their objectivity and "over-identify" with the children's perspective or, in other cases, be so family-centered as to ignore some risk factors. It also should be recognized that some in the helping profession have been abused and may over-identify with either the child or the parent. Some signs of over-identification may include a difficulty or inability seeing a parent's strengths or being unable to see any possible positive intention behind the parent's behavior. This may make it difficult to be empathetic to other family members, which may lead to counterproductive outcomes for the family as a whole.[20]

Respect

Respect refers to the caseworker's communication of acceptance, caring, and concern for the children and family. It involves valuing the individual family members as people, separate from any evaluation of their behavior or thoughts, although this does not mean that caseworkers sanction or approve thoughts or behaviors that society may disapprove.

All human beings need to feel accepted and respected; it is especially important for abused and neglected children and their families to feel accepted and respected by their caseworker. Many abused and neglected children and their families fear or mistrust caseworkers and the social service system. The helping relationship will not be established unless the caseworker communicates respect for each person's potential. Caseworkers should believe that all people have the strength, internal resiliency, and capacity to become more competent.

Respect also means using culturally competent practice. Culturally competent practice entails:

- **Cultural awareness.** Caseworkers should understand and identify the critical cultural values important to the children and family as well as to themselves.
- **Knowledge acquisition.** Caseworkers should understand how these cultural values function as strengths in the children and family.
- **Skill development.** Caseworkers should be able to match services that support the identified cultural values and then incorporate them in the appropriate interventions.
- **Inductive learning.** Caseworkers should continue to seek solutions that include considering indigenous interventions and matching cultural values to Western interventions.[21]

Genuineness

Genuineness refers to caseworkers being themselves. This means simply that caseworkers are consistent in what they say and do, nondefensive, and authentic. They must have clear knowledge and an acceptance of the agency's authority, procedures, and policies, and of their professional role–both in its meaning to the worker and the meaning to abused and neglected children and their families. Genuineness means integrating who we are and our role in the agency with acceptance of children and families and a commitment to their welfare. If this occurs, then what caseworkers say will match their attitudes and beliefs.

However, a worker must use discretion. For example, if a caseworker feels shock, horror, or anger over a parent's abusive behavior, expressing these feelings would not be productive. In fact, it may alienate parents, causing them to be angry, defensive, or resistant. Rather, caseworkers need to be aware of their feelings and at the same time respond in a respectful manner that opens rather than closes communication.

Genuineness contributes to the helping relationship by reducing the emotional distance between the caseworker and the children and family and by helping them to identify the caseworker as another human being similar to himself or herself. Caseworkers can demonstrate genuineness by:

- Being themselves and not taking on a role or acting contrary to how they believe or feel;
- Making sure that their nonverbal and verbal responses match;
- Using nonverbal behaviors–such as eye contact, smiles, or sitting forward in the chair–to communicate trustworthiness and acceptance;
- Being able to express themselves naturally without artificial behaviors;
- Being nondefensive.[22]

Another means by which caseworkers can demonstrate genuineness is through the use of self-disclosure. When used carefully, this can be an effective method for establishing a connection between the caseworker and the client. It is important, however, that self-disclosure is used judiciously to prevent a shift in the focus from the client to the caseworker.

Techniques for Building Rapport

In addition to the core conditions and guiding principles for developing a helping relationship, there are specific techniques caseworkers can use to build rapport. The following list provides some examples:

- Approach each individual involved with an open mind.
- Find out what is important to the child and to the family. For example, do not press the issue of staying sober as the priority if that is not important to the parent or caretaker, but do explain that staying sober will speed up getting the children back if that is their priority.
- Use mirroring. Take note of words used by the child or family and try to incorporate them into your conversations.
- Listen to the child or parent's explanation of the situation without correcting or arguing.
- Ask questions rather than issuing threats or commands.
- Clarify expectations and purposes. Clearly explain the helping process and the caseworker's role in working together toward solutions.
- Help the child and parent or caretaker retain a sense of control; for example, involve them in scheduling appointments and ask how they would like to be addressed.

- Clarify commitment and obligations to the working relationship.
- Acknowledge difficult feelings and encourage open and honest discussion of feelings.
- Be consistent, persistent, and follow through.
- Promote participatory decision-making for meeting needs and solving problems.[23]

These are only a few key techniques; there are many other methods that will help build rapport.

Use of Authority in Child Protective Services

Child protective services (CPS) is an expression of a community's concern for the welfare of its citizens. Child protective services are provided because the community recognizes that children have the right to safety and that parents have obligations and responsibilities. The authority to provide these services is vested in the CPS agency and staff through laws and government policies. Competent CPS practice involves using this authority effectively. The use of CPS authority has special relevance at the initial assessment or investigation stage of the casework process, but is applicable at all other stages as well. In fact, effective use of authority is an essential ingredient in establishing helping relationships with all involuntary clients.

Authority, whatever its source, can impede or enable the development of trust between the CPS caseworker and the children and family. The constructive and positive use of authority involves (1) stating one's purpose and function clearly at all times, (2) supporting and challenging the children and family, and (3) expressing feelings. This approach provides the children and family with a feeling of confidence that the caseworker:

- Knows what he or she is doing;
- Is secure in his or her position;
- Intends the best for the child, parents, family, and society.[24]

Difficulties in Using Authority Effectively

The caseworker's effective use of authority reduces opposition and assists in engaging children and families. There are several factors in CPS work that may make this difficult:

- Even though CPS caseworkers have the legally mandated authority to investigate abuse and neglect, if they lack the children's and family's respect, they may experience difficulty influencing the change process.
- There may not be agreement between CPS, the children, and the family about what constitutes appropriate and effective intervention.
- If the caseworker is not able to overcome any negative perceptions he or she has of the children and family, it may influence engagement.
- Caseworkers may not be adequately prepared to engage families of different cultural backgrounds. As a result, families may feel "invaded" by caseworkers.[25]

Engaging the Resistant Client

Due to the involuntary nature of the majority of CPS cases, it is not unusual for families to resist offers of help. Resistance is a normal and predictable response when people feel forced to change. Caseworkers should not personalize resistance. To deal with resistance effectively, caseworkers should first change their perspective of resistance and try to see the behavior as a potential strength. How the caseworker responds to the resistance is crucial in avoiding continued abuse or escalation of inappropriate behavior. To assist in engaging resistant clients:

- Be clear, honest, and direct. Caseworkers should maintain a nondefensive stance.

- Acknowledge the involuntary nature of the arrangement. Caseworkers should explain the structure and content of intervention to the children and family.
- Be matter-of-fact and nondefensive in explaining the legal authority that permits intervention. Caseworkers should not get into a debate about authority; instead caseworkers should state what their authority is and what legal recourse the children and family may have to challenge it.
- Contact children and families in a manner that is courteous and respectful, and assess strengths as well as risks.
- Elicit the parent's concerns and wishes for assistance and convey understanding of the parent's viewpoint, including reservations about CPS involvement.
- Reduce the children's and family's opposition to contact by clarifying available choices, even when choices are constrained, by emphasizing freedoms still available and by avoiding labeling.
- Earn the respect of the children and family (and gain psychological influence) by being a good listener who strives to understand their point of view.
- Respect the right of the children and family to express values and preferences different from those of the caseworker.
- Establish feasible, small steps to help build in early success in order to recognize client efforts and progress.
- Acknowledge difficult feelings and encourage open and honest discussion of feelings.
- Reframe the family's situation. This is particularly useful when the children and family are making arguments that deny a problem or risk; it acknowledges their statements, but offers a new meaning or interpretation for them. The children's and family's information is recast into a new form and viewed in a new light that is more likely to be helpful and support change.

Techniques for Handling Hostile and Angry Situations

One form of client resistance that is particularly difficult for CPS caseworkers to manage is anger and hostility. The following are techniques for deescalating anger:

- Remain calm; try not to show fear or anxiety.
- Be firm without raising one's voice.
- Make statements simple and direct.
- Recognize and address feelings and do not take hostile statements personally.
- Offer the person a choice between positive alternatives.
- Be alert for the possibility of aggression.
- Attempt to have the person sit down, and distract him or her from the source of anger.
- Give the person lots of space; do not touch them.
- If the person attacks, use only enough force to protect yourself or restrain him or her.
- Remember it takes a person 30-40 minutes to calm down physiologically.
- After the visit, do not sit in front of the house to write notes.
- Carry a cell phone, whistle, or personal alarm and use it, if appropriate.
- Pay attention to intuition or "gut instinct," and leave if warranted.[26]

Stages of Change

All human beings are motivated to meet basic needs. Individuals frequently differ in their state of readiness to change. In addition, client readiness to change may fluctuate over time. Motivation is clearly linked to the degree of hope that change is possible. The degree to which clients are ready to change varies over time and is described in the pattern presented in Exhibit 3-1 (i.e., precontemplation, contemplation, determination, action, and maintenance).

Since most children and families are involved with CPS involuntarily, they enter the CPS system at the precontemplation stage. By the end of the initial assessment or investigation phase, it is hoped that caseworkers will have moved children and families to the contemplation stage or, even better, to the determination stage. It is essential for children and families to be at the determination stage when developing the intervention plan. If children and families have not moved to that point, the likelihood of change is compromised.

Exhibit 3-1 Stages of Change		
Stage	**Description**	**Caseworker Actions**
Precontemplation	*Sees no need to change.* At this stage, the person has not even contemplated having a problem or needing to make a change. This is the stage where denial, minimization, blaming, and resistance are most commonly present.	Provide information and feedback to raise the client's awareness of the problem and the possibility of change. Do not give prescriptive advice.
Contemplation	*Considers change but also rejects it.* At this stage, there is some awareness that a problem exists. This stage is characterized by ambivalence; the person wants to change, but also does not want to. They will go back and forth between reasons for concern and justification for unconcern. This is the stage where clients feel stuck.	Help the client tip the balance in favor of change. Help the client see the benefits of changing and the consequences of not changing.
Determination	*Wants to do something about the problem.* At this stage, there is a window of opportunity for change: the person has decided to change and needs realistic and achievable steps to change.	Help the client find a change strategy that is realistic, acceptable, accessible, appropriate, and effective.
Action	*Takes steps to change.* At this stage, the person engages in specific actions to bring about change. The goal during this stage is to produce change in a particular area or areas.	Support and be an advocate for the client. Help accomplish the steps for change.
Maintenance	*Maintains goal achievement.* Making the change does not guarantee that the change will be maintained. The challenge during this stage is to sustain the change accomplished by previous action and to prevent relapse. Maintaining change may often require a different set of skills than making the change.	Help the client identify the possibility of relapse. Then, help the client identify and use strategies to prevent relapse.[27]

ELEMENTS OF EFFECTIVE TEAMS

Together **E**veryone **A**chieves **M**ore

- ❖
- ❖
- ❖
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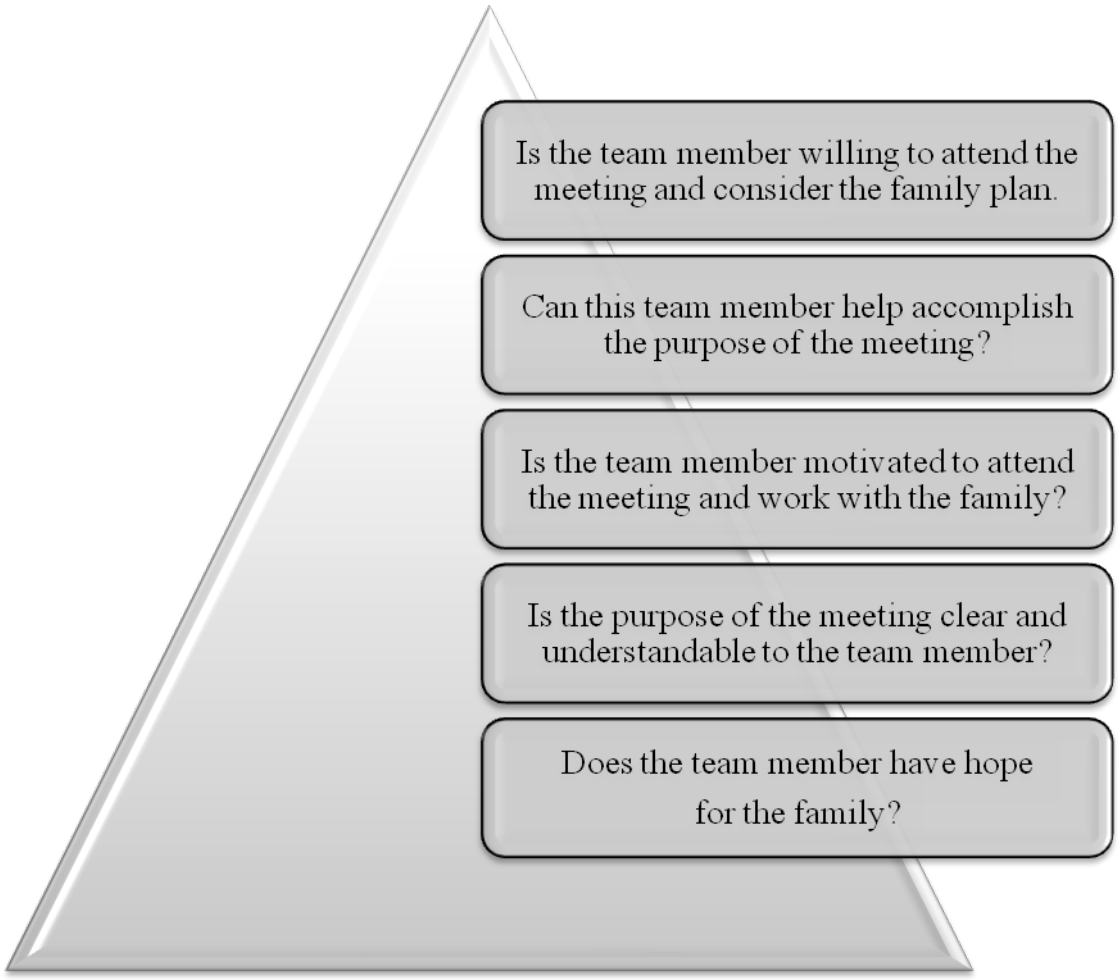
STACKING FOR SUCCESS



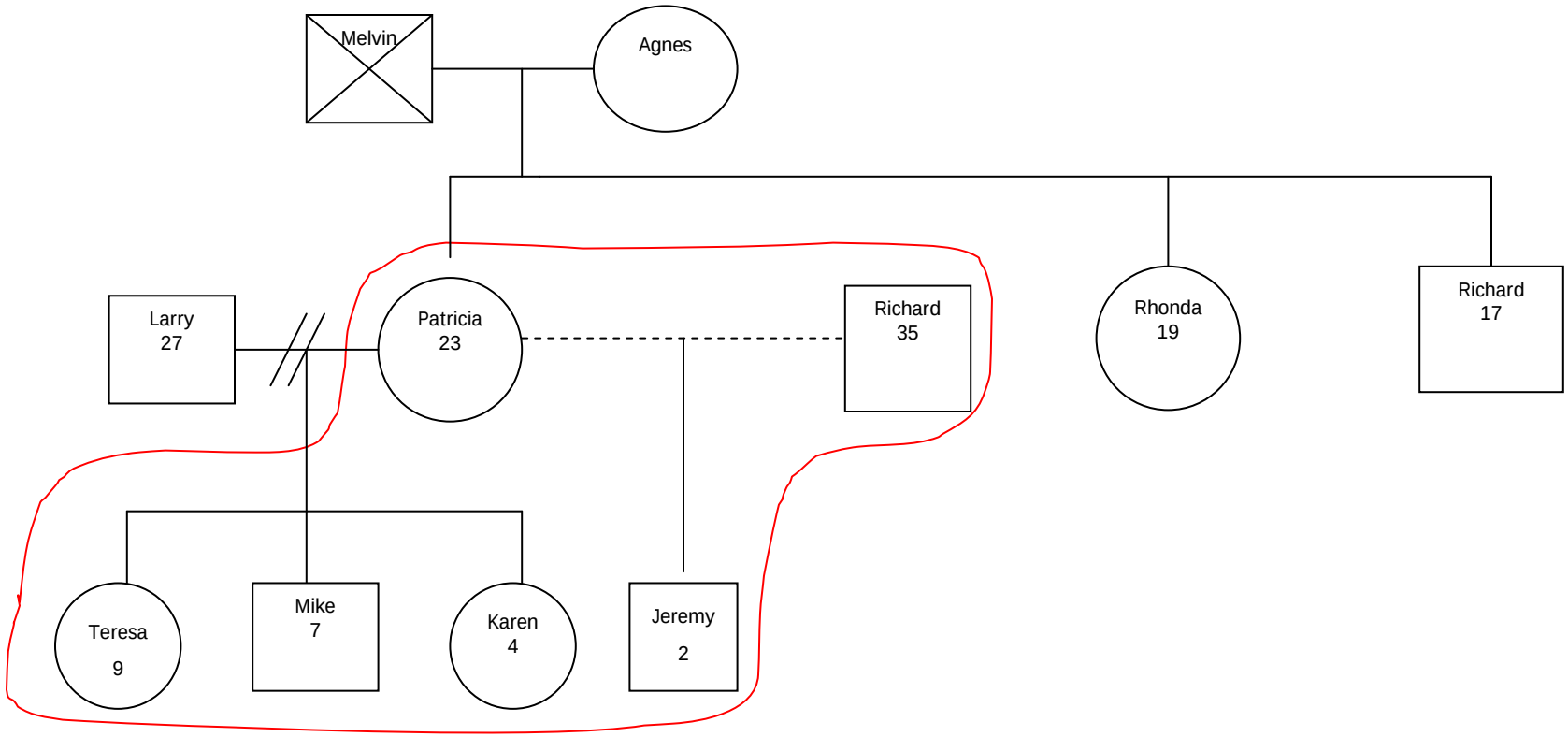
Pictorial Tools: Genogram

Genogram Symbols

- People are depicted as squares, circles, or triangles (square = male, circle = female, and triangle = sex unknown.)
- A marital pair is indicated by a line drawn from the male to the female. It is useful to record the marriage date, especially the year, on this line.
- A break in a relationship is indicated by double hatching (//) through the line connecting the two people. This is most commonly used for death or divorce but could be used to depict family members who no longer maintain contact with each other. Dates, especially years, should be recorded.
- Offspring are generally entered according to age, starting with the oldest on the left side.
- Generations are charted vertically through time.
- An adopted child is identified by a small “a.”
- Admitted, but not legally confirmed, relationships (i.e., “common-law” marriages and same-sex relationships) may be indicated by a dotted line.
- A family member who is no longer living is generally indicated by drawing an “X” through the figure and giving the year of death.
- Relationships are indicated by lines (strong relationship = solid, thick, or parallel lines; tenuous/weak relationship = broken or dotted line; stressful/conflicted relationship = hatching across the line or “railroad tracks”).
- It is useful to draw a circle around the family members who compose the household you are diagramming.

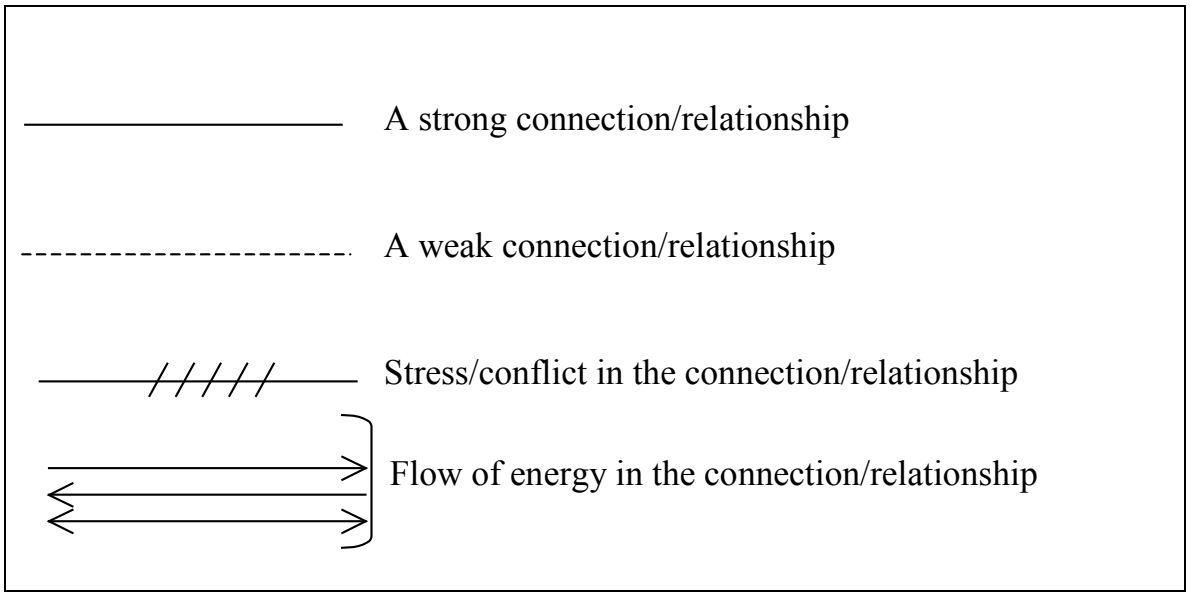
It is also useful to chart the skeletal structure of the family first, then add details related to family dynamics.

Example of a Genogram

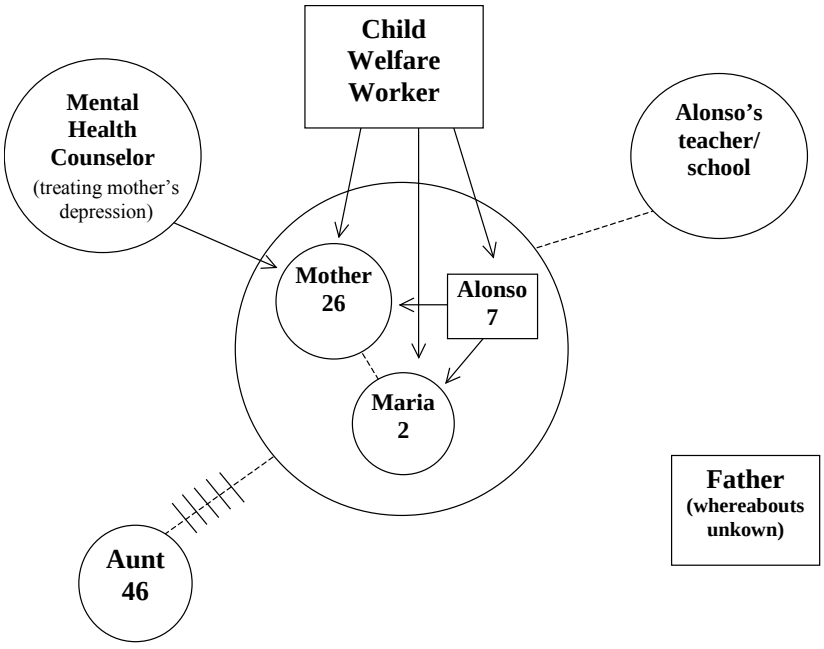


Pictorial Tools: Eco-Map

Eco-Map Symbols



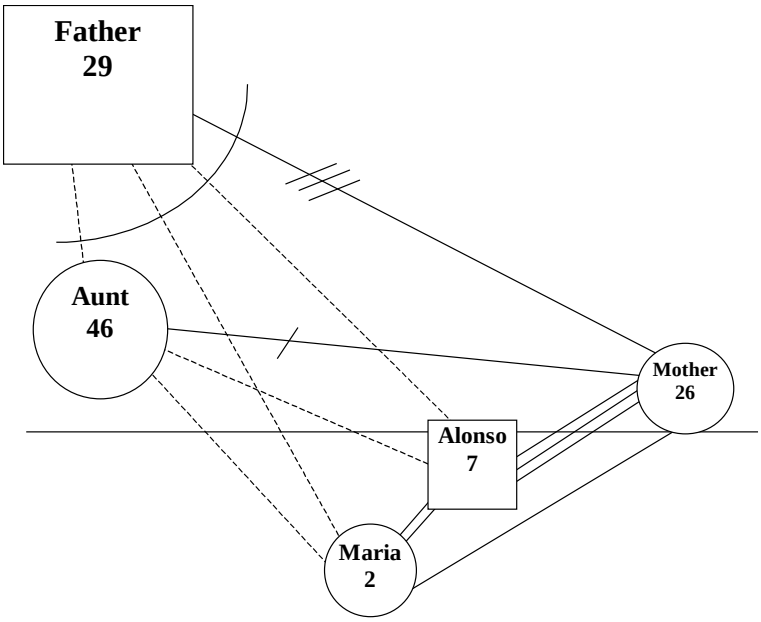
Example of an Eco-Map



Pictorial Tools: Family Map

The family will identify who resides in the household and their current system dynamics. The Family Map provides a visual image of the following aspects of a family system: a) Which family members hold the most and least power (*power* meaning how much influence a person has over the other family members' behavior and/or emotions and/or decision-making); b) How parent-child boundaries are acted out in the family (*parent-child boundaries* referring to whether parents maintain an adult role or allow/encourage children's roles to blur into becoming adult-like, as when parents hold unreasonable expectations that the children meet parents' physical and/or emotional needs, e.g., children parenting themselves, becoming managers of the household or becoming the parents' sexual partners); and c) How the various members of that family system interact and relate to one another.

Example of a Family Map



Family Map Symbols

Figures:

Female — Mother (M) — Age (children) (14)

Male — Father (F) — Deceased grandfather (GF) (Still important to family)

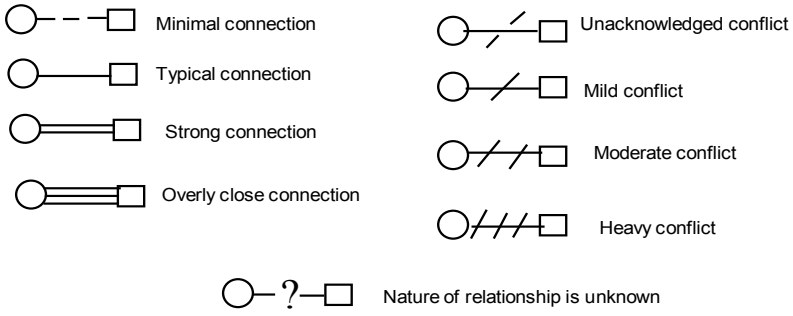
Adopted 14-year-old daughter (A, 14)

Family member who is "cut off" through divorce, abandonment, prison, etc.

Power: Indicate by the size of the male/female figures
a) influence a family member has on the actions and emotions of other family members
b) the family member(s) who most control the decision-making process in the family

Boundaries: Indicate generational boundaries with a line that illustrates parent/child roles. Place figures by line that represent the figure's role within the family.

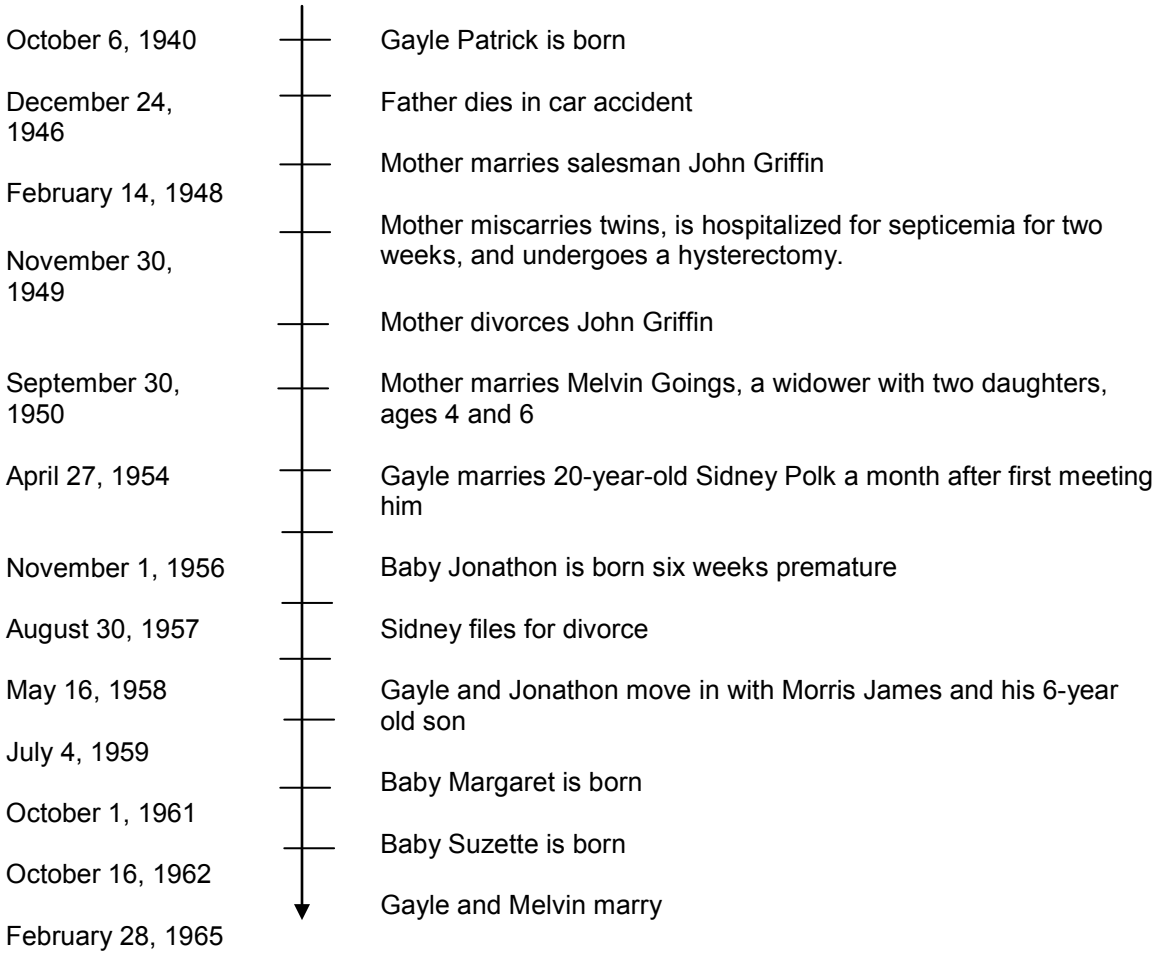
Closeness/Distance with relationships are indicated by different lines between members.



Pictorial Tools: Timeline

The family will identify significant events, key dates and provide a brief description of the event, including who was present. Family members are asked to include the most significant events, especially those that are highs and lows. Reflecting on the timeline can help the family see how they have responded to those events. It will help them examine the variety of ways they have been influenced by events that have been both positive and negative in their lives. This tool can help clarify strengths and help validate the skills that were used to respond to some of the most difficult issues in the family's life.

Example of a Timeline



State of Tennessee
Department of Children's Services

Administrative Policies and Procedures: 31.7

Subject:	**Building, Preparing and Maintaining Child and Family Teams**
Authority:	Brian A. Settlement Agreement; TCA 37-5-106
Standards:	DCS 5-201, 5-202, 5-203, 5-204, 5-401, 5-402, 5-500, 6-507 B
Application:	All DCS Family Service Workers, Provider Agency Staff, CPS Case Managers, and Supervisory Staff

Policy Statement:

Building, preparing and maintaining Child and Family Teams is the model utilized by DCS staff to ensure that families and their support systems are engaged in the planning and decision-making process throughout their relationship with the Department. This team will be convened at certain critical junctures in the case, and it is expected that work with members of the team will be an ongoing process based on the needs of the child and family. DCS will establish working relationships with the Child and Family Team (CFT) that shall be characterized by behaviors that impart respect for human dignity, full disclosure of information, inclusion in the decision-making process, and an awareness of the appropriate use of authority in serving families. Through the use of quality Child and Family Team Meetings (CFTM), accompanied by ongoing work with the child and family team, this model will be utilized to address critical decisions around the placement of children; for the continuous assessment of family strengths and needs; for making permanency decisions and developing individualized case plans; and for conducting ongoing reviews to ensure that plans are being implemented toward achieving permanency for children who are in DCS custody. Staff from DCS will partner with families, their support systems, and private provider staff to ensure that best practice, timelines, and professional standards are met to the maximum extent possible.

Purpose:

Child welfare is a community responsibility requiring a collective approach. The process of building, preparing and maintaining Child and Family Teams ensures that families are included in decision-making and that community supports are engaged to help families meet their needs. The Child and Family Team process is used to engage a group of committed individuals who will work to strengthen the family and help it craft an individualized case plan. This model of practice emphasizes family strengths, mobilizes community resources, and involves all those concerned with the child and family in developing and monitoring plans that will maximize the safety, permanency and well being of the children involved.

Procedures:

A. Engagement of the Child and Family Team	1. From the first contact a family or child has with DCS, they should be engaged with empathy, genuineness and respect. It is important that the child and family are part of a trust-based, mutually-beneficial helping relationship with the DCS worker so that they can be active participants in shaping and directing service arrangements that impact their lives. Collaborative and open casework relationships foster an atmosphere of trust when case managers demonstrate competence and empathy, and communicate a belief in family strengths and

	resilience. When families are engaged in collaborative and open decision making and case planning, they understand their roles in the change process and are better able to develop substantive relationships with case managers and other individuals and agencies with which they work. 2. As risk and safety are being assessed, staff must make every effort to validate the child/family's feelings, elicit their understanding of their strengths, needs, and circumstances, and help them to identify other resources in their family, network, or community that could offer support. These individuals, along with DCS staff, other professionals from community providers, and resource parents should form the foundation of an ongoing, functioning team that will work with the family and DCS to: a) secure the child(ren)'s safety in the least restrictive, least intrusive placement that can meet their needs; b) minimize the trauma associated with separation from family and help the child to maintain meaningful connections with family members and others who are important to him or her; c) contribute to an ongoing assessment of the child and family's strengths and needs; d) develop and support the implementation of quality permanency plans and individual program plans for youth in a YDC; e) ensure that plans are monitored for progress and participate in revising or updating plans as the family/child's circumstances change; f) support the stability of appropriate placements while in DCS custody; and, g) facilitate the timely achievement of permanency for children. 3. Members of the Child and Family Team (CFT) should be actively engaged throughout the department's work with the family. A Child and Family Team Meeting (CFTM) will be convened at certain critical junctures in the life of a case, as well as on an as-needed basis, to help the family and the department work together to achieve permanency for children as soon as possible. The Family Service Worker (FSW) coordinates the efforts of the team to ensure that everyone understands their role and responsibility to help the family achieve their long term goals, or, in the event the family is not a viable resource for the child, to work toward finding a permanent, nurturing home for each child in care.
B. Teamwork and Coordination	1. The FSW has the primary responsibility for building, preparing and maintaining the Child and Family Team. This requires working closely with the family to identify their support systems, extended family members, and community resources that can help the family achieve their goals. The family and child (if age-appropriate) should always be central to the decision-making and planning process of the Child and Family Team. 2. Collaboration among team members from different agencies is essential. Evidence of team functioning lies in its performance over time and the results it achieves for the child and family. The focus and fit of services, authenticity of relationships and commitments, dependability of service system performance, and connectedness of the child and family to critical resources all depend upon an

effective Child and Family Team process.

a) Convening the Child and Family Team

i. The development of the Child and Family Team begins when there is any risk that a child may be removed from his or her home. The Child and Family Team is convened to explore the safety and risk issues, assess how to meet the child's needs for safety in the least restrictive, least intrusive manner possible, and examine whether there are other family resources that can care for the child. No child should enter the custody of DCS without the convening of a Child and Family Team Meeting. In the event a child is removed on an emergency basis, or adjudicated by a juvenile court for delinquency and placed into DCS custody, the team should be convened as soon as possible to ensure that placement is the best alternative to keep the child safe; that the specific placement is appropriate to meet the child's needs; that the resource parents or other provider have the information they need to care for the child; and, that a visitation schedule is arranged with the family. At this meeting, DCS staff should explore who else could be added to the team, such as informal supports, extended family, and community providers. All team members should be prepared to participate in a CFTM for the development of the permanency plan and/or the individual program plan.

ii. The development of an individualized, comprehensive permanency plan depends upon a full, functioning team that can identify the child and family's strengths and resources; address their needs; help them articulate their long term view; identify how to resolve the issues that required DCS intervention; generate creative solutions; and, share the responsibility for helping the family and child overcome any barriers to child safety, permanence, and well being. The more participants engaged in permanency planning, the more likely that permanency plans will be tailored to the child and family's specific needs.

iii. The Child and Family Team should also be re-convened periodically for the revision and tracking of the permanency plan, to ensure that plans are relevant, that progress is being made, and that plans are revised as needed to address any new issues that may emerge. The team should participate in a child and family team meeting whenever a change of permanency goal is being considered.

iv. Disruptions in continuity of care are damaging to children. They can result in additional trauma, delayed development, interruptions in education, and interfere with a child's ability to attach and trust others. No child in DCS custody should change a placement without convening a Placement Stability Child and Family Team Meeting. This meeting is to assess whether that placement is meeting the child's needs; what DCS and the team can do to support the placement, if it is appropriate; or, if not, to help identify a more appropriate placement for the child. It is also necessary, when a change of placement has been planned and represents a move toward permanency, for the team to meet and ensure that all of the services are in place to make that placement successful.

- Depending upon the circumstances for a change of placement,

it may not be necessary to have the full team involved in these meetings. However, the youth, the family, DCS staff, private provider staff (if providing care) and the caregivers should all participate to help identify the resources needed to stabilize the child and ensure a successful placement.

- ♦ In the event a placement disruption has taken place without sufficient time to gather the team, it is still good practice to convene a Placement Stability Child and Family Team Meeting to examine the issues that prompted the disruption, to assess how the child is adjusting to the new placement, and whether the child needs additional services or supports to maintain that placement.

v. Before a child is leaving custody or beginning a trial home visit, a Discharge Planning CFTM should be convened to ensure that all the needed risk and safety issues have been resolved and that there are services in place to support a successful transition.

vi. There may be other occasions when the wisdom and support of the child and family team are crucial to ensuring that services are being delivered, that the barriers to permanency are being addressed, the child and family's needs are being met, and that every effort is being made to minimize the damaging effects of out-of-home placement for children.

vii. Please refer to the Child and Family Team Meeting Protocol for more guidance on the critical junctures that require a Child and Family Team Meeting and what should occur at each type of meeting.

b) Preparing and Planning for the Child and Family Team

i. Advanced preparation is essential to a quality CFTM. DCS staff must ensure that families and other team members are prepared for the purpose of the Child and Family Team Meeting and what they can expect to take place. This includes preparing the family and youth for the issues that will be discussed and exploring with them how difficult or sensitive issues could be handled. FSWs should spend time prior to each meeting helping the family/youth articulate their current situation, to identify their strengths and needs, and to explore their desired outcomes. Similarly, other members of the team should be informed of the purpose of the meeting and how they can contribute to the decisions that must be made and the development of action steps that will result from the meeting.

ii. In the course of preparing the family for the meeting, the FSW can gather valuable assessment information to develop or update the Functional Family Assessment.

iii. When a skilled facilitator will be conducting the meeting, the FSW should have a pre-meeting consultation to prepare the facilitator for the meeting and alert him or her to any special issues or considerations needed.

iv. DCS staff shall plan Child and Family Team Meetings for times and locations that are convenient to the family and child(ren)/youth. Efforts shall be made to schedule the meeting to accommodate as many team

members as possible. The location of the meeting should be conducive to the private discussion of family issues.

v. The FSW must also assess any safety concerns, such as domestic violence or other sensitive issues to be discussed in the meeting, when determining an appropriate location and who should be included in the meeting.

vi. Families and community partners should be given adequate notice of non-emergency meetings, preferably ten (10) calendar days in advance if in writing or seven (7) calendar days if notified by telephone. The ***CS-0746, Meeting Notification*** may be used to provide written notice of any CFTM called by DCS staff. Efforts to schedule meetings and accommodate team members should be clearly documented in the case recording section of TN Kids.

vii. DCS should provide services to support the participation of parents and relatives in Child and Family Team Meetings. Such services may include transportation, childcare, interpreter services, and any other services that would facilitate and support the family's participation.

c) Members of the Child and Family Team

i. The FSW, birth parents, and family members form the core of the child and family team. Other members can be anyone identified by the family, as well as service providers or other professionals serving the child or family. Because it is considered the "family's" meeting and confidentiality must be maintained as much as possible, the family must agree to the inclusion of community members and other professionals who may not be directly related to the case. The FSW must engage the family in exploring how a diverse team could help them resolve their issues more quickly and provide more ongoing support outside of DCS.

ii. A diverse team is preferable to assure that the necessary combination of technical skills, cultural knowledge, community resources and personal relationships are developed and maintained for the child and family. Collectively, the team should have the expertise, family knowledge, authority and ability to flexibly mobilize resources to meet the child's or family's specific needs. Members of the team should have the time available to fulfill commitments made to the child/family. Team competence, support, and ongoing involvement are essential.

iii. The goal of the Child and Family Team Meeting should influence who should participate in any particular meeting, but the child and family must always be the centerpiece of every CFTM. DCS must help youth and families to identify individuals that they want to become part of their team, people they can turn to in a crisis and rely upon. The FSW must make every effort to engage extended family and community-based, informal supports that will continue to help the family after DCS is no longer involved.

- **Child/Youth**
  - Children and youth who are at least 6 years and older should be involved in the planning process to the extent that they are capable of participating. All children and youth who

are 12 years of age and older should be included and prepared to participate in the meeting to the extent that is age-appropriate. In some cases, children younger than 12 can participate in the meeting, according to his or her maturity level and ability to understand. Arrangements should be made to escort younger children out of the meeting and provide supervision when the discussion of sensitive or difficult topics must take place. Usually it's best to include the child in the beginning of the meeting to get his/her understanding of the situation, explore the child's needs and adjustment to placement, etc., and then excuse the child for discussions regarding the treatment needs of parents. Exceptions to this policy must be clearly documented in the case record, with an explanation for why the child's participation would be contrary to his/her best interests.

- o Generally, children/youth and families should be involved together in their Child and Family Team Meetings. However, consideration shall be given to issues related to safety or highly-charged emotional issues, which may call for some adaptation to the meeting format. Staff shall assess this issue on a case-by-case basis and provide alternative means of participation if the child/youth's best interest warrants the exclusion of any team members. Careful preparation for the CFTM will help the FSW assess whether special considerations or adaptations are needed.
- o A Child and Family Team Meeting can be very intimidating to young people. Youth should be encouraged to bring someone with them that they trust, who will help them feel more comfortable. Most youth will need frequent encouragement to participate, as well as protection from team members who may tend to focus only on the youth's behaviors or problems.

♦ **Parent/Families (Including legal, biological and alleged fathers)**

- o Unless a parent's rights have been terminated or surrendered, the department must include all known parents, including legal and biological fathers, in the Child and Family Team process. Depending upon the relationships and circumstances of the family, alleged fathers may need to be included, as well.
- o The Department shall conduct diligent searches (Conducting Diligent Searches, Policy 16.48) throughout the life of the case if there are any unidentified parents, or the Department does not know their whereabouts. Efforts to locate parents should be clearly documented in the case record.
- o The incarceration of a parent will not be a barrier to their participation in the CFTM and permanency planning process. By law, DCS must create opportunities for all

parents to participate in the plan and to meet their parental responsibilities. This may be accomplished by having meetings where they are located, or by arranging for them to participate by telephone.

- o Extended family members and other support persons identified by the family or DCS should also be invited to participate.

♦ **Trained Full-Time Facilitator or Back-up Facilitator**

- o These are staff that have completed the Advanced Facilitation Training and have been certified as a skilled facilitator, whether working full-time as a facilitator or serving as a back-up facilitator. The facilitator is primarily responsible for the process of the CFTM, which includes ensuring that everyone participates and is heard; that everyone understands the purpose of the meeting; that all the relevant safety and risk issues are being addressed; and that the team reaches a consensus on the decisions to be made. The facilitator guides the meeting through a logical process, helping to resolve any differences that may arise, and ensuring that by the end of the CFTM, there is a plan of action developed, with the responsible persons and time frames clearly identified.
- o It is mandatory in all regions that a Trained Full-time Facilitator or Back-up Facilitator conduct all Initial CFTMs and all Placement Stability CFTMs.
- o CFTMs held for the development of permanency plans, the review of progress on permanency plans, or the revision of a permanency plan does not require the use of a skilled facilitator, but one may be requested if one is needed. Regions have the flexibility to determine when they will require a Trained Full-time or Back-up Facilitator for CFTMs apart from the Initial and Placement Stability CFTM.
- o Whenever possible, efforts should be made to ensure that the same facilitator who conducted the Initial meeting remains involved with the family for subsequent meetings.
- o A Trained Full-time or Back-up Facilitator is not required to facilitate Discharge Planning CFTMs.
- o In the event there is a Special Called CFTM, the team may request the presence of a Trained Full-time or Back-up Facilitator, or the FSW or Team Leader can facilitate the meeting, depending upon the nature of the concerns and the parties involved.

♦ **Child's Family Service Worker**

- o The Family Service Worker is responsible for working with the family and team to coordinate the resources needed to meet the needs of the child and family. As described above, the FSW helps the family identify who should be

included on the team, prepares the team members, schedules meetings, and maintains contact with team members as needed between meetings, to ensure that the agreed-upon action steps are being taken. During the CFTM, the FSW is primarily responsible for the content being discussed, i.e., the worker must be prepared to explain why the meeting was needed, describe the precipitating events, the current situation, the history of the problem, what strengths have been identified within the family/youth, and the worker's recommendation. In the absence of the FSW, the Team Leader is expected to present the case and the department's recommendations in the CFTM. For youth placed in a Youth Development Center (YDC) the meetings should be arranged and scheduled by the YDC case manager, but the FSW responsible for the case must participate in the CFTM, even if it is by telephone or via video conferencing.

- **Team Leader**
  - The Team Leader (TL) for the case is required to participate in all Initial CFTMs and all Initial Permanency Planning CFTMs. In the event the Team Leader is not available, another Team Leader can participate in his or her place. It is highly recommended that the Team Leader participate in CFTMs convened for the purposes of reviewing the progress on the permanency plan or to consider a change in the permanency goal, since the Team Leader is responsible for ensuring that children and families are moving toward permanency. For any FSW with less than 1 year of experience with DCS, there must be a Team Leader or FSW 3 participating in CFTMs convened for any reason.
  - For more experienced FSWs, a Team Leader can exercise judgment in deciding whether their participation is needed, based on the competence of the FSW, the complexity of the case, and the availability of others who can participate, such as a FSW 3 or other regional staff.
  - The Team Leader must participate in all Discharge Planning CFTMs, regardless of the FSW's level of experience.
  - In the above instances described, when the assigned Team Leader is unavailable to attend the meeting, he/she can send another Team Leader or an FSW-3 in his or her place.
  - The assigned Team Leader must attend a CFTM for every case under his or her supervision no less often than every 6 months.
- **Resource Parents**
  - Resource parents with DCS or a contract agency are crucial members of the child and family team. Every effort should be made to ensure their full participation in CFTM's. For Initial and Permanency Planning CFTMs, this may involve

	working with the biological family to help them appreciate the benefit of the resource parents' attendance. For CFTMs held to preserve a placement or to explore placement options, it is very important to have the resource parents there, if at all possible. ♦ **Other Participants** o Depending on the purpose of the meeting, Child and Family Team Meetings may also involve some of the following individuals: o Specialized DCS staff persons may be needed to support the work of the child and family team. These may include, but are not limited to, Assessment/Non-Custodial staff that may have worked with the family in the past, Education Specialists, Health Unit Members, Juvenile Justice Staff, DCS Legal Staff, Independent Living Staff, MSW Consultants, and Permanency Specialists. Staff should exercise judgment to avoid overwhelming the family with too many professional staff. o Therapists and/or contract agency staff involved in providing services to the child/youth, family, and/or other identified permanency option; o Any former legal custodian for the child; o Court Appointed Special Advocate (CASA) Volunteer; o Community Partners, including education or school staff where the children attend school, and other support persons identified by the Department. Please note that the inclusion of these parties is subject to the parent(s) consent; o Informal supports that are identified by the family or youth as resources; o Attorneys, to include the guardian ad litem and the attorney for the child/youth's parents; o Persons external to the case, such as OJT coaches, observers, or others not directly involved in the case should not be included without obtaining the permission of the family; and, o An interpreter, as needed.
C. Assessing and Understanding the Child and Family Team	1. The Child and Family Team have an important contribution to make to the FSW's ongoing assessment and understanding of the family and child(ren). This is particularly true with informal supports and extended family members, who know and care about the family. The FSW should explore how each team member perceives the strengths and underlying needs of the family, the risk and safety issues presented, and what is necessary for the child to achieve a permanent home that will meet his/her needs. 2. Members of the team should have a shared understanding of the family that is reflected in coordinated efforts consistent with the goals agreed upon by

the Child and Family Team. As goals are achieved, the team is engaged in reassessing the progress made and modifying strategies or services as needed, to address any new information or problems that may arise.

3. The content of a CFTM should be focused around the purpose of that meeting; and the purpose should guide which team members participate. Assessment information should be shared with the family and their views must be incorporated into the FSW's overall assessment.

4. There is a general agenda for each CFTM that should elicit assessment information and the team's insight into the child and family's strengths, needs, and circumstances. Please refer to Stages of a CFTM for a detailed description of a CFT Meeting agenda. Some highlights follow, which demonstrate how assessment and understanding are woven into the CFTM process:

a) Introductions

Participants are introduced and the purpose of the meeting is made clear to everyone.

b) Identify the Situation – The Family Story

i. This includes clearly identifying the current situation; what precipitated the need for the meeting, and what decision(s) need to be made. DCS staff must support the child and parents/caregivers in sharing their story related to their current situation, their concerns, and in defining what they would like to see result from the meeting.

ii. Every member of the team should be invited to contribute to the team's understanding of the immediate situation before the meeting progresses to the next stage.

iii. Check for consensus that the present situation has been fully identified before moving on

c) Assessing the Situation – Identify Strengths/Needs Concerns

i. The family is invited to identify the strengths, resources and capacities they have to help them address the concern(s). Every member of the team is encouraged to contribute to the list of strengths they see in this family

ii. The team must examine and assess all of the safety and risk issues associated with the concerns identified and the impact these issues may have upon the children involved. This should include some discussion of the history of the problem.

iii. The team should review what services have been utilized to support this family and the effectiveness of those services so far. The family should be encouraged to identify any informal supports they have.

iv. The family and team explore what underlying needs may be contributing to the issues or concerns presented. The child/family/caregivers are helped to articulate what they need to address the concerns; for example, to take care of their children at home, or to maintain the stability of the child's placement.

v. Sensitivity and judgment should be exercised when families or

	youth are reluctant to discuss certain issues in the large group. It is good practice to provide alternatives in the event families are not comfortable addressing all of the issues with the entire team present. vi. The FSW should inform the team of his or her recommendation for this situation. 5. Ensuring that the team works through the stages of **Identifying the Situation** and **Assessing the Situation** prepares them to **Brainstorm Solutions** and **Develop a Plan** that will utilize the resources the Child and Family Team have to help the family meet their goals. 6. Effective CFTM's should engage all family and team members in an ongoing process of assessment and understanding of what the child and family needs to ensure that children are in a safe, permanent home.
D. Planning and Long-Term View	1. The child/family should have a single integrated permanency plan developed by the child and family team that works as a comprehensive, dynamic service organizer and is focused by the long-term view for the child and family. The permanency plan specifies the goals, roles, strategies, resources, and schedules for the coordinated provision of assistance, supports, supervision, and services for the child, caregiver, and family. 2. The broader the representation on the team, the more likely that case plans will be developed that are specific to each family's needs, providing a mix of services and supports that will maximize the resources of the Child and Family Team. 3. Please refer to Policy 16.31Permanency Planning for Children/Youth in the Department of Children's Services Custody for guidance on the permanency planning process. 4. In addition, plans should address the desired outcomes and the long-term view for the child and family. The FSW and the team should encourage the family to explore how they want their family to be in the future, beyond the resolution of the immediate safety issues necessitating DCS involvement. There should be a shared vision among the team defining what things must change and the steps it will take to achieve the goals for the child and family to maintain the change once the case is closed. 5. To be acceptable, a child and family permanency plan should: a) be based on the big picture assessments, including clinical, functional, educational, and informal assessments; b) reflect the views and preferences of the child and family; c) be directed toward the achievement of strategic goals and success of the child; d) be coherent in design, balanced in the use of formal and informal supports; e) be culturally appropriate; and, f) be modified frequently, based on changing circumstances, experience gained, and progress made.

	6. The written child and family permanency plan defines the outcomes and reflects the collective intentions of the Child and Family Team - it describes the path and the process to be followed in order to ensure that children are safe and permanency is achieved in a timely fashion. 7. The Child and Family Team planning process should drive the implementation of strategies, actions, and services.
E. Tracking and Adaptation	1. The FSW is responsible for following up on referrals and tasks assigned to the members of the team to ensure that the services and strategies developed in the plan are being executed in a timely and competent manner. This requires coordination and resource management to ensure that progress is being made. The FSW must maintain regular contact with the family and team to ensure that: a) The strategies, actions, and services planned for the parent/family and child are being implemented in a timely, competent, and dependable manner, consistent with family-centered practice and necessary cultural accommodations. b) Actions, supports, and services linked to change strategies are being provided at a level of intensity and continuity necessary to meet priority needs, reduce risks, facilitate successful transitions, and achieve adequate daily functioning for the parent and child. c) Service providers (e.g., social workers, care staff, teachers, therapists, tutors, mentors) are receiving support and supervision necessary for adequate role performance in conducting the planned change strategies for the parent and child. 2. The FSW reconvenes the Child and Family team for reviews and revisions of the permanency plan when changes are needed, such as services are not being provided as planned, the child or family is not responding well to the services, or new issues have arisen that the team must address. 3. An ongoing examination process should be used to track service implementation, check progress, identify emergent needs and problems, and modify services in a timely manner. 4. The service plan should be modified when objectives are met, strategies are determined to be ineffective, new preferences or dissatisfactions with existing strategies or services are expressed, and/or new needs or circumstances arise. The FSW must play a central role in monitoring and modifying planned strategies, services, supports, and results. Team Leaders should be reviewing the progress on permanency plans with FSWs on a quarterly basis, at the least. Members of the Child and Family Team (including the child and family) should apply the knowledge gained through ongoing assessments, monitoring, and periodic evaluations to adapt strategies, supports, and services. 5. Following a CFTM, the development and progress of the work done with the family is documented, as follows: a) The meeting and outcomes, as well as permanency plans, (if developed), shall be documented in TNKids. b) Additional assessment information gathered from any CFTM should be entered into the Family Functional Assessment by the

	FSW. c) If the child or his/her birth parents did not attend or participate, this must be documented in TNKids, with a description of the efforts that were made to encourage the family's participation. d) For meetings in which a permanency plan is not developed or revised, the ***Child and Family Team Meeting Summary, form CS-0747*** shall be provided to all participants and a copy shall be placed in the case file. The team leader must review and sign off the summary. e) For Initial Permanency Planning CFTMs, a written draft of ***Permanency Plan, form CS-0557,*** should be given to all participants at the close of Permanency Planning CFTMs. Typed copies can be provided to all team members upon completion of the plan in TN Kids. Policy 16.31 Permanency Planning for Children/Youth in the Department of Children's Services Custody for more details about preparing the plan, providing copies for the parents' signatures, and in the event the parents sign a handwritten copy which is later typed, having both versions available at court for the parents and attorneys to review and approve. f) For Discharge Planning CFTM's, the ***Child and Family Team Meeting Summary, form CS-0747*** shall be used to document the discharge plans made and provide the child/family with the contact information for the FSW and TL, in the event they need any additional help to ensure a successful discharge. g) All CFTMs should be documented in the Reviews, Hearings & CFTM icon of TNKids.
F. Child and Family Team Meetings for Delinquent Youth in Youth Development Centers	1. Youth Development Centers have some unique challenges to practicing a child and family team model as envisioned in this policy. Some families may live far from the facility; others may be highly reluctant to be involved in this manner; and, the role of the court may limit some decisions the child and family team can make. Nevertheless, DCS believes that involving families whenever possible is critical to helping delinquent youth succeed in their rehabilitation and to prepare them to return successfully to their families and community. 2. CFTMs are to be conducted at the following critical junctures of a case. Those that require the use of a Trained Full-Time or Back-Up Facilitator (either YDC or regional staff) are **Initial CFTMs** and **Placement Stability CFTMs** when an unplanned move appears imminent or has just occurred (See Child and Family Team Meeting Protocol). **a) Initial CFTM** - The Initial CFTM is held primarily to assist in preventing State's custody, prior to a CPS preliminary hearing or within 7 days before or after the date of custody. For youth entering the YDC, if an Initial CFTM has taken place prior to admission to the facility, another Initial CFTM is not required. All Initial CFTM's are to be conducted by a Trained Full-Time or Back-Up Facilitator (YDC Staff or Regional Staff). A Team Leader must be in attendance at the Initial CFTM.

b) Classification/Individual Program Plan/Permanency Plan Development. The identification of a student's classification, the development of the IPP and the Permanency Plan shall be done in a CFTM. Classification shall be completed within fourteen (14) days of the student's arrival at the center.

CFTMs convened to develop plans do not require a Trained Full-Time or Back-Up Facilitator. However, if the Classification/IPP/Permanency Planning process is being conducted as part of the Initial CFTM, it does require a Trained Full-Time or Back-Up Facilitator.

c) Placement Stability/Unplanned Program Transfer/Disruption- Decisions regarding a disruption, or an unplanned transfer from one YDC facility to another shall be made in a Placement Stability CFTM. These CFTMs require the use of a Trained Full-Time or Back-Up Facilitator. Note: This policy does not supersede DCS Policy 12.10, Transfers between DCS Operated Facilities that allows the superintendent to decide whether a youth should be moved on an emergency basis before a CFTM can be arranged. However, a CFTM with a Trained Full-Time or Back-Up Facilitator should be convened as soon as possible after the move.

d) Placement Stability/Planned Program Transfer - A Placement Stability CFTM is also required for any planned transfer or step-down from the facility, but these CFTMs do not require the use of a Trained Full-Time or Back-Up Facilitator.

e) Discharge Planning/Release - Decisions regarding a release from custody shall be made during a Discharge Planning CFTM to ensure that all safety and risk issues that necessitated custody have been adequately addressed and resolved. This CFTM will allow the team to determine whether necessary supports are in place to support the youth and family once the student has been discharged or released. A YDC Team Leader, Regional Team Leader or CM3 is required to be in attendance at this meeting. This meeting type does not require a Trained Full-Time or Back-Up Facilitator.

f) Progress Reviews/Quarterly Reviews/Staffings – A CFTM should be convened for Quarterly Progress reviews no less often than every three months. These in-depth reviews shall be for the purpose of determining whether the IPP is being implemented to meet the individual needs of the student. More specifically, they are to be utilized to make decisions regarding the student's current status; determine the readiness for step-down; identify the need for increased services or interventions; or, to make changes in the current services or interventions. A Trained Full-Time or Back-Up Facilitator is not required for these reviews.

Staffings are held on a monthly basis on all youth in a YDC to assess that the youth's current goals, objectives and interventions continue to meet the youth's treatment needs.

g) Special Called CFTMs - Any team member, including the youth or the youth's family, may request a CFTM at any point during the life of a case. The need for a Trained Full-Time or Back-Up Facilitator should be

determined by the nature of the case and the request. These CFTMs should be recorded as "Special Called" in the Reviews, Hearings & CFTM icon in TNKids.

h) **Documentation -** With the exception of Permanency Planning CFTMs, all CFTMs should be documented on the ***Child and Family Team Meeting Summary Form, CS-0747***. Each team member is provided a copy of the Child and Family Team Meeting Summary at the conclusion of the meeting. This form will serve as the Discharge Plan for Discharge Planning CFTMs. Other planning-related CFTMs can be documented by the Permanency Plan that is developed or revised during the meeting.

YDC staff will continue to document other internal monthly, quarterly progress, or other administrative reviews according to current policy and practice.

3. Additional Considerations for CFTMs:

a) If interpreter services are required for a CFTM, the YDC residential case manager shall make arrangements as needed.

b) The YDC residential case manager shall inform the youth, family, and family services worker about the purpose of the CFTM and clarify the goal and desired outcome of the meeting.

c) Advanced planning to ensure the participation of families and family service workers is necessary. Conference calls, video conferencing etc. may be used to ensure the participation of families and FSWs when their physical presence is not possible. The Child and Family Team Meeting may proceed when their (FSW or parent/guardian's) participation has been arranged. YDC staff shall document their efforts to secure the participation of the family and family services worker in TNKIDS case recordings.

d) In the event the child and family team cannot come to a consensus decision, the facility Superintendent and Regional Administrator (or his or her designee) shall review the case, confer with the team and make the final determination.

e) In the event that neither the youth nor his or her family participates in a scheduled CFTM, the meeting should not be considered a CFTM. It should not be documented as a CFTM, but rather as an administrative review or staffing. Reasonable efforts to include the youth and family should be documented in TN Kids.

Forms:	***CS-0746 - Meeting Notification*** ***CS-0747– Child and Family Team Meeting Summary***

Collateral documents:	**Child and Family Team Meeting Protocol** **Stages of a Child and Family Team**

REFERRAL CRITERIA & RESPONSE TIMES

Referral Criteria for CPS Involvement

1. There must an alleged *child victim* under the age of 18 at the time of the report.
2. There must be a *relationship* between the alleged victim and the alleged perpetrator. The alleged perpetrator must have a care-giving role with the child, such as a parent, or other person living in the home, an educator or employee of any setting that is responsible for the care of the child, any individual providing treatment or care or supervision for the alleged victim. Allegations regarding the maltreatment of a child by a non-caregiver or family member are reported directly to law enforcement for investigation.
3. There must be an *allegation of harm* as described in policy Chapter 14, Work Aid 1.
4. The report must contain information which would allow the department to *locate and identify* the alleged victim.

There are exceptions to the rules above when sexual abuse is alleged.

- The department accepts all allegations of sexual abuse of a child *under the age of 13*, *regardless of the relationship* to the alleged perpetrator. If the child is older than 13, the alleged abuse must have occurred prior to the child turning 13.
- The department accepts referrals of sexual abuse on children between the age of 13 and 18, whose alleged perpetrator has a relationship with the child, such as a parent, caretaker, other person living in the home, educator, or someone who is in any way responsible for the care of the alleged victim.
- DCS will accept reports alleging sexual abuse when the reporter is unsure about the identity and relationship of an alleged perpetrator.

Response Priorities:

- **P-1**: Cases where the child may be in imminent danger. Face to face contact should be initiated with victim(s) immediately, but no later than 24 hours after the referral.
- **P-2**: Face to face contact should be initiated with the victim(s) within 48 hours of the referral. Alleged injuries or risk of injuries are not imminent, life threatening or do not require immediate medical care and in which a 48 hour delay will not compromise the investigative effort or reduce the chances for identifying the level of risk to the child.
- **P-3**: Face to face contact should be initiated with the victim(s) within 3 business days of the referral. These include allegations in which the risk of harm to the child is low and where a three day delay will not compromise the investigative effort or reduce the chances for identifying the level of risk to the child.

Tennessee Department of Children's Services

Priority Response Definitions/Examples

1. **Priority-1 reports allege that children may be in imminent danger that includes, but not limited to:**
   a) A custodial child with injuries related to allegations of abuse or neglect,
   b) Tormented or tortured,
   c) Life threatening situations or significant injuries (i.e., child under two (2) not being fed properly; under the age of six (6) currently left alone),
   d) Living in a home where another child died as a result of maltreatment,
   e) Sexual abuse where the alleged perpetrator has current access or will have access within next forty-eight (48) hours or perpetrator's access is unknown,
   f) Significant injury (i.e., broken bones, burns, lacerations, injuries to head or torso that suggest the use of an instrument such as boards, irons, cigarettes, etc, poisoning or suffocation, use of restraints, bruises, welts and abrasions covering multiple body surfaces or appear in different stages of healing, etc.),
   g) Family may flee/child made unavailable, or
   h) Reports from law enforcement or medical professionals requiring assistance that meets criteria for immediate response.

2. **Priority-2 reports allege injuries or risk of injuries that are not imminent, life threatening or do not require immediate medical care and includes, but not limited to:**
   a) Minor bruises,
   b) Domestic violence incidents,
   c) Substantial risk of harm,
   d) Drug exposed infant, drug exposed child,
   e) Nutritional neglect,
   f) Medical neglect – non-life threatening.

3. **Priority-3 allege situations/incidents considered to pose low risk of harm and includes, but not limited to:**
   a) Environmental neglect (non-life threatening),
   b) Medical neglect (non-life-threatening),
   c) Educational assessment (an assessment to identify underlying problems must occur),
   d) Lack of supervision (not currently alone or over six (6) years old) and abandoned).

RISK/SEVERITY CONTINUUM

NO RISK	LOW RISK	MODERATE RISK	HIGH RISK
1. VULNERABILITY			
Over age 18	Cares for and can protect self with minimal assistance and has no physical or mental handicap. Typically age 12-17.	Requires adult assistance to care for and protect self or has minor limitation or has mild to moderate impaired development. Typically age 6-11.	Is unable to care for or protect self without adult assistance. Has severe physical or mental handicap or limitation. Is severely impaired developmentally. Typically age 0-5.
2. SEVERITY, FREQUENCY AND/OR RECENTNESS OF ABUSE/NEGLECT			
No injury. No discernable evidence of abuse or neglect. No discernable pattern of inappropriate punishment or discipline. Has basic medical, food and shelter needs met. Receives adequate supervision at all times.	Has minor injury as a result of abuse or neglect which requires no medical attention. May show rare incidence of inappropriate punishment or discipline. Usually has basic medical, food and shelter needs met. On occasion may experience minor distress or discomfort due to neglect or lack of supervision.	Has significant physical injury possibly requiring medical diagnosis or treatment as a result of CAN. May have an ongoing history or pattern of harsh discipline or punishment. CAN is repetitive or cumulative. Injury to torso or back. Implement used resulting in marks or bruises. Not a high risk implement. Imminent risk of above. Child is 6-11 years of age, left alone periodically or left with unsuitable caretakers. Inconsistently has basic medical, food and shelter needs met.	Has serious physical injury. Has been sexually abused. May need immediate medical treatment and/or hospitalization. Suffers severe pain or ongoing history of harsh punishment or discipline. Injury to head, face, neck or genitals internal injuries or sexual assault. High risk implement used. Imminent risk of above. Child is 0-5 years of age, left alone or with an unsuitable caretaker. Rarely has basic medical, food and shelter needs met.
3. PRIOR ABUSE/NEGLECT			
No signs symptoms, credible statements or reports that suggest that prior CAN has occurred.	Isolated report or incident of inappropriate physical discipline. No conclusive or credible statement suggesting prior CAN.	Previous substantiated report of abuse and/or neglect. Observable physical signs of previous CAN. Credible statements of previous abuse or neglect not investigated.	Previous substantiated reports of serious bodily injury. Severe abuse or neglect resulting in a serious condition. Credible statements or documentation of serious bodily injury or neglect not previously investigated. Multiple reports of moderate risk issues.
4. EXTENT OF EMOTIONAL HARM			
Has no emotional harm or behavioral disturbance related to abuse and/or neglect. Is comfortable in caretakers home.	Has minor distress or impairment in role functioning; or development related to CAN. Has doubts or concerns about the caretaker's home.	Has behavioral problems that impair social relationships, development or role functioning related to CAN. Has fear of caretakers or home environment.	Has extensive emotional or behavioral impairment or serious developmental delay related to CAN. Is extremely fearful about caretakers or home environment.
5. AGE, PHYSICAL, INTELLECTUAL OR EMOTIONAL STATUS			
Has no intellectual or physical limitation. Is cognitively able to understand and to provide for child's best needs. Seems mature and able to cope.	Has some physical or mental limitations but there is no evidence of any negative impact on family functioning. Parent is aware of limitations and has made adaptations, including use of appropriate resources.	Is physically/emotionally/ intellectually limited. Has past criminal/mental health record/history. Has poor impulse control. Is under 20.	Is severely handicapped; Has poor conception of reality; Has severe intellectual limitations. Is unable to control anger and impulses. Under 16.
6. COOPERATION			
Caretaker appropriately responsive to requirements of investigation. Actively involved in case planning and services. Participates in services provided to him/her and child. Acknowledges problems. Initiates contact with Caseworker to improve services and may seek additional services.	Caretaker offers minor resistance to investigation. Does not take initiative in obtaining needed services. Occasionally fails to follow through with services. Requires reminders and encouragement to follow through. Appears to make use of services by altering behavior in ways that reduce risk to the child. Willing to take some responsibility for the problem.	Caretaker is hostile or cooperates reluctantly with investigation only with direct instructions. Fails to follow through with case plan despite repeated reminders. Passively undermines interventions by canceling appointments, failing to attend meetings or follow up with referrals. Although expressing compliance, makes no effort to alter behavior lowering risk to the child. Fails to accept responsibility for the problem or their own behavior.	Caretaker actively resists any agency contact or involvement. Will not permit investigation to occur. Is very hostile or will only cooperate with police involvement, may threaten worker or service provider with physical harm. Refuses to take child for treatment or assessment and is disruptive to the point that makes services impossible to deliver. Completely denies problems and has no motivation to change behavior affecting the risk to the child.
7. PARENTING SKILL/KNOWLEDGE			
Exhibits appropriate parenting skills and knowledge pertaining to child rearing techniques or responsibilities. Understands child's developmental needs. Does not use implements or physical means to discipline.	Exhibits minimal deficits in parenting skill and knowledge pertaining to child rearing techniques or responsibilities and/or in understanding child's developmental needs. Does not use high risk implements to discipline.	Is inconsistent or has moderate deficits in necessary parenting skills/knowledge required to provide a minimum level of care. Frequently uses physical means to discipline. Implement used, not a high risk implement.	Is unwilling/unable to provide the minimal level of care needed for normal development. Usually resorts to physical means of discipline. High risk implement(s) used.

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NO RISK	LOW RISK	MODERATE RISK	HIGH RISK
8. ALCOHOL/SUBSTANCE ABUSE			
No past or present abuse.	History of abuse with no current problem; Use without inappropriate consequences.	Reduced effectiveness due to abuse or addiction; Regular use results in problem behavior and/or incapacity.	Substantial incapacity due to abuse.
9. ACCESS TO CHILDREN			
Responsible caretaker is available or perpetrator has no access.	Supervised access or shared responsibility for care of child.	Perpetrator has limited unsupervised access or child being cared for in non-supportive or neglectful environment.	Immediate, unlimited access or full responsibility for care of child..
10. PRIOR ABUSE/NEGLECT			
Not neglected or abused as a child. No information or indication of caretaker as perpetrator of abuse or neglect.	No history of abuse or neglect as a victim or perpetrator. Isolated instances of inappropriate discipline as a victim and/or a perpetrator. Inconclusive statements of CAN history by subjects or collaterals.	Prior indicated or substantiated incident of abuse/neglect as a victim or a perpetrator. Admission to prior instances of abuse or neglect (perp. or victim) not yet investigated. Credible statements of above.	History of chronic and/or severe abuse/neglect; or abuse causing serious bodily injury as a perpetrator. Two indicated reports of CAN. Credible statements suggesting history of severe abusive or neglectful incidents towards children.
11. RELATIONSHIP WITH CHILDREN			
Caretaker/child interaction is frequent and pleasurable to both. Mutual affection is prominent and appropriate. Child is aware of and consistently responds to verbal cues of caretaker.	Caretaker anger regarding child's behavior is rarely directed toward the child inappropriately. Anger is generally controlled. Child occasionally does not respond to verbal cues. Attachments of caretaker and child are obvious and extensive. No indication of role blurring (scapegoating or parentification).	Caretaker anger is occasionally extreme. Child's behavior regularly serves to provoke negative response; Displays of affection are intermittent or irregular; Child is occasionally scapegoated or parentified.	Caretaker anger is usually extreme and results in physical abuse, verbal abuse or extreme criticism. No appropriate affection shown to child. Child is consistently scapegoated or parentified; Role blurring occurs frequently. There is a complete lack of attachment or positive interaction between caretaker and child; Or conversely child is inappropriately dependent upon or clinging to caretaker. Child's behavior quite provocative.
12. FAMILY VIOLENCE			
No use of or threats of violence to resolve conflicts. No history of violence in adult relationships or between adults in family of origin.	Indirect or implied verbal threats only in adult relationships or in family or origin: Some success with problem solving techniques.	Direct physical and/or verbal threats; Use of violence between adults; History of physical threats and injury in family of origin: Other methods of dealing with issues rarely used.	Physical violence between adults resulting in injury. Physical violence primary method of conflict resolution. History of physical violence in family of origin; History of protection orders or criminal charge.
13. CONDITION OF THE HOME			
No health or safety concerns on property.	Minor health or safety concerns on property. Some minor problems posing no immediate threat and easily correctable.	Serious substantiated health or safety hazards, i.e. overcrowding, inoperative or unsafe water and utility hazards; other health and sanitation concerns.	Substantiated life threatening health or safety hazards, i.e., living in condemned and/or structurally unsound residence; exposed wiring and/or other potential fire/safety hazards.
14. FAMILY SUPPORTS			
Frequent supportive contacts with family/friends. Involved with community resources as needed; Child monitored by two or more outside adults.	Occasional contact with supportive family/friends; Effective use of community resources, but could benefit from a larger variety of resources; Child monitored by one outside adult.	Sporadic supportive contact; under-use of community resources; Child is inconsistently monitored by outside adults.	Caretaker geographically or emotionally isolated; Community resources not available or not used. Child has minimal or no contact with outside adults.
15. STRESSORS			
No recent losses or disruptions to family routine. Stable housing history. Coping skills are varied and adequate. One child living in household.	Family circumstances have led to anxiety and/or irritation or minor depression. Caretaker appears to have the ability to care for the children in the household. Housing is stable. Coping skills are functional. Two to three children living in the household.	Family crises, losses or circumstances have led to intense anxiety or major depression. Caretaker has difficulty caring for the children in the household. Family has difficulty maintaining stable housing. Coping skills are limited. Four to five children in the household.	Family crises, losses or circumstances have led to serious psychiatric or emotional problems. Caretaker unable to adequately provide for the number of children in the household. Family has a pattern of frequent moves and homelessness. Coping skills are severely limited. Six or more children living in the household.

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ISSUES RELATED TO MALTREATMENT

- Severity of the maltreatment

- Frequency of the maltreatment

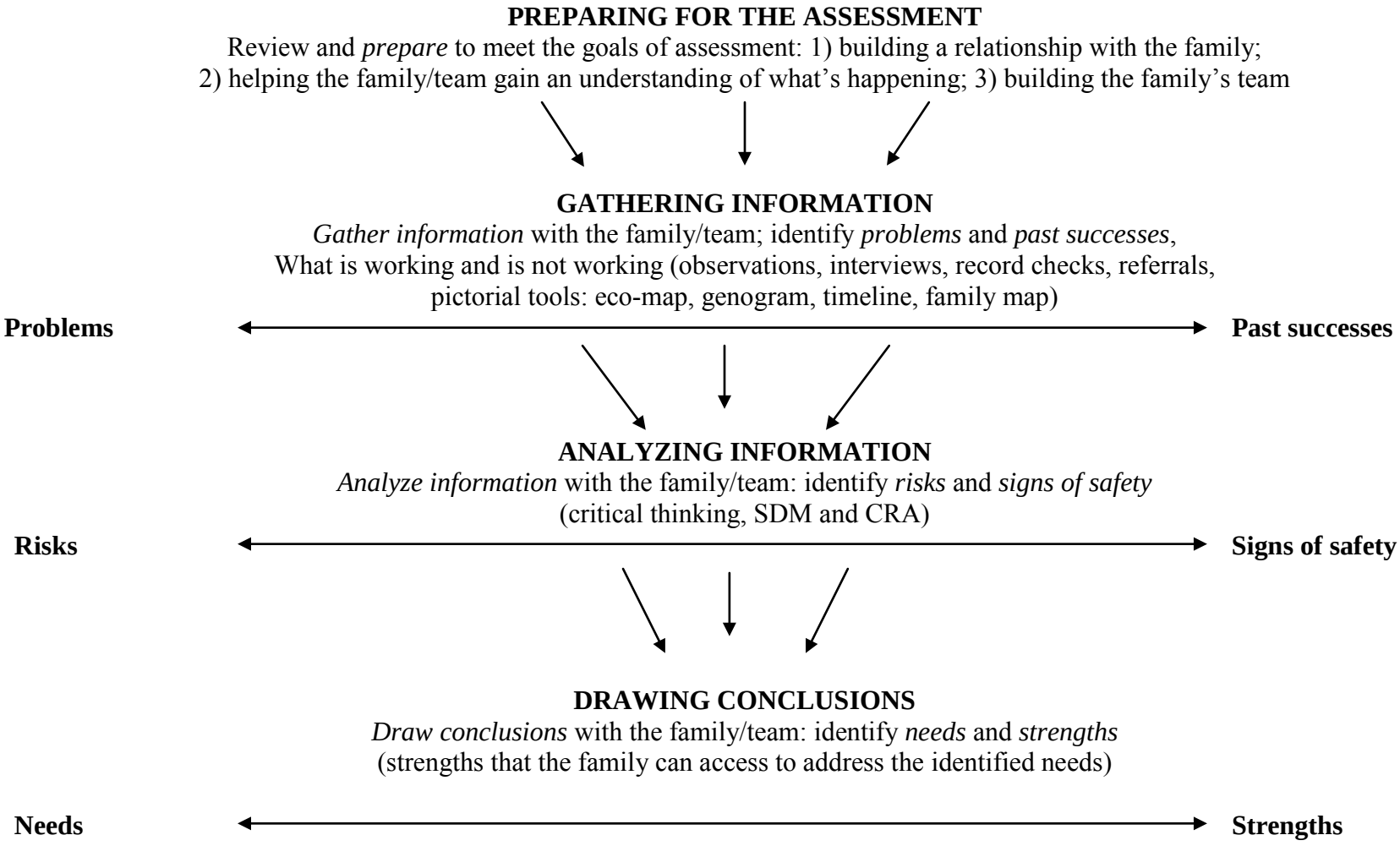
- Prior history of abuse/neglect

- Explanation provided by caregiver about the maltreatment

- Caregiver's ability and willingness to protect the child

- Age and/or physical/mental capacity of the child

Overview of the Assessment Process



Key Questions to Consider During Assessment

Preparing for the Assessment

- √ What is currently known about this family?
- √ Have there been prior referrals or an open case?
- √ What are the immediate risk factors that need to be considered?
- √ How can strengths best be assessed?
- √ How can objectivity in the assessment process be insured?

Gathering Information

- √ What is the incident, behavior or condition that brought the child/youth and family to DCS?
- √ What is the nature of the maltreatment, delinquency or unruly behavior?
- √ If maltreatment, delinquency or unruly behavior is involved, who is responsible?

Analyzing Information

- √ If maltreatment, delinquency or unruly behavior occurred, is it likely to happen again?
- √ What are the signs of risk to the child, family or community?
- √ What are the effects of the maltreatment, delinquency or unruly behavior on child/youth?

Drawing Conclusions/Making Decisions

- √ What are the underlying causes of the maltreatment, delinquency or unruly behavior?
- √ What needs to change in this family?
- √ What are some of the family's strengths and resources?
- √ What are the child/youth's and family's needs?
- √ What is the desired outcome for this family?

Assessment Red Flags

- Family has history of prior investigations and/or involvement with DCS.
- Child is 6 years old or younger.
- Child has physical or developmental disability.
- Child and/or family attempts to isolate themselves from others.
- Caretaker has history of abuse/neglect as a child.
- Caretaker has mental health issues.
- Caretaker has alcohol/drug issues.
- Caretaker has history of criminal arrest as an adult or juvenile.
- Family has history of domestic violence.
- Home environment is unsafe or unstable.
- Caretaker's explanation of the incident is questionable or inconsistent with the injury.
- Caretaker blames the child and/or responds to the child in negative terms.
- Caretaker is unable or unwilling to protect the child.
- Caretaker is unable or unwilling to provide for the child's immediate needs.

Gathering Information

HEAR THE FAMILY'S STORY

Gather information about:

Behaviors

Presenting problems

Risk factors

Understand each person's perspective

Use various tools:

Interviews

Observation

DCS Assessment Tools

Collateral Reports

Records

Pictorial story tools

Hearing The Family's Story to Assess Safety

1. Understand the *position* of each family and team member.

Each family member's story about the alleged maltreatment provides important information regarding both risk and safety. It is vital that you listen to these stories and understand the *position* of each family member. This understanding allows you to communicate with the family in its own language and facilitate the process of change.

The following questions provide avenues for exploring the position of family members:

Regarding the presenting issue:

- From the report, you can see how others view things. What is your perspective on this situation?
- How would you describe what is happening in your family as a result of this issue?
- How is this an issue for you?
- How do you make sense of what s/he does?
- How do you explain what you did?
- How do you think your child would explain what happened?

Regarding solutions and plans:

- Why do you think that course of action would be most helpful?
- What makes you think that these plans won't make any difference?
- Some people might say you need to do _____ in this situation. What do you think about that?
- If we were to suggest that s/he do _____ (or that we will do _____), what would be the best way of explaining that to him/her?

Regarding the worker and agency:

- How hopeful are you that I/we can be of assistance to you?
- I'm sure many people would say we're not interested in your opinions and what you want. What could I say or do that would let you know I am interested in what you want?

Note: It is always useful to check your perception against those of the family and team members. Therefore, the following question can be beneficial: It seems to me that your opinion could be summarized as _____ (*insert position*). Is that right?

2. Find exceptions to the maltreatment.

Search for exceptions to the presenting issue. This creates hope for case managers and families by proving that the presenting issue does not always exist. Exceptions may also indicate solutions that have worked in the past. Where no exceptions exist, you may be alerted to a more serious problem.

Some useful questions for exploring exceptions include:

- You said earlier on that it's not always like this. Can you tell me more about the other times?
- When was the last time this happened? How have you managed to avoid it since then?
- What was different about the times you felt like you handled the situation well?
- Have you been in this situation before? What did you do that helped?
- Can you tell me about a time when this parent has responded appropriately in keeping the child safe? What did s/he do?
- Clearly, there are many times when you do keep track of your son when you are tired. Can you tell me how you do that?
- When was the last time you felt you had the energy to care for your children well? How were you able to do that?

Exception questions must build upon an acknowledgement of the allegation or at least of a problem scenario.

3. Discover family strengths and resources.

Investigations and assessments related to child maltreatment allegations can paint a very bleak picture. It is important to expand the picture to get a better idea of how the family functions.

Information about family strengths and resources can be elicited through questions such as:

- We have been talking about some very serious matters. To give me a more balanced picture, can you tell me some of the things that you feel are good about this family?
- If you were describing yourself to others, what sorts of things would you say you are good at?
- What do you like about being a parent? What have you learned from the experience?
- Can you tell me what you like about your dad? What sorts of things do you like doing together?
- What do you like about your son? What would you say he's good at?
- How do you usually solve family issues? Who does what?
- What do you do to cope in times of stress?
- Who do you turn to for help in dealing with issues? How do they help you?
- Who could best support you in dealing with these issues? How could they help?
- What do you do to help yourself deal with the pressures of raising children?
- Clearly, things have been difficult for you. How have you coped with these pressures? What's kept you going?
- How is it that, even though you are faced with all this, you have been determined to do the best you can for your children?
- Can you tell me about the times when you get on well with your partner or child? What do you like about those times?
- What do you consider is good and what do you like about your family?
- What's good about your relationship with your child/mom/dad/sibling?
- What do you think they would say is good about their relationship with you?

4. Focus on goals.

Elicit the family's goals to improve the safety of the child and their life in general.
Questions to elicit the family's safety goals could include:

- On a scale of 1-10, how safe do you think your children are? What can we do to help you move up one degree?
- Okay, we both see the need to make your child safe. What I'm really interested in are the ideas you have for doing this.
- How can we help you make things better and make your child safer?
- What do you suppose you, your partner, your child and other family members can do to increase safety?
- Let's suppose we could do anything to make your child safer. What would that be?
- In your opinion, what would it take to make your child safer?
- When we ask your son what would make him feel safer, what do you think he will say?
- For our involvement with your family to be useful to you, what would need to happen? What would change in your family? What would change about your partner/your child?
- How have you solved these sorts of problems before? How did you know to do that? How were you able to do that? Could you do that again?
- On those times when you've been successful with this child/situation, what was happening?
- As a parent/child, what would you really like to learn about this situation?
- If you got exactly the sort of support you wanted to deal with these issues and resolve them, what would that support look like?
- It's really clear to me that you don't want us continually in your life. What do you think we need to see to close the case?

5. Scale safety and progress.

Scaling questions can offer invaluable assistance in helping you gather specific, detailed information. Careful exploration of family members' perspectives regarding willingness, confidence and capacity broadens the risk and safety assessment and is an essential part of insuring that the plans that are developed will actually be implemented.

Following are questions related to each aspect:

Willingness:

- On a scale of 0 to 10, where 10 means you are willing to do anything to make the child safer (stop the abuse) and 0 means you're not willing to do anything, where would you place yourself on that scale?
- If I were to ask you to do _____, on a scale of 0 to 10, how willing would you be?
- You talked earlier about the possibility of you doing _____. On a scale of 0 to 10, how willing are you to try that?
- What, if anything, would increase your willingness to do something about these issues?

Capacity to Take Action

- On a scale of 0 to 10, how would you rate your ability to do something about these issues?
- What aspects of these issues do you feel most able to tackle?
- On a scale of 0 to 10, how would you rate your ability to implement the plans we talked about?
- What parts of these plans would you feel most able to try?
- What or who could help you do these things?
- How much control or influence do you think you have over this situation?
- I can see that you really want things to change, and you're willing to do almost anything to make that happen. To what extent do you think you can do something that will make a difference?

Confidence

- On a scale of 0 to 10, where 10 means you are certain things will improve in your family and 0 indicates you think things will never get better, how would you rate things? What gives you that level of confidence?
- On a scale of 0 to 10, how confident are you that you (your family) can do things to make your child safer (stop the abuse)? What would increase your confidence?
- On a scale of 0 to 10, how confident are you that the perpetrator can change his or her behavior to make your child safer (stop the abuse)? What makes you this confident?
- Thinking specifically about doing _____. On a scale of 0 to 10 how confident are you that this would improve things?

CHILD AND FAMILY FUNCTIONING

Safety
Maltreatment Allegations/Delinquency Behaviors
Domestic Violence
Substance Abuse

Well Being
Current Functioning of Child
- ✓ View of current situation
- ✓ General mood and affect

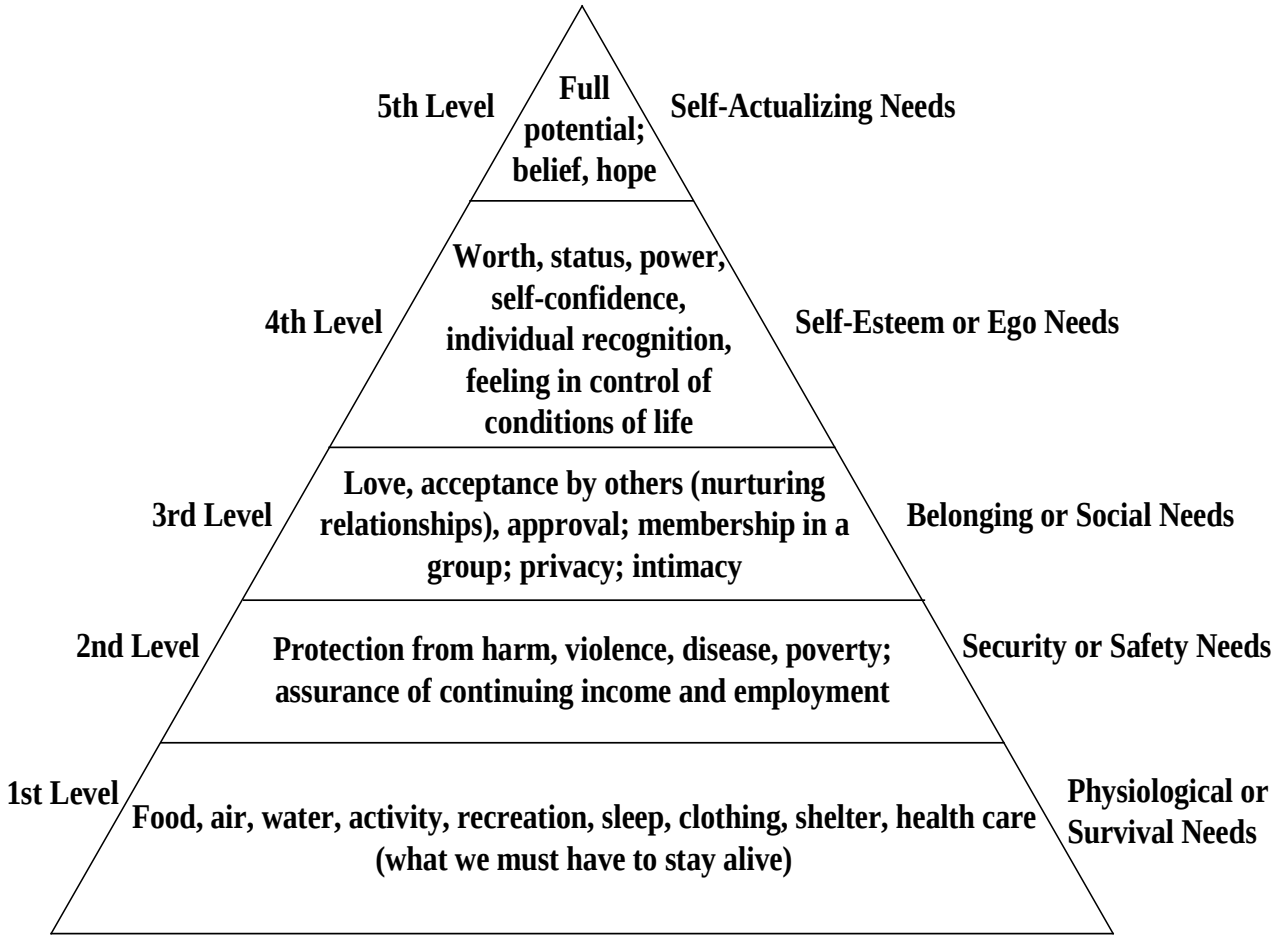
Family's Parenting Capabilities
Educational Status
Physical Health Status
Mental Health Status

Permanence
Family Relationships
- ✓ Parent/Child Relationships
- ✓ Sibling Relationships
- ✓ Relationships of Other Adults in Home
- ✓ Social Interactions

Current Placement and Concurrent Plan
Stability and Transitions
Long-term View

Resources
Home Environment
Community/Neighborhood
Access and Coordination of Team/Service Delivery

Maslow's Hierarchy of Needs



Assumptions About Child Development

1. **Children grow in stages**. During each stage of development, children display a particular set of physical, psychological and emotional characteristics, and develop a particular set of skills and abilities.
2. **Developmental tasks follow a predictable sequence.** All children must accomplish the same tasks, and the tasks follow a relatively predictable sequence. Each set of developmental tasks is more complex than the previous one and is based on the learning of the previous stage, so stages cannot be skipped, but the range of task achievement varies from minimal to mastery.
3. **The capacity to accomplish a task is biologically based.** Children cannot be pushed to move faster than their biological capabilities allow. For example, accomplishing the task of toilet training is dependent upon certain physiological capabilities that aren't present until a certain age.
4. **What is considered "normal" for each age varies widely.** A child approaches each developmental task with her or his own unique personality, set of circumstances, and physical attributes. Therefore, what is considered "normal" behavior for each stage may vary widely. For example, some children walk at 8 months while others don't walk until 15 months. A child who has not begun to walk by 3 years of age may have developmental delays.
5. **Support for growth and development comes from caregivers.** Although the capacity for development is biological, children need the support, protection, and involvement of the adults in their lives in order to actualize that capacity. The most important source of support for growth comes from the child's caregivers. Mastering a new developmental stage is not a complete, all-at-once transformation, and there are frustrations and regressions to previous behaviors at every transition stage. An example of this is "potty training." A child may appear to be "potty trained," then get sick, go visit grandma, or go on a long trip and regress back to soiling and wetting. Once the family is back home in familiar surroundings and the child is back in his or her typical routine, the child is once again toileting herself or himself. Behaviors that occur when a child transitions from one stage to another are not very pleasant for the adult caregiver. It is important that the child's caregiver and other adults in the child's life understand these behaviors as normal and temporary, and understand how to support the child in the child's growth to the next stage.

DEVELOPMENTAL CHARTS

Things to keep in mind when looking at developmental charts:

Developmental charts let us know where the child is developmentally, **not** where a child should be.

Developmental charts let us know what the child needs.

DCS case managers will never be in the position of making a diagnostic developmental assessment of a child, but it is important for the case manager to be familiar with the basic developmental stages and milestones in order to make an accurate assessment of whether or not a child is at risk of harm, to know what factors may be contributing to the risk, and to determine what services could be offered to minimize it.

Erikson's Eight Stages of Psychosocial Development

Stage	Typical Age Range	Positive Resolution	Negative Resolution
1	Birth to 1 years	Sense of trust	Sense of mistrust
2	1 to 2 years	Sense of autonomy	Sense of shame and doubt
3	2 to 6 years	Sense of initiative	Sense of guilt
4	6 to 12 years	Sense of industry	Sense of inferiority
5	12 to 18 years	Sense of identity	Sense of role confusion
6	19 to 40 years	Sense of intimacy	Sense of isolation
7	40 to 65 years	Sense of generativity	Sense of stagnation
8	65 years to death	Sense of ego integrity	Sense of despair

Normal Stages of Human Development: Birth to 5 Years

	Physical and Language	Emotional	Social
Birth to 1 month	**Feedings:** 5 to 8 per day **Sleep:** 20 hrs. per day **Sensory Capacities:** makes basic distinctions in vision, hearing, smelling, tasting, touch, temperature, and perception of pain	Generalized tension	Helpless Asocial Fed by mother
2 to 3 months	**Sensory Capacities:** color perception, visual exploration, oral exploration **Sounds:** cries, coos, grunts **Motor Ability:** control of eye muscles, lifts head when on stomach	Delight Distress Smiles at a face	Visually fixates at a face, smiles at a face, may be soothed by rocking
4 to 6 months	**Sensory Capacities:** localizes sounds **Sounds:** babbling, makes most vowels and about half of the consonants **Feedings:** 3 to 5 per day **Motor Ability:** control of head and arm movements, purposive grasping, rolls over	Enjoys being cuddled	Recognizes his mother. Distinguishes between familiar persons and strangers, no longer smiles indiscriminately. Expects feeding, dressing, and bathing.
7 to 9 months	**Motor Ability:** control of trunk and hands, sits without support, crawls about	Specific emotional attachment to mother. Protests separation from mother.	Enjoys “peek-a-boo”
10 to 12 months	**Motor Ability:** control of legs and feet, stands, creeps, apposition of thumb and forefinger **Language:** says one or two words, imitates sounds, responds to simple commands **Feedings:** 3 meals, 2 snacks **Sleep:** 12 hours, 2 naps	Anger Affection Fear of strangers Curiosity, exploration	Responsive to own name. Waves bye-bye. Plays pat-a-cake, understands “no-no!” Gives and takes objects.

1 to 1 ½ years	**Motor Ability:** creeps up stairs, walks (10 to 20 min.), makes lines on paper with crayon	Dependent behavior Very upset when separated from mother Fear of bath	Obeys limited commands. Repeats a few words. Interested in his mirror image. Feeds himself.
1 ½ to 2 years	**Motor Ability:** runs, kicks a ball, builds 6-cube tower (2 yrs.). Capable of bowel and bladder control. **Language:** vocabulary of more than 200 words **Sleep:** 12 hours at night, 1 to 2-hour nap	Temper tantrums (1 to 3 yrs.) Resentment of new baby	Does opposite of what he is told (18 months).
2 to 3 years	**Motor Ability:** jumps off a step, rides a tricycle, uses crayons, builds a 9 to 10 cube tower **Language:** starts to use short sentences, controls and explores world with language, stuttering may appear briefly	Fear of separation Negativistic (2 ½ yrs) Violent emotions, anger Differentiates facial expressions of anger, sorrow, and joy Sense of humor (plays tricks)	Talks, uses "I," "me," "you." Copies parents' actions. Dependent, clinging, possessive about toys, enjoys playing alongside another child. Negativism (2 ½ yrs). Resists parental demands. Gives orders. Rigid insistence on sameness of routine. Inability to make decisions.
3 to 4 years	**Motor Ability:** stands on one leg, jumps up and down, draws a circle and a cross (4 yrs.). Self-sufficient in many routines of home life.	Affectionate toward parents Pleasure in genital manipulation Romantic attachment to parent of opposite sex (3 to 5 yrs) Jealousy of same-sex parent Imaginary fears of dark, injury, etc. (3 to 5 years)	Likes to share, uses "we." Cooperative play with other children in settings such as nursery school. Imitates parents. Beginning of identification with same-sex parent, practices sex-role activities. Intense curiosity and interest in other children's bodies. Imaginary friend.
4 to 5 years	**Motor Ability:** mature motor control, skips, broad jumps, dresses himself, copies a square and a triangle **Language:** talks clearly, uses adult speech sounds, has mastered basic grammar, relates a story, knows more than 2,000 words (5 yrs.)	Responsibility and guilt Feels pride in accomplishment	Prefers to play with other children, becomes competitive, prefers sex-appropriate activities.

General Characteristics: School-Age Children

	General	Relationship with Peers	Relationship with Adults	Physical-Motor Development	Interests-Intelligence
5 Years	friendly competent dependable likes: praise, to dress up, feel independent project-minded interested in adult activities	poor group member tattletale demanding hits and pushes needs adult supervision	companionable likes: to help parents, to run simple errands, conversation with adults	hops and skips cuts, pastes, draws handles: sled and tricycle well, tools geared to size, most dressing	knows numbers up to 10 vague concept of time has questions that are purposeful more goal-directed than at 4 years enjoys being read to
6 Years	excitable preoccupied with self dependable likes to help dawdles tends to go to extremes in behavior active	poor group member but plays well with companion tattletale demanding has no group loyalty needs adult supervision plays with food	companionable delightful demanding hesitant wants approval	1 or 2 permanent teeth ugly duckling stage losing knock-knees and protruding abdomen active has most basic motor skills eye-hand coordination artistic likes to sing	advancing vocabulary knows numbers up to 30 knows common coins writes some numbers and letters backwards carries on long conversations imaginative play losing interest in toys

					interested in school subjects
7 Years	intensively preoccupied dissatisfied complaining competitive blaming sulks, mutters good listener alibis has musing moods minor strains of sadness	participates in group play that is loosely organized strong loyalty of short duration needs adult supervision not a good loser shows evidence of sex cleavage likes secrets with friends	nags challenges parents sensitive to other's attitudes fond of teacher show-off	permanent teeth appearing rapidly may show "tics" steady, smooth growth handles dressing completely well coordinated practices motor skills well established head-eye coordination can whistle and throw with skill	knows basic numbers fair concept of time beginning of sexual curiosity uses "bathroom" language periods of self- absorption
8 Years	brassy expansive evaluative argumentative sensitive to criticism peer-oriented loud, continually talking independent	engages spontaneous grouping—is short lived highly critical of siblings muddles through, but play continues evidence that sexes are growing apart	not consistently obedient demanding of mother challenges parents expects and asks for praise can admit wrong- doing to adults eavesdrops on adults	10-11 permanent teeth losing baby-body look writes with effort may swim well bicycles, roller skates interest in games requiring coordination and small muscle-control	makes small change can tell day of month and year interest in past is skeptical likes: leisure-time, reading, collections, dramatic play sense of humor

9 Years	independent widening interests truthful, honest more self-dependent more self-motivated strong peer orientation resents interruption bossy competitive aware of grades	joins in spontaneous groups of one sex may have friends outside of immediate neighborhood shares reluctantly expresses contempt for opposite sex begins secret codes and languages interest in team sports impatient	needs reminders can accept blame but "who started it?" makes increasingly accurate estimates of adults begins to pull away from parents more interested in friends respect for teacher more than love	slow, even growth cares for own needs variation in size perfecting motor skills uses tools increasingly well not graceful	clearly acquiring a conscience manners appearing perfecting tool-subject skill inventories possession collects things relates events well art appreciation beginning
10 Years	alert poised casual & relaxed interesting congenial clear on age-sex role likes privacy	likes rules and teamwork is intense in friendship highly selective in friendships strong indication of sex cleavage affectionate with peers of same sex	loyal hero worshiper affectionate with parents finds mother all-important has great pride in father enjoys creative companionship with parents	14-16 permanent teeth Girl: may begin rapid increase in weight, on brink of pubescence interested in hazardous activities motor skills well in hand uses motor skills for group participation begins development of selective motor skills	begins to use fractions can budget time uses thought and reasoning interested in others' ideas short interest span begins to show talent asserts leadership likes to read
11 to 12 Years	critical of adults	interested in organized competitive games	hero worships adults not present	Girl: rapid increase in weight; begins to show secondary sex	critical of own art increases ability for delayed

	rebels at routine moody resents being told what to do strives for unreasonable independence considerable individual differences craves alone periods strong urge to conform to groups intense interest in teams	membership in clubs is important enjoys participating in community drives Boys: admires boys who are skillful, bold, daring Girls: interested in boys	highly critical of adults refrains from communication with adults challenges adults' knowledge	characteristics Boy: ahead of girls in physical endurance good personal hygiene increases in muscle growth may prefer to be a spectator has strongly individualized motor skill interests may show self-consciousness in learning new skills	gratification increases ability to use logic interests: earning money, jobs, religions, world about him develops tool-subject to high level

Developmental Chart for Adolescence

	Early Adolescence (12 to 14)	Middle Adolescence (14 to 17)	Late Adolescence (17 to 19)
Physical and Sexual Development	Weighs 98–100 pounds 61–62 inches tall at age 13 Increased energy and appetite Girls have first menstruation Boys start growth of sex characteristics Same-sex relationships still common although some concern, anxiety, and experimentation with opposite sex Shyness, blushing, and modesty Greater interest in privacy Experimentation with body (masturbation) Worry about being normal Girls highly concerned with body image and physical changes	Weighs 111–125 pounds 63-66 inches tall at age 15 Grows quickly Boys developing secondary sex characteristics Relationships with opposite sex increase; same-sex relationships continue to be dominant Girls are somewhat more comfortable with body image and changes Boys highly concerned with body image and changes as puberty begins Concern about sexual attractiveness—may begin sexual experimentation, including intercourse	Weighs 125–153 pounds 64–70 inches tall at age 18 Generally physically and sexually mature Dating, sex, and possibly marriage are concerns for this age Body image reasonably well established, especially among girls
Cognitive, Intellectual, Language, and Moral Development	Moving from concrete to abstract thinking Information processing improves, as does ability to use written and verbal skills Increased interest in ideas, values, social issues; often narrow understanding and dogmatic—may be moralistic Frequent rule and limit testing Occasional experimentation with alcohol/drugs Intense interest in music, clothes, hair, body image—especially common for girls	Abstract and symbolic thought is fully developed (usually by age 15) and can be applied in more situations Rate of new cognitive growth slows Advanced logical skills generally in place—ability to consider all aspects of a situation before making a decision Continued interest in ideas, ideals, values, morals, and social issues Greater capacity for setting goals May experiment with alcohol/drugs	Abstract thinking is well established Thought processes mature Ability to make application to own current and future situations and to broader issues (e.g., social concerns, academic studies, etc.) Moral development largely complete Use of language becoming more conventional (less slang)

	Although conflict with family increases, most express attitudes that place strong value on family		Makes career and/or schooling decisions for future Capable of useful insight Places importance on personal dignity and self-esteem Ability to set goals and follow through Acceptance of social institutions and cultural traditions
Social, Emotional, and Personality Development	Still dependent on family but increased testing of limits Conflicts with peers/family are means to establish independence Concern with self-identity Egocentric Anxious about peer acceptance—consequently, peer group influences interests and clothing styles Close friendships become important, but changing friends is common Difficulty controlling feelings—abrupt mood and behavior swings More likely to express feelings by action than by words May dress/act differently to gain attention	Increased independence from family, less overt testing of limits Peer group very important— continuing reliance on and anxiety about peer relationships Tries on various identities to establish own self-concept Wants to be independent but alternates between unrealistically high expectations of self and poor self-concept May act like a know-it-all Involved in organized clubs and activities May be emotionally labile (have mood swings) Concerned with achievement, experiences, feelings of accomplishment, receiving recognition	Increasingly concerned and interested in movement toward independence As a major emancipation step becomes imminent (e.g., graduation, moving out of the house, going to college, partial or total self-support), there may be marked increase in anxiety and avoidance behaviors Can maintain more mature relationships with adults/peers Greater concern for others (less egocentric) More realistic and stable view of self and others, nature of problems, and better at problem solving Polishes social skills Ability to delay gratification Ability to think through ideas

			Ability to express feelings in words More developed sense of humor
	Self-critical Less affection shown to parents, with occasional rudeness Strong need for achievement and recognition of accomplishments, although may be masked by feigned indifference	Continued interest in appearance, music, and other elements of peer culture	Stable interests Greater emotional stability Ability to make independent decisions Ability to compromise Pride in one's work Self-reliance Continued need for achievement and recognition for accomplishment

Source: From Understanding Middle Childhood: A Training Manual for Professionals, by C. Ellis, K. Golden, B. Mahan, H. Nevels, and C. Oliva. Published with permission by the Meharry Community Mental Health Center, Nashville, TN.

Thinking Critically in the Assessment Process

Critical thinking involves:

- Inquisitiveness and a desire to be well informed
- Trust in the process of reason
- Open-mindedness about differing views
- Flexibility in considering alternatives and options
- Understanding of the opinions of others
- Honesty in facing one's own biases, prejudices or stereotypes
- Willingness to look beyond limited thinking or responses
- Prudence in suspending judgments
- Willingness to reconsider and revise one's viewpoint

FAMILY GAP ANALYSIS

Analyze current and recent data related to the family that may be available in past or current CPS/Assessment reports and/or other information that may be available in the family's case file.

CURRENT SITUATION

Engage the family in a self assessment (using assessment tools such as the genogram, family map, or ecomap) to get the family's story about their current situation and the events/issues leading up to their current situation.

The gap that exists between the family's current situation and the situation the family desires for their future is your starting point.

Statement of Presenting Problem and Analysis of Underlying Causes of the Family's Current Situation

Assessment of Strengths and Needs Related to Realizing the Family's Desired Future Situation

Development of Family's Permanency Plan

DESIRED FUTURE SITUATION

Engage the family in thinking and talking about what they would like their future to be like.

Types of Resources

Formal Resources

- include people in a professional role or official capacity such as representatives from state, local, and community agencies or institutions
- are available to the general public
- are usually paid resources.

Examples:

Informal Resources

- include people, activities, internal assets, or things that currently have had personal connections or importance with family members
- are specific to the family
- are not contingent upon the exchange of money.

Examples:

When to Seek a Collateral Assessment for Children and Youth

The goal of evaluation is to specifically identify the family's strengths, needs, risks and wants in the context of the family's functioning. Nagging, unresolved questions about a child's needs or a parent's parenting capabilities can occur in any case. Evaluations of children and youth are probably most needed in four types of cases:

- Children and youth with developmental delays
- Children and youth with educational problems
- Children and youth with severe behavior problems
- Children and youth who have been sexually abused

Parental evaluations are probably most often needed of parents with mental illness and mental retardation, those who abuse substances and who are severely physically abusive, and in sexual abuse cases (both the parent who has abused the child and the non-abusive parent).

Child welfare workers are cautioned that the term "dysfunctional family" is used so frequently that it has become meaningless. Many families do not provide an optimal environment for the developing child. Labeling dysfunctional characteristics is of little help in planning effective services. The assessment of parents and families is useful in determining what is *functional* about the family: the strength of the child's ties to family members, parental skills that can be enhanced and services that will best meet the parents' and family's needs.

Deciding on the Type of Evaluation to Request

Although the findings of psychological, educational (and vocational), psychiatric and neurological assessment can overlap, they are quite different from each other.

Psychological Assessment

A psychological evaluation generally provides the following three types of information.

- *Intelligence Quotient*
- *Possible Learning Disabilities/Brain Damage*
- *Personality Characteristics*

An assessment by a psychologist is essential for identifying mental retardation, exceptional intelligence, possible learning difficulties or brain damage. The degree to which a psychological evaluation is useful for planning services for children and families will depend on the questions asked by the child welfare worker and the ability of the psychologist to apply information generated in the evaluation to the decisions being made about the child.

Educational Assessment

Educational testing includes standardized tests and observation. The examiner is usually certified in special education, with training in testing and classroom teaching; some are trained as school psychologists.

Educational assessment is essential for correct school placement for students who are handicapped, low achieving and gifted and those who have been out of school for a long time. Children with

auditory and/or visual processing problems, emotional disturbances and developmental delays have difficulty understanding what occurs in the mainstream classroom and may require "multisensory" teaching techniques and other supports in a special education classroom. Individual testing is needed to discover the pattern of learning strengths and weaknesses, from which a special instructional program can be designed. If requested, educational assessment can also suggest steps which can be taken to remedy a child's chronic truancy.

Vocational Assessments

Vocational assessments can be done by psychologists, educators, social workers or vocational counselors with training in testing. A wide variety of questionnaires are used, depending in part on the age and sophistication of the individual being assessed.

Vocational assessment is usually accomplished in one or two interviews lasting from one to four hours. Scoring the tests and preparing the report usually takes an hour or more.

Depending on how far the individual has progressed in thinking about careers, interest levels and specialized aptitudes for vocations can be assessed. The assessment can also describe the career awareness of the individual.

A vocational assessment is essential for young people 16 and older who are preparing for independent living. Knowing what they are good at will help young people select vocational instruction and employment with a higher likelihood of success.

Psychiatric Evaluation

A psychiatrist is a physician who, in addition to four years of medical school, has specialized training and experience in mental health settings. Psychiatrists are certified in adult or child psychiatry by a national medical board and have a state license.

A standard psychiatric assessment is typically a single interview lasting an hour or less. Preparing the report usually takes an hour or less. The psychiatrist can be asked to spend more time with the child and to interview family members. An assessment by a psychiatrist generally provides four kinds of information:

- **Mental status**

The psychiatrist assesses how aware individuals are of the world around them: Are they hearing voices or seeing things? Do they know what day and year it is? Are they unusually frightened or worried?

- ***Danger to self or others***

Hospital admission is based on a psychiatrist's judgment of whether the individual is suicidal or may injure other people and whether this behavior cannot be managed outside the hospital.

- ***Potential value of medication***

The psychiatrist assesses whether medication is likely to help the individual feel less depressed or worried, reduce hallucinations, reduce hyperactivity or control violence. These are called "psychotropic" or "antipsychotic" or "antidepressant" or "antianxiety" drugs. If medication is prescribed, regular follow-up by a psychiatrist, with blood chemistry analysis as needed, is required. There are standard protocols for regular medication monitoring for some psychotropic drugs.

- ***Diagnosis***

In general, psychiatrists will give a DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Revised) diagnosis, with a numerical code (see Appendix II for a description of several common diagnoses of children).* These diagnoses are based on ascertaining the degree to which the individual's symptoms match those listed in the DSM-IV. Diagnostic categories have the advantage of being standardized. On the other hand, some diagnoses bias the treatment because of widespread pessimism about prognosis for some children's disorders. Prognosis is not a science, even with standardized diagnostic procedures.

An assessment by a psychiatrist is essential for deciding on the need for hospitalization or assessing whether an individual is psychotic (or too disturbed to function without medication or protection).

Neurological Assessment

A neurological assessment is done by a physician, usually in an outpatient hospital setting. A neurological assessment involves an examination by the neurologist, an EEG and sometimes a CAT scan, each of which can take a half hour or longer. The latter two can be frightening procedures because of the equipment involved, and care must be taken to prepare and comfort the child.

Neurological assessment can identify organic problems in the brain that account for seizure disorders and sometimes erratic behavior. Neurological assessments may recommend medication (called "anticonvulsant" drugs).

Neurological assessment is warranted for children with head injuries, prenatal drug or alcohol exposure, or seizures.

Some individuals are referred to as having a "dual diagnosis," which usually means an emotional problem (a psychiatric diagnosis such as depression) with mental retardation although it sometimes is used for individuals who have both an emotional problem and abuse alcohol or other substances. DSM IV diagnoses are sometimes given as a single diagnosis, but can also be written on five different axes. (Axes I and II cover mental disorders, Axis III covers physical disorders, Axis IV covers severity of psychosocial stressors, and Axis V covers global assessment of functioning.)

*Impaired fine muscle coordination, visual-motor perception problems and other mild neurological deficits have not been shown to reflect damage to the central nervous system or to cause behavior disorders in children, although they appear to be common in hyperactive and learning disabled children. EEG abnormalities are not always present in children with behavior disorders.

Source: *Adapted from Beyer, Marty, 1992, Alabama Certification Training.*

Professional Collateral Assessments: Asking the Right Questions

When a case manager finds nagging, unresolved questions within a child or family, professional assessments can help to identify the strengths and needs of that child and/or family. Children with development delays, educational problems, severe behavior problems and who have been sexually abused may need evaluations.

Case managers can increase the effectiveness of these evaluations in their overall assessments by giving the evaluator the case background and asking specific questions to be answered by the evaluator, including:

- What are the individual's strengths?
- What are the individual's emotional needs?
- What specific services could meet those needs?
- What are the individual's educational needs (How are the child's basic skills? What are the child's academic deficiencies?)
- What specific services could meet those needs?
- What are the family's needs?
- What specifically could meet those needs?

Sometimes evaluations conclude with a diagnosis which the layperson cannot understand. The evaluator should be asked to explain in the report what the diagnosis means and to prescribe specifically the optimal treatment and setting for the individual. This is especially important with children, because diagnosis of their fluctuating problems is more complicated (and may be less reliable) than for adults.

The most useful evaluations result from a letter which 1) presents the background and service dilemmas presented by the case; 2) lists the questions to be answered; 3) requires easily understood language and full explanation of the diagnosis; 4) requests a specific itemized list of the individual's strengths and needs; 5) requests a specific prescription of services to build on strengths and meet those needs; and 6) provides the evaluator with observations of the individual which have led to the request for evaluation. If an evaluation does not answer the questions that have been identified in advance, case managers should request that the evaluator write an addendum to the report answering these questions.

Children and adults should be prepared for an evaluation by explaining simply the purpose of the session and what they will be asked to do. Children will usually be anxious about evaluations. It is usually helpful to tell the child or adult that they were not referred for an evaluation because someone thinks they are "crazy." The child welfare worker

might say, “You and I have been trying to figure out why a child as smart as you is having trouble in school. I thought we should ask someone who knows more about school problems than we do to help us. You and I can use what we learn today to plan a better school program for you.”

Psychiatric, psychological, neurological, educational and vocational evaluations have several characteristics in common:

- They are only as good as the examiner. It is not easy to find evaluators with experience with children who are abused or neglected and their families.

- They are culture-bound. Virtually all standardized techniques have been developed for middle-class males. In subtle ways, the language or pictures used may be outside the experience of minorities. Thus an “incorrect” response can be misinterpreted rather than recognized as a limitation of the assessment technique itself. Culture-free measures can be requested, although many are not considered standardized.

- They are written by professionals to *their* colleagues. Most evaluators are not accustomed to writing reports specifying what parents and other caregivers can do to meet the needs of the child. Typically reports read as if they were answering the question, “What is the child’s problem?” rather than the question, “What specifically can we do to relieve the child’s problem?” It is essential that the child welfare worker specifically define the questions the evaluator must answer to assist in service planning and placement. Evaluators must be able to communicate their findings in a language understandable to child welfare workers, easily applicable to casework.

- A danger of any evaluation is that it can attach a stigmatizing label that remains with a child or family for years, sometimes without the benefit of special treatment designed to remedy the identified problems.

CASE RECORDINGS GUIDELINES

Policy

Each contact (successful or unsuccessful) with or on behalf of clients will be documented in TN Kids case recordings within 30 days from the date of the contact. Regions may stipulate a shorter time period.

Purpose of Case Recordings

1. Case recordings serve as the official record of efforts made to serve DCS client children/youth and families. This information may be used in administrative hearings, court proceedings, audits, and reviews.
2. Case recordings serve as a supervisory tool for management and administrative staff.
3. Case recordings serve as a reference tool for the case management staff for preparing court summaries and other documents, and as the point of case transfer when new professionals are assigned and in need of historical information on the current case.
4. Case recordings capture historical information that may be useful after the case is closed if the family has a subsequent relationship with DCS through referrals, reentry, or through the next generation.
5. Case recordings can provide important information about the child/youth's life should s/he request it after s/he becomes an adult.

Content Guidelines

Case recordings should follow a standard case recordings outline and will include certain minimum information. Case managers are to adhere to the following list of Do's and Don'ts when recording information in TN Kids.

Do's

1. Follow policy 31.14 and the PC-COP Outline.
2. Write in complete sentences, in a concise manner, and without omitting relevant information.
3. List each adult and child contacted individually by name and by relationship to the child.

4. When referring to an adult, use appropriate title (Mr./Mrs./Ms./Dr.) and state relationship to the child (example: Ms. Becky Jarvis, Joey's classroom teacher).
5. Use direct quotes of those contacted when anything of significance is stated (rather than paraphrasing).
6. Refer to the permanency plan goals and progress on those goals.
7. When drawing a conclusion or making a subjective statement, include the supporting facts.

Use spell-check and proofread what you have written.

Don'ts

1. Don't use slang language (example: "kids").
2. Don't use all capital letters when typing (too hard to read).
3. Don't include personal opinions/value judgments (example: "looked cute").
4. Don't discuss details regarding an unrelated client.
5. Don't paste e-mail messages into case recordings.

Procedures

Confidentiality and Sensitivity

- When writing case recordings, staff should be mindful of the right to confidentiality and shall not include information about persons unrelated to the case, except where those persons have a direct effect on the client child/youth and family (in those cases, only relevant information shall be documented).
- When writing case recordings, without sacrificing accuracy and completeness, staff shall be sensitive to the emotional well being of the client child/youth and family in the choice of terminology used (being mindful that the client child/youth and family may be voluntarily or involuntarily exposed to the documentation in the future.).

Appropriateness and Quality of Case Recordings

- Case recordings
  - Must be written in clear and complete sentences.
  - Must be written concisely without omitting relevant information, and
  - Must not include slang language or subjective/personal value judgments.
- Abbreviations and acronyms used must be commonly understood and acceptable.
- E-mail should not be posted directly into case recordings.

Case Recordings and Permanency Planning

- Case recordings for custodial cases shall:
    - Specifically address the strengths and needs identified in the permanency plan, whenever appropriate.
    - Specifically address the efforts and progress made toward permanency plan activities and goals.
    - Include information regarding the child/youth's development.

Contact Outline

- Case recordings that document contacts with or on behalf of client children/youth and families shall identify:
    - The name (and relationship to the client child/youth) of each person contacted;
    - The location of the contact (if the contact is face-to-face or an unsuccessful face-to-face attempt or if the contact documents a family or sibling visitation that was not supervised by the person entering the contact).
    - The beginning and end times of the contact, and
    - If telephone contact was made, who initiated the telephone call.
- The narrative of case recordings that document contacts (face-to-face, or significant phone calls) with or on behalf of the client children/youth and families shall be written in the PC-COP format.

Unsuccessful Contacts

- Unsuccessful attempts to make direct or telephone contact with or on behalf of client children/youth and families shall be entered as a case recording.
- The following minimum information must be included in such case recordings:
    - Date and time of the unsuccessful contact.
    - Who was to be contacted.
    - The location of the unsuccessful contact.
    - If it was an attempted direct contact, whether the person(s) to be contacted was/were aware of the planned contact.
    - Plan for rescheduling the contact.

Correspondence and Other Documentation

- Documentation of e-mail, regular mail, facsimiles (faxes), and other materials received/sent may be recorded in TN Kids case recordings and, if documented, will include the following minimum information:
    - Date sent or received.
    - Name (and relationship to the client child/youth) of the sender and recipient.
    - Type and date of the document.
    - Summary of the pertinent information.
    - Any planned action to be taken based on the content of the document.
    - Location of the document.

Supervisory Responsibility

- When supervisory staff give directions to case management staff regarding a specific action to be taken (or not taken) related to a case, that conversation shall be entered by the supervisor as a TN Kids case recording.
- Supervisors will review TN Kids case recordings in accordance with DCS policy 31.1., Program Operations Quarterly File Review and as needed to ensure that appropriate case work and documentation are occurring for each case under their supervision.

Contact with DCS Attorneys

- Conversations between DCS case management staff and DCS attorneys may be documented in TN Kids case recordings, but shall be limited to the date, time, person(s) contacted, and purpose of contact.
- Specific content of the discussion is considered attorney-client privilege, and should not be recorded in the official record (neither TN Kids, nor the child/youth's file).

Printing Case Recordings

- TN Kids case recordings may be printed and placed in the child/youth's record for convenience, however, that process is not required.
- If the case recordings are printed and placed in the child/youth's record, the process must comply with DCS Policies 9.2, Youth Case Files in DCS Community Residential Facilities, 9.7-DOE, Standardization and Confidentiality of Youth Master Files and 31.5, Program Operations Child Case Files.
- Regardless of whether or not the TN Kids case recordings are printed and placed in the child/youth's record, the official case recordings are those in TN Kids.

Resource
PC-COP Outline

The narrative of case recordings that document contacts (face-to-face, or significant phone calls) with or on behalf of the client children/youth and families shall be written in the PC-COP format:

Basics

Date of Contact

Time Contact Began and Ended

Person(s) Contacted

Person Who Made Contact

Location of Contact

PC (Purpose of Contact): focus on goal(s) of permanency plan

C (Content): State what was discussed and/or accomplished.

O (Observation/Assessment): (Write in observable/measurable terms.)

Individual behaviors

Appearance of children

Interaction among client/family members

Interaction among client/family and case manager

Significant environmental factors

Any progress (i.e., maintaining sobriety)

P (Plan): State what will be done next as a result of this contact, or as a natural progression of the case management (including date/time of next planned contact.)

CHAPTER 7
Family Assessment

During the initial assessment, the child protective services (CPS) caseworker has identified behaviors and conditions about the child, parent, and family that contribute to the risk of maltreatment. During the family assessment, the CPS caseworker engages the family in a process designed to gain a greater understanding about family strengths, needs, and resources so that children are safe and the risk of maltreatment is reduced. The family assessment is initiated immediately after the decision is made that ongoing services are needed.

This chapter explores principles for conducting family assessments, key decisions made during family assessments, the family assessment process, community collaboration, and special practice issues related to cultural sensitivity and cultural competence.

Family Assessment Principles

Family assessments, in order to be most effective, should be culturally sensitive, strength-based, and developed with the family. They should be designed to help parents or caretakers recognize and remedy conditions so children can safely remain in their own home.[77] Given the emphasis on timeliness built into the Adoption and Safe Families Act (ASFA), the assessment of the family's strengths and needs should be considered in the context of the length of time it will take for the family to provide a safe, stable home environment.

A culturally sensitive assessment recognizes that parenting practices and family structures vary as a result of ethnic, community, and familial differences, and that this wide range can result in different but safe and adequate care for children within the parameters of the law. Each family has its own structure, roles, values, beliefs, and coping styles. Respect for and acceptance of this diversity is a cornerstone of family-centered assessments. The assessment process must acknowledge, respect, and honor the diversity of families.[78]

A strength-based assessment "recognizes that people, regardless of their difficulties, can change and grow, that healing occurs when a family's strengths, not its weaknesses, are engaged, and that the family is the agent of its own change."[79] While an outline for the family assessment process increases the likelihood that all assessment areas are covered, family assessments must be individualized and tailored to the unique strengths and needs of each family.[80] An individualized assessment is undertaken in conjunction with other service providers to form a comprehensive picture of the individual, interpersonal, and societal pressures on the family members—individually and as a group. This holistic approach takes both client competencies and environment into consideration and views the environment as both a source of and solution to families' problems.[81] When possible, the assessment process also should be conducted in conjunction with the families' extended family and

support network through the use of family decision-making meetings and other formats.[82]

For both practice accountability and empirical usefulness, CPS caseworkers should consider using assessment tools and standardized clinical measures to evaluate risk and protective factors. Tools that support the assessment of specific family strengths, needs, and resources include:

- Genogram—diagram resembling a family tree completed with the family's assistance;
- Ecomap—diagram linking the family tree with outside systems and resources;
- Self-report instruments—questionnaire or survey measuring beliefs, strengths, risks, and behaviors;
- Observational tools—devices enabling professionals to examine personal and family dynamics.[83]

Using such tools, identified needs are translated into specific intervention outcomes that form the basis of time-limited, individualized case plans.

In summary, while the initial assessment identifies the risk factors of concern in the family, the family assessment considers the relationship between strengths and risks and identifies what must change in order to keep children safe, reduce the risk of future maltreatment, increase permanency, and enhance child and family well-being. Consequently, where the initial assessment identifies problems, the family assessment promotes an understanding of the problems and becomes the basis for an intervention plan.

Family Assessment Decisions

Based on the additional information gathered and analyzed, the caseworker must ask the following questions to inform the assessment:

- What are the risk factors and needs of the family that affect safety, permanency, and well-being?
- What are the effects of maltreatment that affect safety, permanency, and well-being?
- What are the individual and family strengths?
- What do the family members perceive as their problems and strengths?
- What must change in order for the effects of maltreatment to be addressed and for the risk of maltreatment to be reduced or eliminated?
- What are the parent's or caregiver's level of readiness for change and motivation and capacity to assure safety, permanency, and well-being?

To arrive at effective decisions during the family assessment process, the CPS caseworker should use competent interviewing skills to engage the family in a partnership; gather and organize information; analyze and interpret the meaning of the information; and draw accurate conclusions based on the assessment.

Family Assessment Process

To accomplish the purposes of the family assessment, caseworkers should:

- Review the initial assessment or investigation information;
- Develop a family assessment plan;
- Conduct the family assessment by interviewing all members of the household and other individuals the family identifies as having an interest in the safety and well-being of the child;
- Consult with other professionals as appropriate;
- Analyze information and make decisions.

Review the Initial Assessment or Investigation Information

To provide focus for the family assessment, the caseworker should begin by reviewing the information previously gathered and analyzed during the initial assessment or investigation. Based on an analysis of this information, the caseworker should develop a list of questions that need to be answered during the family assessment process. The following questions are examples of areas that the caseworker may want to examine:

- What was the nature of the maltreatment (type, severity, chronicity)?
- What was the family's understanding of the maltreatment?
- Which risk factors identified during the initial assessment or investigation are most concerning?
- What is the child's current living situation with regard to safety and stability?
- Was a safety plan developed? What has been the family's response to this plan?
- What is currently known about the parent or caregiver's history? Are there clues that suggest that further information about the past will help to explain the parent or caregiver's current functioning?
- What is known about the family's social support network? Who else is supporting the family and who will be available on an ongoing basis for the family to rely on?
- Are there any behavioral symptoms observed in the child? How has the child functioned in school and in social relationships? Who else may have information about any behavioral or emotional concerns?
- Have problems been identified that may need further examination or evaluation (e.g., drug or alcohol problems, psychiatric or psychological problems, and health needs)?
- What further information about the family will help provide an understanding of the risks and protective factors related to the potential of continued maltreatment?

Develop a Family Assessment Plan

Based on the areas identified through the review, the caseworker should develop a plan for how the assessment process will occur. In general, it takes an average of 4 to 6 weeks to "get to know" the family enough to draw accurate conclusions, although laws may vary from State to State regarding the time before an assessment is required. The following issues need to be considered in developing the plan for the assessment:

- When will the first meeting be held with the family?
- How often will meetings with the family occur?
- Where will meetings be held and how will the setting be controlled?
- Who will be involved in each meeting? Are there other persons (e.g., friends, extended family, other professionals) who have critical information about the needs of this family? How will they be involved in the process?
- Will the services of other professionals be needed (e.g., for psychological tests, or alcohol or other drug abuse assessments)?
- What reports may be available to provide information about a particular family member or the family as a system (e.g., from school or health care providers)?
- When will the information be analyzed and a family assessment summary completed?
- How will the caseworker share this information with the family?

Conduct the Family Assessment

Once the plan for the assessment has been established, the caseworker should conduct interviews with the child and family to determine the treatment needs of the family. Four types of meetings are held:

Meeting with the Family

If possible and if it is safe for all family members, the caseworker should meet with the entire family to begin the family assessment. This ensures that each family member knows the expectations from the beginning; everyone's participation is judged important; and communication is open and shared among family members.

During this initial contact, the caseworker should provide an opportunity for the family to discuss the initial assessment, share the plan for conducting the family assessment, and seek agreement on scheduling and participation. The caseworker should be specific with the family about the purposes of the family assessment and should avoid technical or professional terminology. It also is important to affirm that the intention of CPS is to help the family keep the child safe and address mutually identified problems to reduce the risk of child maltreatment in the future. The caseworker should attempt to gain an initial understanding of the family's perception of CPS and its current situation.

To gain a better understanding of family dynamics, at least one assessment meeting beyond the introductory session should be conducted with the entire family to observe and assess the roles and interactions. Caseworkers should consider communication patterns, alliances, roles and relationships, habitual patterns of interaction, and other family-related concepts.

Meeting with the Individual Family Members

Meetings with individual family members, including the children, should be held. At the beginning of each meeting, the caseworker should clarify the primary purpose of the interview and attempt to build rapport by identifying areas of common interest. It is important to demonstrate appreciation of the person and his or her situation and worth. This is not an interrogation; the caseworker is trying to better understand the person and the situation.

In each individual meeting, the caseworker should carefully explore the areas that have been identified previously for study. In interviews with the children, the emphasis will likely be on understanding more about any effects of maltreatment. In interviews with the parents, the emphasis is on trying to uncover the causes for the behaviors and conditions that present risk and obtain the parents' perceptions of their problems. As part of meetings with the parents, it is important that the caseworker examines the influence that family history and culture may have on current behavior and functioning. In meetings with both children and parents, the caseworker should also attempt to obtain family members' perceptions about the strengths in their family and how these strengths can be maximized to reduce the risk of maltreatment.

Meeting with the Parent or Caregiver

In families with more than one adult caregiver, the caseworker should arrange to hold at least one of the meetings with the adults together, if it is possible and safe for both adults. During this interview, the caseworker should observe and evaluate the nature of the relationship and how the two communicate and relate. The caseworker should also consider and discuss parenting issues and the health and quality of the marital relationship as well as seek the parent or caregiver's perception of problems, the current situation, and the family. The worker should be alert to signs that could indicate the possibility of partner abuse and avoid placing either adult in a situation that could increase risk, such as referring to sensitive information that may have been disclosed in individual meetings. As appropriate or if requested, the caseworker may also provide referrals for resources or services to clients experiencing difficulties that are not risk factors.

Consulting with Other Professionals

While the CPS caseworker has primary responsibility for conducting the family assessment, frequently other community providers may be called upon to assist with the assessment. Other providers should be consulted when there is a specific client condition or behavior that requires additional professional assessment. For example:

- The child or parent exhibits undiagnosed physical health concerns or the child's behaviors or emotions do not appear to be age-appropriate (e.g., hyperactivity, excessive sadness and withdrawal, chronic nightmares, bed wetting, or aggressive behavior at home or at school);
- The parent exhibits behaviors or emotions that do not appear to be controlled, such as violent outbursts, extreme lethargy, depression, or frequent mood swings;
- The child or parent has a chemical dependency.

A good way to judge whether outside referrals are needed is to review the gathered information and assess whether significant questions still exist about the risks and strengths in this family. If the caseworker is having difficulty writing the tentative assessment, he or she should consult the supervisor to determine whether consultation with an interdisciplinary team or an evaluation of presenting problems by others in the community may be appropriate.

If the assessment identifies the need for specific evaluation, the referral should specify the following:

- The reason for referral, including specific areas for assessment as they relate to the risk of maltreatment;
- The parent's knowledge regarding the referral and their response;
- The time frames for assessment, and when the agency will need a report back from the provider;
- The type of report requested regarding the results of the evaluation;
- The purpose and objectives of the evaluation (e.g., the parents' level of alcohol use and its effects on their ability to parent);
- The specific questions the caseworker wants answered to assist in decision-making;
- The need for a confidentiality release.

In addition, sometimes other providers contribute to the assessment process because of their role as advocates for the child. For example, if juvenile or family court is involved, the child may have a Guardian ad Litem (GAL) or court-appointed special advocate (CASA) who advises the court on needed services based on interviews conducted with the child and other family members.

Analyze Information and Make Decisions

Once adequate information has been gathered, the caseworker must analyze the information with regard to the key decisions. The CPS caseworker must identify which risk factors are most critical and what is causing them. This is determined by examining the information in terms of cause, nature, and extent; effects; strengths; and the family's perception of the maltreatment in order to individualize the CPS response to each child and family.

At the conclusion of the family assessment, the caseworker and family have identified changes necessary to keep children safe and reduce the risk of child maltreatment. These conclusions are then translated into desired outcomes and matched with the correct intervention response that will increase safety, well-being, and permanency for children. While the specific areas studied in the assessment are unique to each family circumstance, the following guide identifies areas for gathering essential information needed to draw necessary assessment conclusions.

Family Assessment Guide

Reasons for Referral. Briefly summarize the primary reasons this family is receiving continuing child welfare services and define the terms of any safety plan that was developed with the family.

Sources of Information. Identify all sources of information used to frame this assessment and refer to the specific dates of contact with the family and other persons or systems that relate to assessment information.

Identifying Information. Describe the family system, as defined by the family. Include members' names, ages, and relationship to the primary caregiver; sources of economic support and whether it is perceived as adequate; and current school or vocational training status. Describe the current household situation, including sleeping arrangements, and the client's perception of their neighborhood, especially as it pertains to safety.

Presenting Problems, Needs, and Strengths. Describe family members' perceptions of the presenting needs as they relate to each individual member, the family system, and its environment. As appropriate, include a history of the problem development and previous attempts to address it, as well as an explanation of family members' readiness and motivation to engage in help for the problem at this particular time. Also, identify the family's stated goals as they relate to each problem.

Family Background and History. Write a social history. Ideally, the primary caregiver(s) should be described first. Begin with his or her birth, and describe the family of origin—its members, their relationships with each other, and significant descriptive characteristics of each member. Follow that member's development into adulthood and up to but not including the present time. Genograms are particularly helpful in understanding life events over time. Identify important personal relationships, including those characterized by maltreatment, substance abuse, or violence; identify positive life events as well as stressful ones; and describe relationships with systems, including educational, vocational, legal, religious, medical, mental health, and employment. The history of other adults and children in the household should be summarized, addressing the preceding points, as appropriate and available. Complete this history in chronological order, if possible.

Present Status. Describe the present life situation of the family, particularly information about risks and strengths related to each child in the family, each caregiver's functioning, the family system, and the environment and community. Standardized assessment measures may be helpful to better understand the family and identify areas to be recorded in the casefile.

Tentative Assessment. Summarize risks and strengths related to each family member. This is the opportunity for the worker to analyze the collected information and to draw conclusions about the most important strengths and needs of individual family members and the family as a system. Knowledge of human development, personality theory and psychopathology, family systems, ecological theory, and psychosocial theory should be drawn on to form these conclusions. The worker should make informed judgments about the objective and observational information that has been collected and recorded. In this section, the caseworker specifically summarizes what must change to reduce the risk of child maltreatment.

Special Practice Issue—Cultural Sensitivity

Cultural sensitivity is a critical element in obtaining a comprehensive understanding of a family's situation. For a thorough analysis, it is also a necessary component of the family assessment process. There are three important principles to consider when working with families from different cultures:

- Believe that diversity is a good thing and that having different ideals, customs, attitudes, practices, and beliefs does not, in and of itself, constitute deviance or pathology. If a worker approaches culturally different clients from this perspective, the client is more likely to perceive that the worker has communicated respect for them as persons, and the assessment will be more accurate.
- Accept that everyone has biases and prejudices. This helps to increase objectivity and guard against judgments affected by unconscious biases.
- Understand that the nature of the CPS caseworker and client relationship represents a power imbalance. If there are cultural differences between the caseworker and the client, the client may have difficulty trusting that the caseworker truly intends to empower the client to be an equal partner in the helping relationship.[84]

For example, to develop rapport with clients during the family assessment effectively, the caseworker should be sensitive to cultural similarities and differences with the client. In order to be empathetic, the caseworker should be aware of both the individual uniqueness and the cultural or historical roots of the client.[85] In all assessments, the client is the most important source of information about the family, including providing information about cultural aspects and lifestyles unique to that family. Effective cultural competence requires that caseworkers:

- Respect how clients differ from them;
- Be open to learning about cultural differences when assessing strengths and needs of families;
- Avoid judgments and decision-making resulting from biases, myths, or stereotypes;
- Ask the client about a practice's history and meaning if unfamiliar with it;
- Explain the law that regards a particular cultural practice as abuse;
- Elicit information from the client regarding strongly held family traditions, values, and beliefs, especially child rearing practices.

Guide to Understanding Cultural Differences

With every family assessment, there are certain areas that may be affected by a person's history and culture. The following questions may be used as a guide to understand cultural difference as part of the assessment. According to the client:

- What is the purpose and function of the nuclear family?
- What roles do males and females play in the family?
- What is the role of religion for the family? How do these beliefs influence child-rearing practices?
- What is the meaning, identity, and involvement of the larger homogenous group (e.g., tribe, race, nationality)?
- What family rituals, traditions, or behaviors exist?
- What is the usual role of children in the family?
- What is the perception of the role of children in society?
- What types of discipline does the family consider to be appropriate?
- Who is usually responsible for childcare?
- What are the family's attitudes or beliefs regarding health care?
- What are the family's sexual attitudes and values?
- How are cultural beliefs incorporated into family functioning?
- How does the family maintain its cultural beliefs?
- Who is assigned authority and power for decision-making?
- What tasks are assigned based on traditional roles in the family?
- How do family members express and receive affection? How do they relate to closeness and distance?
- What are the communication styles of the family?
- How does the family solve problems?
- How do family members usually deal with conflict? Is anger an acceptable emotion? Do members yell and scream or withdraw from conflict situations?[86]

CHAPTER 3
What Is Child Maltreatment?

To prevent and respond to child abuse and neglect effectively, there needs to be a common understanding of the definitions of those actions and omissions that constitute child maltreatment. Unfortunately, there is no single, universally applied definition of child abuse and neglect. Over the past several decades, different stakeholders—including State and Federal legislative bodies, agency officials, and researchers—have developed definitions of maltreatment for different purposes. Definitions vary across these groups and within them. For example, legal definitions describing the different forms of child maltreatment for reporting and criminal prosecution purposes are found mainly in State statutes, and definitions vary from State to State. Similarly, agency guidelines for accepting reports, conducting investigations, and providing interventions vary from State to State and sometimes from county to county. In addition, researchers use varying methods to measure and define abuse and neglect, making it difficult to compare findings across studies. Despite the differences, there are commonalities across definitions. This chapter describes sources of definitions in Federal and State laws and summarizes those elements commonly recognized as child maltreatment.

Definitions in Federal Law

The Child Abuse Prevention and Treatment Act (CAPTA) provides minimum standards for defining physical child abuse, child neglect, and sexual abuse that States must incorporate in their statutory definitions to receive Federal funds. Under CAPTA, child abuse and neglect means:

- Any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse, or exploitation;
- An act or failure to act that presents an imminent risk of serious harm.

The definition of child abuse and neglect refers specifically to parents and other caregivers. A "child" under this definition generally means a person who is under the age of 18 or who is not an emancipated minor. In cases of child sexual abuse, a "child" is one who has not attained the age of 18 or the age specified by the child protection law of the State in which the child resides, whichever is younger.

While CAPTA provides definitions for sexual abuse and the special cases related to withholding or failing to provide medically indicated treatment, it does not provide specific definitions for other types of maltreatment—physical abuse, neglect, or psychological maltreatment.

CAPTA Definition of Sexual Abuse

CAPTA defines "sexual abuse" as:

"[T]he employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct;"

"[T]he rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children."

CAPTA Definition of Withholding of Medically Indicated Treatment

CAPTA defines the "withholding of medically indicated treatment" as:

"[T]he failure to respond to the infant's life-threatening conditions by providing treatment...which, in the treating physician's reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions."

The term "withholding of medically indicated treatment" does not include the failure to provide treatment (other than appropriate nutrition, hydration, and medication) to an infant when, in the treating physician's reasonable medical judgment:

- The infant is chronically and irreversibly comatose;
- The provision of such treatment would merely prolong dying;
- The provision of such treatment would not be effective in ameliorating or correcting all of the infant's life-threatening conditions;
- The provision of such treatment would otherwise be futile in terms of the survival of the infant;
- The provision of such treatment would be virtually futile in terms of the survival of the infant, and the treatment itself under such circumstances would be inhumane.[2]

Sources of Definitions in State Law

While the Federal legislation sets minimum definitional standards, each State is responsible for providing its own definition of maltreatment within civil and criminal contexts. The problem of child maltreatment is generally subject to State laws (both statutes and case law) and administrative regulations. Definitions of child abuse and neglect are located primarily in three places within each State's statutory code:

- **Mandatory child maltreatment reporting statutes (civil laws)** provide definitions of child maltreatment to guide those individuals mandated to identify and report suspected child abuse. These reports activate the child protection process. (See Chapter 9, "What Does the Child Protection Process Look Like?," for more information on mandated reporters and reporting procedures.)
- **Criminal statutes** define those forms of child maltreatment that are criminally punishable. In most jurisdictions, child maltreatment is criminally punishable when one or more of the following statutory crimes have been committed: homicide, murder, manslaughter, false imprisonment, assault, battery, criminal neglect and abandonment, emotional and physical abuse, child pornography, child prostitution, computer crimes, rape, deviant sexual assault, indecent exposure, child endangerment, and reckless endangerment.
- **Juvenile court jurisdiction statutes** provide definitions of the circumstances necessary for the court to have jurisdiction over a child alleged to have been abused or neglected. When the child's safety cannot be ensured in the home, these statutes allow the court to take custody of a child and to order specific treatment services for the parents and child.

Together, these legal definitions of child abuse and neglect determine the minimum standards of care and protection for children and serve as important guidelines for professionals regarding those acts and omissions that constitute child maltreatment.

Child protective services (CPS) workers use statutory definitions of child maltreatment to determine whether maltreatment has occurred and when intervention into family life is necessary. For particular localities within a State, local CPS policies and procedures, based on statutes and regulations, further define different types of maltreatment and the conditions under which intervention and services are warranted.

State Statutes

To review a summary of reporting laws, visit the State Statutes section of the National Clearinghouse on Child Abuse and Neglect's Web site at **www.calib.com/nccanch/statutes.**

General Definitions by Type of Maltreatment

There are four commonly recognized forms of child abuse or maltreatment:

- Physical
- Sexual
- Neglect
- Psychological

There is great variation from State to State regarding the details and specificity of child abuse definitions, but it is still possible to identify commonalities among each different type of child maltreatment. These commonalities, in part, reflect societal views of parental actions that are seen as improper or unacceptable because they place children at a risk of physical and emotional harm.

Physical Abuse

Generally, physical abuse is characterized by physical injury, such as bruises and fractures that result from:

- Punching
- Beating
- Kicking
- Biting
- Shaking
- Throwing
- Stabbing
- Choking
- Hitting with a hand, stick, strap, or other object
- Burning

Although an injury resulting from physical abuse is not accidental, the parent or caregiver may not have intended to hurt the child. The injury may have resulted from severe discipline, including injurious spanking, or physical punishment that is inappropriate to the child's age or condition. The injury may be the result of a single episode or of repeated episodes and can range in severity from minor marks and bruising to death.

Some cultural practices are generally not defined as physical abuse, but may result in physically hurting children. For example:

- "Coining" or *cao gio*—a practice to treat illness by rubbing the body forcefully with a coin or other hard object.
- *Moxabustion*—an Asian folkloric remedy that burns the skin.

As Howard Dubowitz, a leading researcher in the field, explains: "While cultural practices are generally respected, if the injury or harm is significant, professionals typically work with parents to discourage harmful behavior and suggest preferable alternatives."[3]

Sexual Abuse

Child sexual abuse generally refers to sexual acts, sexually motivated behaviors involving children, or sexual exploitation of children.[4] Child sexual abuse includes a wide range of behaviors, such as:

- Oral, anal, or genital penile penetration;
- Anal or genital digital or other penetration;
- Genital contact with no intrusion;
- Fondling of a child's breasts or buttocks;
- Indecent exposure;
- Inadequate or inappropriate supervision of a child's voluntary sexual activities;

- Use of a child in prostitution, pornography, Internet crimes, or other sexually exploitative activities.

Sexual abuse includes both touching offenses (fondling or sexual intercourse) and nontouching offenses (exposing a child to pornographic materials) and can involve varying degrees of violence and emotional trauma. The most commonly reported cases involve incest–sexual abuse occurring among family members, including those in biological families, adoptive families, and step-families.[5] Incest most often occurs within a father-daughter relationship; however, mother-son, father-son, and sibling-sibling incest also occurs. Sexual abuse is also sometimes committed by other relatives or caretakers, such as aunts, uncles, grandparents, cousins, or the boyfriend or girlfriend of a parent.

Child Neglect

Child neglect, the most common form of child maltreatment, is generally characterized by omissions in care resulting in significant harm or risk of significant harm. Neglect is frequently defined in terms of a failure to provide for the child's basic needs–deprivation of adequate food, clothing, shelter, supervision, or medical care. Neglect laws often exclude circumstances in which a child's needs are not met because of poverty or an inability to provide. In addition, many States establish religious exemptions for parents who choose not to seek medical care for their children due to religious beliefs that may prohibit medical intervention.

The Department of Health and Human Services' *Third National Incidence Study of Child Abuse and Neglect* (NIS-3)[6] is the single most comprehensive source of information about the current incidence of child maltreatment in the United States. NIS-3 worked with researchers and practitioners to define physical, educational, and emotional neglect in a succinct and clear manner, as described below.

Physical Neglect

- **Refusal of health care**–the failure to provide or allow needed care in accordance with recommendations of a competent health care professional for a physical injury, illness, medical condition, or impairment.
- **Delay in health care**–the failure to seek timely and appropriate medical care for a serious health problem that any reasonable layman would have recognized as needing professional medical attention.
- **Abandonment**–the desertion of a child without arranging for reasonable care and supervision.
- **Expulsion**–other blatant refusals of custody, such as permanent or indefinite expulsion of a child from the home without adequate arrangement for care by others or refusal to accept custody of a returned runaway.
- **Inadequate supervision**–leaving a child unsupervised or inadequately supervised for extended periods of time or allowing the child to remain away from home overnight without the parent or caretaker knowing or attempting to determine the child's whereabouts.
- **Other physical neglect**–includes inadequate nutrition, clothing, or hygiene; conspicuous inattention to avoidable hazards in the home; and other forms of reckless disregard of the child's safety and welfare (e.g., driving with the child while intoxicated, leaving a young child in a car unattended).

Educational Neglect

- **Permitted chronic truancy**–habitual absenteeism from school averaging at least 5 days a month if the parent or guardian is informed of the problem and does not attempt to intervene.

- **Failure to enroll or other truancy**—failure to register or enroll a child of mandatory school age, causing the child to miss at least 1 month of school; or a pattern of keeping a school-aged child home without valid reasons.
- **Inattention to special education need**—refusal to allow or failure to obtain recommended remedial education services or neglect in obtaining or following through with treatment for a child's diagnosed learning disorder or other special education need without reasonable cause.

Emotional Neglect

- **Inadequate nurturing or affection**—marked inattention to the child's needs for affection, emotional support, or attention.
- **Chronic or extreme spouse abuse**—exposure to chronic or extreme spouse abuse or other domestic violence in the child's presence.
- **Permitted drug or alcohol abuse**—encouragement or permitting of drug or alcohol use by the child.
- **Permitted other maladaptive behavior**—encouragement or permitting of other maladaptive behavior (e.g., chronic delinquency, severe assault) under circumstances where the parent or caregiver has reason to be aware of the existence and seriousness of the problem but does not intervene.
- **Refusal of psychological care**—refusal to allow needed and available treatment for a child's emotional or behavioral impairment or problem in accordance with a competent professional recommendation.
- **Delay in psychological care**—failure to seek or provide needed treatment for a child's emotional or behavioral impairment or problem that any reasonable layman would have recognized as needing professional, psychological attention (e.g., suicide attempt).

Spotlight on Chronic Neglect

One issue in defining child neglect involves consideration of "incidents" of neglect versus a pattern of behavior that indicates neglect. Susan J. Zuravin, from the University of Maryland at Baltimore School of Social Work, recommends that if some behaviors occur in a "chronic pattern," they should be considered neglectful.[7] Examples include lack of supervision, inadequate hygiene, and failure to meet a child's educational needs. This suggests that rather than focusing on individual incidents that may or may not be classified as "neglectful," one should look at an accumulation of incidents that may together constitute neglect. "If CPS focuses only on the immediate allegation before them and not the pattern reflected in multiple referrals, then many neglected children will continue to be inappropriately excluded from the CPS system."[8] For example, a family exhibiting a pattern of behavior that may constitute neglect might include frequent reports of not having enough food in the home or keeping older children home from school to watch younger children. In most CPS systems, however, the criteria for identifying neglect focuses on recent, discrete, verifiable incidents.

One study found that many children who had been referred to CPS for neglect did not receive services because their cases did not meet the criteria for "incidents" of neglect. It also found, however, that all of these children had, in fact, suffered severe developmental consequences. In recognition of this issue, the Missouri Division of Family Services (n.d.) has assigned one of its CPS staff as a "Chronic Neglect Specialist." This office defines chronic neglect as ". . . a persistent pattern of family functioning in which the caregiver has not sustained and/or met the basic needs of the children which results in harm to the child." The focus here is on the "accumulation of harm." CPS and community agencies across the country are recognizing the importance of early intervention and service provision to support families so that neglect does not become chronic or lead to other negative consequences.[9]

Psychological Maltreatment

Psychological maltreatment—also known as emotional abuse and neglect—refers to "a repeated pattern of caregiver behavior or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs."[10] Summarizing research and expert opinion, Stuart N. Hart, Ph.D., and Marla R. Brassard, Ph.D., present six categories of psychological maltreatment:

- Spurning (e.g., belittling, hostile rejecting, ridiculing);
- Terrorizing (e.g., threatening violence against a child, placing a child in a recognizably dangerous situation);
- Isolating (e.g., confining the child, placing unreasonable limitations on the child's freedom of movement, restricting the child from social interactions);
- Exploiting or corrupting (e.g., modeling antisocial behavior such as criminal activities, encouraging prostitution, permitting substance abuse);
- Denying emotional responsiveness (e.g., ignoring the child's attempts to interact, failing to express affection);
- Mental health, medical, and educational neglect (e.g., refusing to allow or failing to provide treatment for serious mental health or medical problems, ignoring the need for services for serious educational needs).[11]

To warrant intervention, psychological maltreatment must be sustained and repetitive. For less severe acts, such as habitual scapegoating or belittling, demonstrable harm to the child is often required for CPS to intervene.

Psychological maltreatment is the most difficult form of child maltreatment to identify. In part, the difficulty in detection occurs because the effects of psychological maltreatment, such as lags in development, learning problems, and speech disorders, are often evident in both children who have experienced and those who have *not* experienced maltreatment. Additionally, the effects of psychological maltreatment may only become evident in later developmental stages of the child's life.

Although any of the forms of child maltreatment may be found alone, they often occur in combination. Psychological maltreatment is almost always present when other forms are identified.

Case Examples of Maltreatment

Physical Abuse

During a violent fight between her mother and her mother's boyfriend, 8-year-old Kerry called 911. She told the operator that her mother's boyfriend always hit her mommy when he came home drunk. In addition, Kerry said she was worried about her 5-year-old brother, Aaron, because he tried to help their mom and the boyfriend punched him in the face. As a result, Aaron fell, hit his head on the coffee table, and had not moved since. The operator heard yelling in the background and the mother screaming, "Get off the phone!" When the police and paramedics arrived, Aaron was unconscious and the mother had numerous bruises on her face.

Child Neglect

Robert and Carlotta are the parents of a 9-month-old son named Ruiz. Robert and Carlotta used various drugs together until Robert was arrested and sent to prison for distributing cocaine. Since Robert's arrest, Carlotta has been living with different relatives and friends. Recently, she left her son with her sister who also has a history of drug use. Her sister then went to a local bar and left Ruiz unattended. After hearing the baby boy cry for over an hour, the neighbors called the police. When Carlotta arrived to pick up Ruiz, the police and the CPS worker were also there. It appeared that she had been using drugs.

Sexual Abuse

Jody, age 11, said that she was asleep in her bedroom and that her father came in and took off his robe and underwear. She stated that he got into bed with her and pulled up her nightgown and put his private part on her private part. She stated that he pushed hard and it hurt. Jody said that the same thing had happened before while her mother was at work. Jody stated that she told her mother, but her father insisted that she was telling a lie.

Psychological Abuse

Jackie is a 7-year-old girl who lives with her mother. Jackie's mother often screams at her, calls her degrading names, and threatens to kill her when Jackie misbehaves. Jackie doesn't talk in class anymore, doesn't have any friends in her neighborhood, and has lost a lot of weight.

Tennessee Department of Children's Services

Work Aid- 1 - CPS Categories and Definitions of Abuse/Neglect

Central Intake will accept reports alleging abuse or neglect that meet established criteria and definitions of abuse and neglect. To determine the response priority of the report, Central Intake will categorize the report information into one of the following abuse/neglect categories:

Abuse/Neglect Category	Definition
A. Physical Abuse Category [1]	**1. <u>Physical abuse</u>:** [2] Non-accidental physical trauma or abuse inflicted by a parent or caretaker on a child. Physical abuse also includes but not limited to: a) A parent or caretaker's failure to protect a child from another person who perpetrated physical abuse on a child; b) When an injury goes beyond temporary redness, e.g., a bruise, broken bone, cut, burn; c) When injuries are received due to parental behavior, e.g., domestic violence; or d) When a child is allegedly struck on parts of the body in such a way that could result in internal injuries. e) Munchausen Syndrome by Proxy could be considered physical abuse or psychological abuse. 2. **<u>Drug exposed infant/child (Investigation)</u>: (**The <u>medical definition</u> of infant is age 0 to 1 year old. Child – is over the age of 1 year old.) This allegation pertains to an: a) Infant/child who has been exposed to a drug or chemical substance (e.g., alcohol, cannabis, hallucinogens, stimulants, sedatives, narcotics, meth, heroin, inhalants or any other illegal substances), as verified by a positive drug screen. b) Infant/child who has been exposed to a drug or chemical substance that could adversely affect his/her physical, mental, or emotional functioning. This includes but is not limited to the following situations:

Abuse/Neglect Category	Definition
	♦ Drugs or chemical substances are administered to or given to children; ♦ Children exposed to or living within close physical proximity to where drugs or chemical substances are manufactured (the manufacturing of methamphetamine in a home where children are present, is always considered severe abuse). c) Parents/caretakers use of drugs or chemical substances that impairs the parent/caretakers ability to meet child-care responsibilities. **3. <u>Drug exposed infant/child (Assessment Track):</u>** This allegation pertains to children who: a) Have parents/caretaker who have a positive drug screen or have admitted to the use of a drug or chemical substance. b) Do not live in an environment nor are exposed to the manufacturing of a drug or chemical substance. c) Parents/caretakers use of drugs or chemical substances does not impair the parent/caretaker's ability to meet child-care responsibilities.
B. Neglect Category [3]	**<u>Neglect</u>** A parent or caretaker's omission in relation to a child's needs. Neglect is best considered contextually, especially based on the age and developmental stages of a child. Neglect includes: **1. <u>Environmental neglect</u>:** A living situation either inside or outside the residence that is dangerous or unhealthy. The situation described can cause harm or significant risk of harm to the child(ren) in the home. The child's age and developmental status must be considered when evaluating the impact of the environmental condition of the child. The following are some examples of environmental situations as they relate to the child's age and developmental status: a) Leaking gas from stove or heating unit; b) Substances or objects accessible to the child that may endanger health/safety; c) Open/broken/missing windows; d) Structural hazards such as caving roof, holes in floor or walls, etc.; e) Exposed electrical wires; f) Children lack clothing so that they are dangerously exposed to the elements, for example, not having shoes or warm

Abuse/Neglect Category	Definition
	clothes for winter; g) Excessive garbage or rotted or spoiled food, which threatens health; h) Evidence of human or animal waste in the living quarters; and i) Insect or rodent infestation **2. <u>Nutritional neglect</u>: [4]** A parent or caretaker's failure to provide adequate nutrition to a child. Nutritional neglect occurs when children repeatedly experience hunger for hours or a large part of the day, and no food is available. These behaviors may include: a) Begging from neighbors for food, b) Eating out of garbage cans, or c) Constantly stating a need for food. **3. <u>Medical neglect</u>: [5]** A situation in which a child does not receive adequate health care, resulting in actual or potential harm. Medical maltreatment does not pertain to elective health care or treatment. a) It applies to procedures or treatment that a physician or other health, medical professional deems medically necessary. b) Medical neglect may rise to the level of severe child abuse if the absence of medical care endangers the life of the child or is likely to result in severe impairment. **4. <u>Educational neglect</u>: [6]** Repeated failure of the caretaker to meet the child's educational needs. This allegation applies to: a) Children legally mandated to be in an educational program through 18 years of age. When applying this allegation to children 12 and over, it should only be considered after the inability of the school to engage the caretaker to improve the child's school attendance. b) Caretaker's failure to enroll a child in school or failure to register a home-schooled child with the Board of Education. **5. <u>Lack of supervision</u>:** Failure to provide adequate supervision, by a parent or other caretaker, who is able to do so. A lack of supervision allegation or determination means that: a) The child has been placed in a situation that requires actions beyond the child's level of maturity, physical ability,

Abuse/Neglect Category	Definition
	and/or mental ability; or b) Caregiver inadequately supervises a child. The caregiver is with the child but is unable or unwilling to supervise (e.g., the caregiver is under the influence of alcohol or drugs, is depressed, sleeps during the day, or has inadequate parenting knowledge or skills). **6. Abandonment:** Deliberate absence of the parent or other caretaker for an extended period with no plan or an inadequate plan or provision for the child's care. It may include: a) Abandonment of the child in the child's own home, in day care or in substitute care; b) Abandonment of the child in a car, on the highway or in a public place; c) Child left in the care of a suitable caregiver but without proper planning or consent. The caregiver leaves the child but does not return when scheduled or has a history of leaving the child without providing essentials for care (e.g., diapers, formula). c) Newborn infants who are aged 72-hours or younger and voluntarily delivered by the infant's mother to any professional medical facility as defined by *TCA 68-11-255, Procedure for Surrendering Custody of Unwanted Infant Without Criminal Liability,* (per *TCA 36-1-142*) does not apply to the definition of abandonment. Procedures shall be followed as outlined in ***Work Aid 5- Protocol for Anonymous Voluntary Abandonment of Unharmed Newborn Infant***. **Exception**: Parents/caretakers with unruly children who exhibit unmanageable behavior and require intervention services will be referred to Family Crisis Intervention Program (FCIP) services.
C. Sexual Abuse Category [7]	**Child Sexual abuse**: Occurs when: 1. The target is a child. Children are presumed unable to give informed consent to sexual relationships with adults. 2. Sexually motivated behavior includes intentional acts that produce sexual arousal or gratification. These include: ♦ Explicit sexual acts; ♦ Sexual penetration, (vaginal, oral, anal, digital, and/or with an object);

Abuse/Neglect Category	Definition
	♦ Sexual touching -intentional contact with genitals, buttocks or breasts. This also includes when adolescents or adults instruct children to engage in such behaviors with each other; ♦ Indecent exposure and voyeurism; and ♦ Intentionally exposing child to sexually explicit material. 3. Sexual exploitation: Sexual behaviors or situations in which the motivation may or may not be sexual, but there is a clear sexual component such as: a) Taking pictures or videos of children engaging in sexual activities or in sexually explicit poses; b) Making children available to others for sexual purposes; c) The sexual gratification or benefit of an adult; d) Use of a child for prostitution; and d) Willful failure of the child's caretaker to stop child sexual abuse by another person.
D. Psychological Harm Category	**Psychological harm:** A repeated pattern of caregiver behavior or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs and may include both abusive acts against a child and failure to act; neglectful behavior when age appropriate action is required for a child's healthy development, e.g., when a child is shown no affection. It can occur as part of an extreme one-time incident, (e.g., a parent frustrated about continual bed-wetting forces a six (6) year old to wear diapers in the neighborhood), but is usually chronic. Some types of psychological harm might include: 1. An injury to a child by a caregiver that impairs his/her intellectual, emotional or psychological development.

Abuse/Neglect Category	Definition
	2. Verbal and non-verbal caregiver acts that reject and degrade a child such as belittling, degrading, shaming and ridiculing. 3. Terrorizing; including caregiver behavior that threatens or is likely to physically hurt, kill, abandon or place the child or child's siblings, toys or objects in recognizable dangerous positions or situations to terrorize the child. 4. Isolating that includes caregiver behaviors that consistently deny the child opportunities to meet needs for interacting or communicating with peers or adults inside or outside the home. Confining the child or placing unreasonable limitations on the child's freedom of movement within his or her environment. **Note:** A report of concern regarding psychological harm does not have to come from a professional. A supporting mental health evaluation is required to indicate this allegation.
E. Child Fatality/Near Fatality	1. Any unexplained death of a child when the cause of death is unknown or pending an autopsy report. 2. Any child death caused by abuse resulting from direct action of the child's caretaker **or** the consequence of the child's caretaker's failure to stop another person's direct action that resulted in the death of a child. Child fatalities are always treated as severe child abuse. **3.** Any child death that is the result of the caretaker's failure to meet childcare responsibilities. Neglect death is always treated as severe child abuse.

[1] In its most severe form, physical abuse is likely to cause great bodily harm or death.

[2] Physical abuse should not be confused with developmentally appropriate, discipline-related marks and bruises on the buttocks or legs of children six (6) years of age and older when there are no developmental or physical delays, past history of abuse or recent (within the past year) screened-out reports.

[3] In its most severe form, serious illness or significant injury has occurred due to living conditions and these conditions still exist (for example; lead poisoning, rat bites). See Section *F* for more details.

[4] In its more severe form, nutritional neglect is the failure to feed a child that result in poor growth which may include the child's weight, height and head circumference falling significantly below the growth rates of average children, malnutrition and non-organic failure to thrive.

[5] In its most severe form, medical neglect occurs when the absence of medical care endangers the life of the child or is likely to result in severe impairment.

[6] This allegation is not appropriate for reports of children who willfully refuse to attend school.

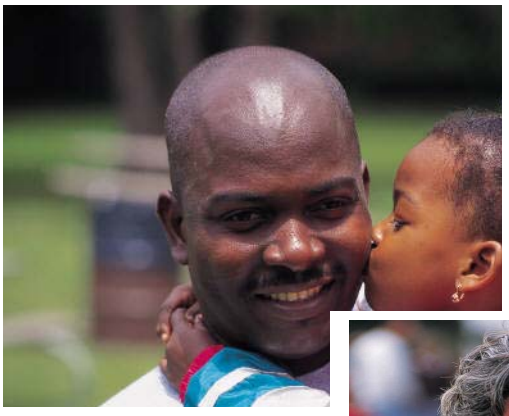
[7] All allegations of sexual abuse are considered to be allegations of severe abuse.

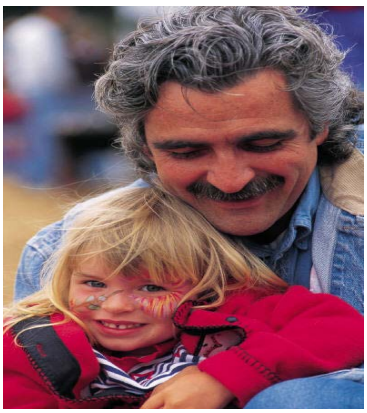
FAMILY CENTERED ASSESSMENT GUIDEBOOK:

THE ART OF ASSESSMENT

NRCFCPP
NRCFCP

JULY 2002





Family-Centered Assessment Guidebook

About Family Centered Practice

Family Centered Practice requires that the entire system of care seek to engage the family system in helping them improve their ability to safely parent their children.

Family centered practice requires that the family be viewed as a system of interrelated people and that action and change in one part of the system impacts the other. While the ultimate goals are the safety, permanence and well being of the child, the entire family is the focus of intervention. In family centered practice, the work is not intended to solely be one of "diagnosis and treatment". Many families that come to the attention of the child welfare system are in need of assistance in basic parenting tools such as daily living skills and managing normal child developmental stages of behavior. Additionally, many of the families that come to the attention of the system need access to community resources that can help them keep food on the table, provide rental assistance, etc. Family Centered practice requires the delivery of an individualized array of informal and formal services and supports to meet these needs. The development of creative community options is often necessary to meet the needs of families served. In effective service systems, the delivery of services appears seamless to the family—providers working together as a collaborative team.[1]

Family Centered Practice also requires an understanding of the importance that relatives and other kin can play in planning for and ensuring child safety and permanence. The tradition of extended family and other significant adults caring for children when the child/youth's parents are not able to do so is strong in all cultures. This tradition has been based on the strengths of family members and networks of community support to ensure that children remain within their own families and communities when parents cannot provide the care, protection, and nurturing that children need. It has really only been in the past ten years that effective child welfare practice has begun to include and plan for "kinship care" as part of its many permanency options for children. In the late 1980s and early 1990s as growing numbers of children were entering foster care and, simultaneously, the number of traditional foster families was declining, child welfare systems began to look to children's extended families as resources for the care of child/youth who entered the formal child welfare system. Since that time, increasing numbers of children who enter foster care have been placed in the care of kin.[2]

The core principles of a family centered practice model include:

- Preservation of the family whenever possible. When it is not possible that children remain living with their birth family—that connections are preserved for children to their kin, their culture, and their community.

[1] Much of the work of Annie E. Casey's community building is based on research that children who grow up in strong caring communities far better in nearly every indicator; health, education, social experiences, family interaction. (2002)

[2] Children's Bureau Express (a publication of DHHS). 2003.

- When children must be removed from their homes, we ensure that parent child interactions occur as frequent as possible between parent and child, between case manager and family. [3]
- "Family directed" intervention—we do not seek to tell the family what to do but to create an environment where families can best determine their own actions.
- Honest feedback to families.[4]
- Ensuring that services are intentionally/planfully directed toward teaching the family skills to function independently without the formal helping system.
- Respect for families is at the core of service provision.
- Work with both the child and the family system.
- Children have voice in decisions that impact their life.
- Community partnerships serve as a vehicle for much of the service delivery.
- Work from a strengths perspective.

This document contains possible questions that can assist you in gathering information from a family during the assessment phase. It is critical that you do not ask a family all of these questions—but try to use those questions that will best elicit information from the family.

Additional valuable tools in learning about a family are **Lifelines, EcoMaps and Genograms.**

The categories that are addressed in this assessment include the following:

- The family telling their story
- Parenting
- Family fears
- Family resources and strengths
- Kinship/neighbor care options–family connections–support system
- Child Needs
- Child Mental Health
- Parental Mental Health
- Parental Child/Substance Abuse
- Domestic Violence in the Home
- Employment/Vocational
- Educational
- Housing/Basic Needs
- Medical/Dental
- Successful Visitation
- Reunification/Case Closure

[3] Some of the best research on the importance of frequent parent-child interaction has been conducted by Hess. Case and Context: Determinants of Planned Visit Frequency in Foster Family Care. (CWLA 1998). Family Visiting of Children in Out of Home Care: A practical Guide (CWLA 1999). Family Connection Center: An Innovative Visitation Program. (CWLA 1999).

[4] Full Disclosure is a practice model that is inherent in a strong Family Centered/Concurrent Planning Environment. Frankel. Family Centered, Home Based Services in Child Protection: A Review of the Research. Social Service Review (1997).

FAMILY TELLING THEIR STORY	
Ways to Ask Questions	• What are the family's perceptions of the reasons that the system is involved—or why the child has been removed? • What has your life been like in the past year? Have there been any big events or changes? How are you and your child dealing with theses changes? • Describe your childhood – what was it like growing up in your family? • In the Native American Community the story may begin many years ago—story telling takes time—workers need to listen to their entire story. Need to be sensitive to the tension between time and honoring relationship—genuine and respect. • Are any of the safety and risk issues valid from the families' perspectives?
Success Factors on Which You Can Build	• Bonding between child and parents—connection, stories of positive healthy interaction. • Support systems and connections that serve to provide the family with care giving, and/or financial options. • The parent acknowledges the problem and is willing and open to intervention.
Considerations and Areas we need to explore	• Lack of parental acknowledgement and understanding of the issues –and a seeming lack of motivation to change the problem.
Comments:	
PARENTING	
Ways to Ask Questions	• Parenting is not something that you wake up and know how to do…it is just hard for all of us. Do you ever get lost as a parent? • How often do you eat with your children? • Do the children have breakfast before they go to school? • Scaling question—On a scale of 1-10, where are you at in comparison with where would you like to be as a parent?

	• What is a day in your life like? • If one of your kids is being really difficult "lies all of the time" what is one creative way that you have used to deal with it?" • What bugs you about your child – what pushes your button—who does he/she remind you of? Describe each of your children? • Describe a great memory you have of your family. • When is a time when your child was very successful—what part did you play in that success? • What are the ways that you show love to your children? • Who taught you to be a parent? Who is your biggest influence as a parent?
Success Factors on Which You Can Build	• Can they recall something with their child that is a good memory? • Clear verbal statement that they love their children • If the parent can still laugh about some of the things that their children are doing…find the humor and tenderness in the frustrations. • Is there some understanding of the process that they are going through? • Parent willingness to modify parenting style—willing to try new ideas. • Can reach out to find family members or neighbors who can provide relief to some of the day-to-day stressors of parenting. • Parent is willing and able to parent (physically & mentally).
Considerations	• Parent is young or had a child at an early age. • Parent is single with little parenting support. • Child has taken on parenting role in the family. • Parent has unrealistic expectations for the child. • There is a lack of consistent supervision. • Responds negatively, harshly, tone of voice is generally angry or harsh. Excludes the child. Negative to normal developmental behaviors.

Comments:	
FAMILY FEARS	
Ways to Ask Questions	• What scares you the most about CPS involvement? • We are all afraid to be judged…are you afraid of how I might perceive you? • Do you think that you are going to be able to do what the judge or child protection wants you to do? • Are you afraid of what your children might think? • How do you think the rest of your family is going to respond to our involvement?
Success Factors on Which You Can Build	• Where do we leave the room for the family to say, "I cannot parent"? Strength and courage to say that someone else would do this better---and I would like to be apart of deciding whom it should be. • Parent, while uncomfortable, does what it takes to meet child's needs—regardless of own feelings of pride.
Considerations and Areas to explore	• Remember a family under stress does not assimilate all of the information that we are sharing. Their thoughts are often illogical and they usually are in the fight or flight mode of survival. • Child fears parent or other adult within the home. • Family expresses fears of long-term parenting—does not see self as a long term parent to this child either through capacity or willingness? • Parent's pride or unwillingness to receive help hinders their ability to correct risk and to meet children's needs.
Comments:	
FAMILY RESOURCES AND STRENGTHS	
Ways to Ask Questions	*Adult/Family/Adolescent Strengths:* • What was something that you did in the last 30 days that you are proud of?

	• When do things work well in your family? • What do you enjoy doing? • What are you good at? • How does your family have fun? What activities do you and your child like to do outside of the home? • What gets you through a bad day? • When was the last time you felt really good about yourself—what were you doing *Child Strengths:* • What things can your child do by himself? • What is he/she really good at?
Success Factors on Which You Can Build	• Can recall when someone's needs were met by his/her action. • Parent put someone else's needs ahead of his/her own. • Parent sees possibilities. • Parent completed a task. • They can measure that they are improving in something…recognize that they are moving in the direction that they want to. • Parent is able to identify their own needs and their child's needs. • Family is open to feedback and support.
Considerations and areas to explore	• Self concept is so stressed that parents do nothing for themselves—and cannot recall any times of joy or happiness.

Comments:	
KINSHIP/NEIGHBOR CARE OPTIONS– FAMILY CONNECTIONS–SUPPORT SYSTEM	
Ways to Ask Questions	• What family members are you close to? • Who can you rely on? • Who helps you when you are stressed out? • Who do you trust? • For a Native American family, do you visit your relatives? What do you consider home? • Who do you consider family? • Are you connected to any tribe or family? • Are you involved with any church or community group? • Sometimes when you don't know how you are going to feed your children, it is hard to focus on anything else---do you ever struggle? Who helps you during these times? • How long have you lived in this community?
Success Factors on Which You Can Build	• Family clearly has connections and support systems. These people are clearly there for the family. • Parent is involved with activities outside the home.
Considerations and Areas to explore	• Recent death or loss of a family member that served as a support system. • Does not seem to trust anyone to get close. • Lives in a geographically isolated area. • If exploring kinship care, can and will this relative meet the safety and well-being needs of the child?

Comments:

CHILD NEEDS

This need to be completed for every child in the family. Remember every child in the family may be causing stress—not just the "identified" child.

Ways to Ask Questions	*Ask the parent:* • Based on the child's experiences –what do they need? • What do you think that your child needs? • Do you think that you will, in the near future, be able to give your child what you want them to have? • With whom is it important to this child to stay connected? *Ask the child:* • What do you think you need? • Grant you three wishes what would they be? • Are there times that you feel scared…what is happening then? Who is around? • What is the best time at home? • What is the worst time at home? • What are you good at? What do you love to do? What do you like about school—what is your favorite subject in school? • Is it easy to make friends? Do you have a close friend? What do you do together? • What would you like to see change about your family?
Success Factors on Which You Can Build	• Child goes to parent to get needs met. • Child appears to feel safe with parent. • Child has toys that are age appropriate. • Child knows not to talk to strangers and other safety tips.
Considerations and Areas to explore	• Does any child within the family have special physical or developmental needs that are very demanding?

Comments:

CHILD MENTAL HEALTH	
Ways to Ask Questions	• Does your child have any behavioral problems, problems at school or bedwetting? If so, please describe your child's behaviors. • If so, have you had to miss work or school because of these problems?
Success Factors on Which You Can Build	• Child appears to be happy, has friends and is well adjusted. • The family has sought out mental health services for the child • Child follows recommendations of mental health professionals. • The parent voices concern and asks for help around the child's behavior health needs.
Considerations and Areas to explore	• Has the child had a suicidal gesture in the past? • Are the behavioral issues of the child such that the family is isolating the child—or focuses solely negative interaction with the child?
Comments:	
PARENTAL MENTAL HEALTH	
Ways to Ask Questions	• As a child did you ever experience any type of abuse? • Do you ever feel like you just can't take it any more? • Do you ever have a hard time just getting going? • When you cannot "get going" who takes care of your child?
Success Factors on Which You Can Build	• Family giving themselves permission to not parent—they are OK with it…we make it OK. • Parent has or is seeking mental health treatment • Parent consistently follows recommendations from therapist
Considerations and Areas to explore	• Parent appears depressed, unkempt, sleeping all-day, tearful—unable to plan for the needs of the child.

Comments:

PARENT and/or CHILD SUBSTANCE ABUSE	
Ways to Ask Questions	• Has drinking or drugs been an issue in your family? • Have you ever felt like you should cut back on your drinking or drug use—or felt bad or guilty about it? • Have you ever used alcohol or drugs to get you through a bad time? • Has your drinking or drug use caused job, school, family, or legal problems? • Have you ever felt annoyed by criticism of your drinking or drug use? • Do others in the home use alcohol or other drugs?
Success Factors on Which You Can Build	• Treatment was successful and parent or child maintains sobriety. • Attends AA, NA or other support group • Child or parent says that he is able to say no to peers. • Child admits using and has frank conversations with parents. • Child is able to express concerns about personal use.
Considerations and Areas to explore	• History of drinking per report by the family. • Binge drinking that results in a disruption in the family and reduces the parent's ability to care for the child.
Comments:	
DOMESTIC VIOLENCE	
Ways to Ask Questions	• How is your relationship with your partner/spouse/significant other? • Have you ever felt worried about your safety because of your partner...in what way? • Have you ever been concerned about the safety of your children? • Do you have a pet—if so have you ever been worried about the safety of your pet?

Success Factors on Which You Can Build	• Parents are able to identify methods for non-violent resolution of conflicts and can provide examples of times they have successfully used these methods. • Non-offending parent protects child by sending child to relatives, friends or another safe place.
Considerations and Areas to explore	• Household has a history of family violence • One parents is afraid of another adult within the family • Child expresses concern for parent's safety • Child attempts to intervene during a domestic violence incident • Child is injured during a domestic violence incident
Comments:	
EMPLOYMENT/VOCATIONAL	
Ways to Ask Questions	• Do you currently have a job? • What is the longest time that you have had a job? • What kind of work do you do? • What kind of work do you enjoy? • Have you had any training that you wish you could use in your work? • Are people in your life supportive of you working?
Success Factors on which you can build	• Parent has held a job for one year or longer. • Parent is or has participated in job training, GED classes, or higher education classes • Parent has successfully completed job training or GED/education.
Comments	

EDUCATIONAL	
Ways to Ask Questions	*Ask the Parent:* • What was the highest grade you as the parent completed—did you like school? • If you had the opportunity would you like to get more education? • What are your hopes for your child's education? • When your child is in school are you involved in their education? • How does your child do in school? Does he/she/they like school? • Do you think that your child in need of special services –and you cannot obtain them from the school? *Ask the Child:* • What do you think about school? • Do you have a favorite subject or class? • What would you like to be when you grow up?
Success Factors on which we can build	• Parent completed high school • Parent completed or is enrolled in GED classes • Parent attends (or has) secondary education program • Child attends school regularly • Child makes good grades • Child has good behavior while at school
Considerations and Areas to explore	• Child is frequently truant–and parent is accepting of this. • Child does not concentrate at school—per teacher report. • Child struggles with ADD or ADHD.
Comments:	
HOUSING/BASIC NEEDS	
Ways to Ask Questions	• How many times have you moved in the past year? • Why did you move? • Most months, are you able to pay rent? • When was the last time that you had to ask for assistance in paying rent, mortgage, and/or utilities? • Have you ever applied for public assistance (TANF, food

	stamps, day care subsidy, utility assistance)? • Do you ever have concerns about your house or your neighborhood being safe for you or your children?
Success Factors on Which You Can Build	• Being poor does not mean that the family needs child protection involvement. • Creatively finds supports to meet child's needs—has a strong sense of community options. • Family is able to meet their basic needs either on their own or from their community.
Considerations and Areas to explore	• Homeless—which is a stressor. • Family moves frequently
Comments:	

MEDICAL/DENTAL	
Ways to Ask Questions	• Does you/or your child have a medical provider? • When was the last time that you saw him/her? • Does you or your child or any member of the family have any health conditions we should know about? • Has you or your child/any member of your family been sick lately? • Has your health ever held you back from getting a job or taking care of your children? • Are there any medications that you/your family is taking? • Have you and your children been to the dentist? • When was the last time your children visited the dentist?
Success Factors on Which You Can Build	• Parent able to verbalize child's medical conditions—knows what they need. Has plan for caring for child. • Parent maintains their own health by having check ups • Parent maintains their child's immunizations and regular medical check ups. • Parent and child visit a dentist every 6 months. • Both parent and child are healthy.
Considerations and Areas to explore	• Parent has a medical condition that does not allow them to care for their child—no outside support. • Cannot meet ongoing medical needs of the family due to lack of resources. • Child has medical condition that places stress on the family physically, emotionally, and/or financially.
Comments:	
SUCCESSFUL VISITATION	
Assessment for Successful Visitation and Planning for children in Out of Home Care.	• There needs to be a conversation about the real (higher) purpose of this visit. Parent's perspective and workers perspective. • Visitation is only denied due to a parent being under the influence if it harmful to the child or if denied by the court. • Remember that there is an expectation that the foster family work/team/support with the birth family—so the worker can expect this/suggest this/encourage this—but you cannot mandate

	it. • There is a positive correlation between family contact and family reunification. For this reason visitation is critical. • If the child is in placement, what are the ways to make visitation successful and consistent? • What is the best time for visitation? For the parent? For the child? For the out-of-home care provider? • If we had the resources, how many times a week do you think that you would like to visit your child? • Does the parent have/need transportation? • Where would you feel most comfortable visiting? • Ask the parent, Could we plan a specific activity for the visit? What are the things that your children like to do…could you bring along a game? • Who do you want to be at the visit? Why is it important that this person be there? Who is your child connected to?
Success Factors on Which You Can Build	• Look for ways that it can occur in the home—we need this to be productive and conducive to bonding. • If the parent says that there is someone who is connected to the family and *is safe*—could this person be the individual who supervises the visit? This must be addressed only in the context of safety. • Our job as social workers is to try to wrap the supports around the family to get as much visitation as possible. We cannot always do this, but with our supervisor we need to find a way. • Have the parent at school conferences, at doctor's appointments, etc. • Really look at sibling relationships and visitation. • Explore ways that all family members (parents, siblings, grandparents, etc.) can keep in touch through visitation, telephone calls, mail, email, photographs, and videos.
Considerations and Areas to explore	• Child has extreme emotional and/or behavioral reaction to visits that is chronic (lasts longer than a few days) in nature. May need to look at therapeutic visitation techniques. • Resource Parents and Birth Parents are not able to work effectively together.

Comments:

REUNIFICATION/CASE CLOSURE	
Ways to Ask Questions	• What do you think is keeping your family from being together? OR What do you think is keeping CPS involved in your life? • What is it going to take, from both of us, to get your family back together? OR close your case safely? • What are you willing to change to reunite your family? • Of all the things that CPS or the courts have asked you to do, what do you think you will need the most help with? • Of all that we have offered, what is most helpful?
Success Factors on which you can build	• Parent is able to identify successes. • Parent is motivated to change—has initiated changes on their own. • Parent seeks and uses community resources.

Comments:

Child Welfare Information Gateway
PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

BULLETIN FOR PROFESSIONALS

August 2003

Children and Domestic Violence

What's Inside:

- Impact of domestic violence on children
- Implications for practice
- Resources for further information

Scope of the Problem

Domestic violence is a devastating social problem that impacts every segment of the population. While system responses are primarily targeted toward adult victims of abuse, increased attention is now being focused on the children who witness domestic violence. Studies estimate that 10 to 20 percent of children are at risk for exposure to domestic violence (Carlson, 2000). These findings translate into approximately 3.3 to 10 million children who witness the abuse of a parent or adult

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
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caregiver each year (Carlson, 1984; Straus & Gelles, 1990). Research also indicates children exposed to domestic violence are at an increased risk of being abused or neglected. A majority of studies reveal there are adult and child victims in 30 to 60 percent of families experiencing domestic violence (Appel & Holden, 1998; Edleson, 1999).

Impact of Domestic Violence on Children

Children who live with domestic violence face increased risks: the risk of exposure to traumatic events, the risk of neglect, the risk of being directly abused, and the risk of losing one or both of their parents. All of these may lead to negative outcomes for children and may affect their well-being, safety, and stability (Carlson, 2000; Edleson, 1999; Rossman, 2001). Childhood problems associated with exposure to domestic violence fall into three primary categories:

- **Behavioral, social, and emotional problems.** Higher levels of aggression, anger, hostility, oppositional behavior, and disobedience; fear, anxiety, withdrawal, and depression; poor peer, sibling, and social relationships; and low self-esteem.
- **Cognitive and attitudinal problems.** Lower cognitive functioning, poor school performance, lack of conflict resolution skills, limited problem solving skills, pro-violence attitudes, and belief in rigid gender stereotypes and male privilege.
- **Long-term problems.** Higher levels of adult depression and trauma symptoms and increased tolerance for and use of violence in adult relationships.

Children's risk levels and reactions to domestic violence exist on a continuum where some children demonstrate enormous resiliency while others show signs of significant maladaptive adjustment (Carlson, 2000; Edleson, 1999; Hughes, Graham-Bermann, & Gruber, 2001). Protective factors, such as social competence, intelligence, high self-esteem, outgoing temperament, strong sibling and peer relationships, and a supportive relationship with an adult, can help protect children from the adverse effects of exposure to domestic violence.

Comprehensive assessment regarding protective factors and the effects of domestic violence on children can inform decision-making regarding the types of services and interventions needed for children living with violence. Additional assessment factors that influence the impact of domestic violence on children include:

- **Nature of the violence.** Children who witness frequent and severe forms of violence or fail to observe their caretakers resolving conflict may undergo more distress than children who witness fewer incidences of physical violence and experience positive interactions between their caregivers.
- **Coping strategies and skills.** Children with poor coping skills are more likely to experience problems than children with strong coping skills and supportive social networks.
- **Age of the child.** Younger children appear to exhibit higher levels of emotional and psychological distress than older children. Age-related differences might result from

older children's more fully developed cognitive abilities to understand the violence and select various coping strategies to alleviate upsetting symptoms.

- **Elapsed time since exposure.** Children often have heightened levels of anxiety and fear immediately after a violent event. Fewer observable effects are seen in children as more time passes after the violent event.
- **Gender.** In general, boys exhibit more externalized behaviors (e.g., aggression or acting out) while girls exhibit more internalized behaviors (e.g., withdrawal or depression).
- **Presence of child physical or sexual abuse.** Children who witness domestic violence and are physically abused are at risk for increased levels of emotional and psychological maladjustment than children who only witness violence and are not abused themselves (Carlson, 2000; Edleson, 1999; Hughes et al., 2001).

Implications for Practice

Since children respond differently to domestic violence, professionals are cautioned against assuming that witnessing domestic violence constitutes child maltreatment or requires child protective services intervention (Aron & Olson, 1997; Beeman, Hagemeister, & Edelson, 1999; Carter & Schechter, 1997; Findlater & Kelly, 1999; Spears, 2000; Whitney & Davis, 1999). Some States are considering legislation that broadens the definition of child neglect to include children who witness domestic violence. Expanding the legal definition of child maltreatment, however, may not always be the most effective method to address the needs of these children. Communities can better serve families by allocating resources that build partnerships among service providers, child protective services, and the array of informal and formal systems that offer a continuum of services based upon the level of risk present (Carter & Schechter, 1997; Edleson, 1999; Spears, 2000).

Increased awareness regarding the co-occurrence of domestic violence and child abuse compelled child welfare and domestic violence programs to re-evaluate their services and interventions with families experiencing both forms of violence. Although adult and child victims often are found in the same families, child welfare and domestic violence programs historically responded separately to victims. The divergent responses are largely due to differences in each system's development, philosophy, mandate, policies, and practices (Aron & Olson, 1997; Beeman, Hagemeister, & Edleson, 1999; Carter & Schechter, 1997; Findlater & Kelly, 1999; Spears, 2000; Whitney & Davis, 1999). For example, some child welfare advocates have charged domestic violence service providers with discounting the safety needs of children by focusing solely on the adult victim. Conversely, some domestic violence advocates accuse child protective services caseworkers of "revictimizing" adult victims by blaming them for the violence, removing their children and charging them with "failure to protect."

Despite these differences, child welfare advocates and service providers share areas of common ground that can bridge the gap between them, including:

- Ending violence against adults and children
- Ensuring children's safety

- Protecting adult victims so their children are not harmed by the violence
- Promoting parents' strengths
- Deferring child protective services intervention, if possible, and referring adult victims and children to community-based services

A number of national, State, and local initiatives are demonstrating that a collective ownership and intolerance for abuse against adults and children can form the foundation of a solid, coordinated, and comprehensive approach to ending child abuse and domestic violence.

Examples of promising practice approaches include:

- Co-locating domestic violence advocates in child welfare offices for case consultation and supportive services
- Developing cross-system protocols and partnerships to ensure coordinated services and responses to families
- Instituting family court models that address overlapping domestic violence and child abuse cases
- Cross training domestic violence and child welfare advocates
- Creating domestic violence units in child welfare agencies
- Using the Temporary Assistance for Needy Families Program to provide funding, services, exceptions from work requirements, and other waivers, under the Family Violence Option, for families experiencing domestic violence

Institutional and societal changes can only begin when an expansive network of service providers integrate their expertise, resources, and services to eliminate domestic violence in their communities. Thus, child welfare and domestic violence service providers can collaborate to achieve a shared goal of freeing victims from violence and working to prevent future violence.

Resources for Further Information

Websites

The Link Research Project: Understanding the Link Between Child Maltreatment and Woman Battering
www.mincava.umn.edu/link
Provides up-to-date information on research, practice, and promising intervention models with families experiencing domestic violence and child abuse and neglect.

Resource Center on Domestic Violence: Child Protection and Custody
www.nationalcouncilfvd.org
Comprehensive publications and technical assistance to the fields of domestic violence, child protection, and custody regarding policy and practice issues inherent in work with children exposed to domestic violence.

Child Witness to Violence Project
www.bostonchildhealth.org/special/CWTV/overview.html
Offers general information about the effects of domestic violence on children, statistics, and the *Report on Violence and Children*.

The "Greenbook" Federal Initiative
www.thegreenbook.info
Provides resources and information regarding the six federally funded communities implementing the National Council of Juvenile and Family Court Judges guidelines, *Effective Intervention in Domestic Violence & Child Maltreatment Cases: Guidelines for Policy and Practice*.

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FACTSHEET FOR FAMILIES

January 2009

Parental Substance Use and the Child Welfare System

Parental substance use continues to be a serious issue in the child welfare system. Maltreated children of parents with substance use disorders often remain in the child welfare system longer and experience poorer outcomes than other children (U.S. Department of Health and Human Services [HHS], 1999). Addressing the multiple needs of these children and families is challenging.

What's Inside:

- Statistics and costs
- Impact of parental substance use on parenting
- Impact on child outcomes
- Methamphetamine
- Other substances
- Service delivery issues
- Promising practices
- Resources for further information

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This factsheet provides a brief overview of some of the issues confronting families affected by parental substance use who enter the child welfare system, and it examines some of the service barriers as well as the innovative approaches child welfare agencies have developed to best meet the needs of these children and families.

Statistics and Costs

It is estimated that 9 percent of children in this country (6 million) live with at least one parent who abuses alcohol or other drugs (Substance Abuse and Mental Health Services Administration [SAMHSA], 2003). Studies indicate that between one-third and two-thirds of child maltreatment cases involve substance use to some degree (HHS, 1999).

It is difficult to determine the numbers of child welfare cases that involve substance-using parents. One article notes that not all child welfare agencies systematically record information on parental substance use disorders, and many substance abuse treatment programs do not routinely ask patients if they have children (Young, Boles, & Otero, 2007). The article goes on to summarize available data from a number of national studies, estimating that 22,440 children receiving in-home services for maltreatment and 128,640 to 211,720 children in out-of-home care had a parent with a substance use disorder in 2004. In that same year, approximately 295,000 parents receiving treatment for substance use had one or more children removed by child protective services.

Expenditures related to substance use are significant, because maltreated children of parents with a substance use disorder may experience more severe problems and remain in the foster care system longer than maltreated children from other families (HHS, 1999). One study estimates that of the more than $24 billion States spend annually to address different aspects of substance use, $5.3 billion (slightly more than 20 percent) goes to child welfare costs related to substance abuse (National Center on Addiction and Substance Abuse at Columbia University, 2001).

Impact of Parental Substance Use on Parenting

Parents with substance use disorders may not be able to function effectively in a parental role. This can be due to:

- Impairments (both physical and mental) caused by alcohol or other drugs
- Domestic violence, which may be a result of substance use
- Expenditure of often limited household resources on purchasing alcohol or other drugs
- Frequent arrests, incarceration, and court dates
- Time spent seeking out, manufacturing, or using alcohol or other drugs
- Estrangement from primary family and related support

Families in which one or both parents have substance use disorders, and particularly families with an addicted parent, often experience a number of other problems that affect parenting, including mental illness, unemployment, high levels of stress, and impaired family functioning, all of which can put children at risk for maltreatment (National Center on Addiction and Substance Abuse at Columbia University, 2005). The basic needs of children, including nutrition, supervision, and nurturing, may go unmet due to parental substance use, resulting in neglect. Depending on the extent of the substance use and other circumstances (e.g., the presence of another caregiver), dysfunctional parenting can also include physical and other kinds of abuse (HHS, 1999).

Impact on Child Outcomes

The impact of parental substance use disorders on a child can begin before the child is born. While the full effects of prenatal drug exposure depend on a number of factors, alcohol or drug use during pregnancy has been associated with infant mortality, premature birth, miscarriage, low birth weight, and a variety of behavioral and cognitive problems in the child (National Institute on Drug Abuse, n.d.; Maternal Substance Abuse and Child Development Project, n.d.). A 2007 study of children in foster care found that prenatal maternal alcohol use predicted child maltreatment, and combined prenatal maternal alcohol and drug use predicted foster care transitions (Smith, Johnson, Pears, Fisher, & DeGarmo).

Fetal alcohol spectrum disorders (FASD) are among the most well-known consequences, affecting an estimated 40,000 infants born each year. Children with FASD may experience mental, physical, behavioral, and learning disabilities (National Organization on Fetal Alcohol Syndrome, 2006). Children with the most severe disorders may suffer from fetal alcohol syndrome, alcohol-related neurodevelopmental disorder, or alcohol-related birth defects.

Research has demonstrated that children of parents with substance use disorders are more likely to experience abuse (physical, sexual, or emotional) or neglect than children in other households (DeBellis et al., 2001; Dube et al., 2001; Hanson et al., 2006). As infants, they may suffer from attachment difficulties that develop because of inconsistent care and nurturing, which may interfere with their emotional development (Tay, 2005). As growing children, they may experience chaotic households that lack structure, positive role models, and adequate opportunities for socialization (Hornberger, 2008).

In addition, children of parents who use or abuse substances have an increased chance of experiencing a variety of other negative outcomes (HHS, 1999):

- Maltreated children of parents with substance use disorders are more likely to have poorer physical, intellectual, social, and emotional outcomes.
- They are at greater risk of developing substance use problems themselves.

- They are more likely to be placed in foster care and to remain there longer than maltreated children of parents without substance use problems.

Methamphetamine

Over the last decade, there has been an increase in the manufacture and use of methamphetamine. From 1995 to 2005, the percentage of substance abuse treatment admissions for primary abuse of methamphetamine/amphetamine more than doubled from 4 percent to 9 percent (National Clearinghouse for Drug and Alcohol Information, n.d.).

Parental use of methamphetamine has many of the same effects on children as other kinds of drug use. Prenatal exposure can produce birth defects and low birth weight and may lead to developmental disorders (Brown University, 2006). Parents who use methamphetamine may suffer physical and psychological effects that lead to abuse and neglect of their children (National Institute on Drug Abuse, 2006). In addition, some methamphetamine users also are producers of the drug, which can be manufactured using common household products. These home "labs" put children in additional danger from exposure to the drugs and the conditions under which they are manufactured and distributed (Swetlow, 2003).

Surveys conducted by the National Association of Counties indicate that methamphetamine has increased the burden of child welfare agencies in many areas of the country (National Association of Counties, 2005). In addition to increasing caseloads in some areas, the unique dangers of methamphetamine labs have prompted many jurisdictions to develop specific protocols for meeting the needs of children who may have been exposed to the drug (Swetlow, 2003).

Other Substances

While methamphetamine continues to garner much attention, other drugs actually account for the bulk of substance use disorders. According to SAMHSA (2007):

- Marijuana was the most commonly used illicit drug in 2006, accounting for 72.8 percent of illicit drug use.
- In 2006, there were 2.4 million cocaine users, a figure that remained the same from 2005 but was an increase from 2002 (at 2.0 million).
- The number of heroin users increased from 136,000 in 2005 to 338,000 in 2006, and the corresponding prevalence rate increased from 0.06 to 0.14 percent.
- The most widely used substance continues to be alcohol. In 2006, heavy drinking was reported by 6.9 percent of the population (17 million people), while binge drinking was reported by 23 percent (57 million people).

Service Delivery Issues

Child welfare agencies face a number of difficulties in serving children and families affected by parental substance use disorders:

- Inadequate funds for services and/or dependence on client insurance coverage
- Insufficient service availability or scope of services to meet existing needs
- Lack of training for child welfare workers on substance use issues
- Lack of coordination between the child welfare system and other services and systems, including hospitals that may screen for drug exposure, the criminal justice system, and the courts
- Conflicts in the time required for sufficient progress in substance abuse recovery to develop adequate parenting potential, legislative requirements regarding child permanency, and the developmental needs of children (Young & Gardner, 2003)

Agencies are faced with timeframes imposed by the Adoption and Safe Families Act of 1997 (ASFA) that may not coincide with substance abuse treatment. Although ASFA requires that an agency file a petition for termination of parental rights if a child has been in foster care for 15 of the past 22 months, unless it is not in the best interest of the child, many States cannot adhere to this timeframe due to problems with accessing substance abuse services in a timely manner. This results in delayed permanency decisions for children in the foster care system (U.S. General Accounting Office [GAO], 2003). For example, despite a Federal mandate that pregnant and parenting women receive priority for accessing substance abuse treatment services, States report it is often difficult for these parents to access an open treatment slot quickly (GAO, 2003). Once a slot is available, treatment itself may take many months, and achieving sufficient stability to care for their children may take parents even longer. In addition, relapse is often part of the recovery process for parents undergoing treatment, especially in the early phases, so it is especially important that parents access treatment quickly (HHS, 1999). Custodial parents who require residential treatment may face an additional barrier since many of these programs do not allow children to live in the facility.

Promising Practices

There is a growing movement toward collaboration among the child welfare, substance abuse, courts, and other systems that provide services for children and families affected by substance use by their parents. Communication, understanding, and active collaboration among service systems are vital to ensuring that child welfare-involved parents in need of substance abuse treatment are accurately identified and receive appropriate treatment in a timely manner (Child Welfare League of America, 2001; HHS, 1999).

Some examples of effective approaches include:

Prevention and Treatment

- Focusing on early identification of at-risk families in substance abuse treatment programs so that prevention services can be provided to ensure children's safety and well-being in the home
- Providing coaching or mentoring to parents for their treatment, recovery, and parenting (Ryan, 2006)
- Offering shared family care in which a family experiencing parental substance use and resulting child maltreatment is placed with a host family for support and mentoring (National Abandoned Infants Assistance Resource Center, n.d.)
- Giving mothers involved in the child welfare system priority access to substance abuse treatment slots
- Providing inpatient treatment for mothers in facilities where they can have their children with them
- Motivating parents to enter and complete treatment by offering such incentives as support groups or housing (Voices for America's Children, November 2004).

Systems Changes

- Stationing addiction counselors in child welfare offices or forming ongoing teams of child welfare and substance abuse workers
- Developing or modifying dependency drug courts to ensure treatment access and therapeutic monitoring of compliance with court orders
- Developing cross-system partnerships to ensure coordinated services (e.g., formal linkages between child welfare and other community agencies to address each family's needs)
- Providing wraparound services that streamline the recovery and reunification processes
- Conducting cross-system training
- Recruiting and training a diverse workforce and including training in cultural competence (National Center on Substance Abuse and Child Welfare, 2005)
- Exploring various funding streams to support these efforts (e.g., using State or local funds to maximize child welfare funding for substance abuse-related services or using Temporary Assistance to Needy Families [TANF] funds to support substance abuse treatment for families also involved with the child welfare system) (Young and Gardner, 2002)

The Children's Bureau has funded a number of discretionary grants to promote demonstration projects with a goal of improved outcomes for children growing up in families in which one or more parents has a substance use problem. These grants have included:

- Family Support Services for Grandparents and Other Relatives Providing Care for Children and Substance Abusing and HIV-Positive Women (awarded in 2001 with six grantees)
- Family Support Services for Grandparents and Other Relatives Providing Caregiving for Children of Substance Abusing and/or HIV-Positive Women (awarded in 2004 with four grantees)

- Model Development or Replication to Implement the CAPTA Requirement to Identify and Serve Substance Exposed Newborns (awarded in 2005, with four grantees)
- Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine or Other Substance Abuse (awarded in 2007, with 53 grantees under four program options)

(For more information on these awards, visit the Children's Bureau Discretionary Grants Library online at http://basis.caliber.com/cbgrants/ws/library/docs/cb_grants/GrantHome.)

Replication or adaptation of any of the above approaches requires a careful assessment of State or local capacity, including needs and strengths of families served, as well as a careful assessment of the evaluation findings to ensure funds are targeted toward effective programs. Agencies also should focus on the specific needs of the families they serve when selecting among these (and other) approaches.

Resources for Further Information

Child Welfare Information Gateway

www.childwelfare.gov/systemwide/service_array/substance/

The Substance Abuse web section of the Information Gateway website links to information on prevention and treatment services for families affected by parental substance use and involved with the child welfare system.

Children's Bureau

www.acf.hhs.gov/programs/cb

The Children's Bureau funds a variety of programs and initiatives that promote the safety, permanency, and well-being of children and their families, including initiatives designed to address parental substance use.

Children and Family Futures

www.cffutures.com

Children and Family Futures' mission is to improve the lives of children and families, particularly those affected by substance use disorders. CFF advises Federal, State, and local government and community-based agencies, conducts research on the best ways to prevent and address the problem, and provides comprehensive and innovative solutions to policy makers and practitioners.

MethResources.Gov

www.methresources.gov

This agency is part of the White House Office of National Drug Control Policy, U.S. Department of Justice, & the U.S. Department of Health and Human Services. The website offers factsheets, FAQs, and information and resources on prevention, intervention, and treatment for methamphetamine use.

National Abandoned Infants Assistance Resource Center

http://aia.berkeley.edu

The National Abandoned Infants Assistance Resource Center's mission is to enhance

the quality of social and health services delivered to children who are abandoned or at-risk of abandonment due to the presence of drugs and/or HIV in the family. The Resource Center, which is funded by the Children's Bureau, provides training, information, support, and resources to service providers who assist these children and their families.

National Center on Substance Abuse and Child Welfare

www.ncsacw.samhsa.gov

NCSACW was formed to improve systems and practice for families with substance use disorders who are involved in the child welfare and family judicial systems by assisting local, State, and Tribal agencies. NCSACW is jointly funded by the Children's Bureau and SAMHSA.

National Clearinghouse for Alcohol & Drug Information

http://ncadi.samhsa.gov

Sponsored by SAMHSA, NCADI is a one-stop resource for information about substance abuse prevention and addiction treatment; resources include the Prevention Materials database, with more than 8,000 prevention-related materials, and the Treatment Resources database, available to the public in electronic form.

National Institute on Alcohol Abuse and Alcoholism

www.niaaa.nih.gov

Part of the National Institutes of Health, the NIAAA is the primary U.S. agency for conducting and supporting research on the causes, consequences, prevention, and treatment of alcohol abuse, alcoholism, and alcohol problems and disseminates research findings to general, professional, and academic audiences.

National Institute on Drug Abuse

www.nida.nih.gov

The National Institute on Drug Abuse supports over 85 percent of the world's research on the health aspects of drug abuse and addiction. NIDA works to ensure that the foundation for the nation's drug abuse reduction efforts are based on science.

National Organization on Fetal Alcohol Syndrome

www.nofas.org

NOFAS works to raise public awareness of Fetal Alcohol Syndrome (FAS) and to develop and implement innovative ideas in prevention, intervention, education, and advocacy in communities throughout the nation.

National Registry of Evidence-Based Programs and Practices

www.nrepp.samhsa.gov

SAMHSA sponsors this searchable database of interventions for the prevention and treatment of substance abuse and mental health disorders.

The Rocky Mountain Quality Improvement Center

www.americanhumane.org/site/PageServer?pagename=pc_best_practice_rmqic_homepage

The Rocky Mountain Quality Improvement Center (RMQIC) has completed its Children's Bureau-funded project, but

the website continues to offer resources and information on providing safety, permanency, and well-being for children of families with substance abuse problems.

Self-Help Groups

http://ncadistore.samhsa.gov/catalog/referrals.aspx?topic=83&h=resources

SAMHSA provides this list of national self-help groups with contact information so that local meetings and resources can be identified. Groups include Alcoholics Anonymous, Al-Anon, National Association for Children of Alcoholics, Women for Sobriety, and more.

Substance Abuse and Mental Health Services Administration

www.samhsa.gov

SAMHSA is the Federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

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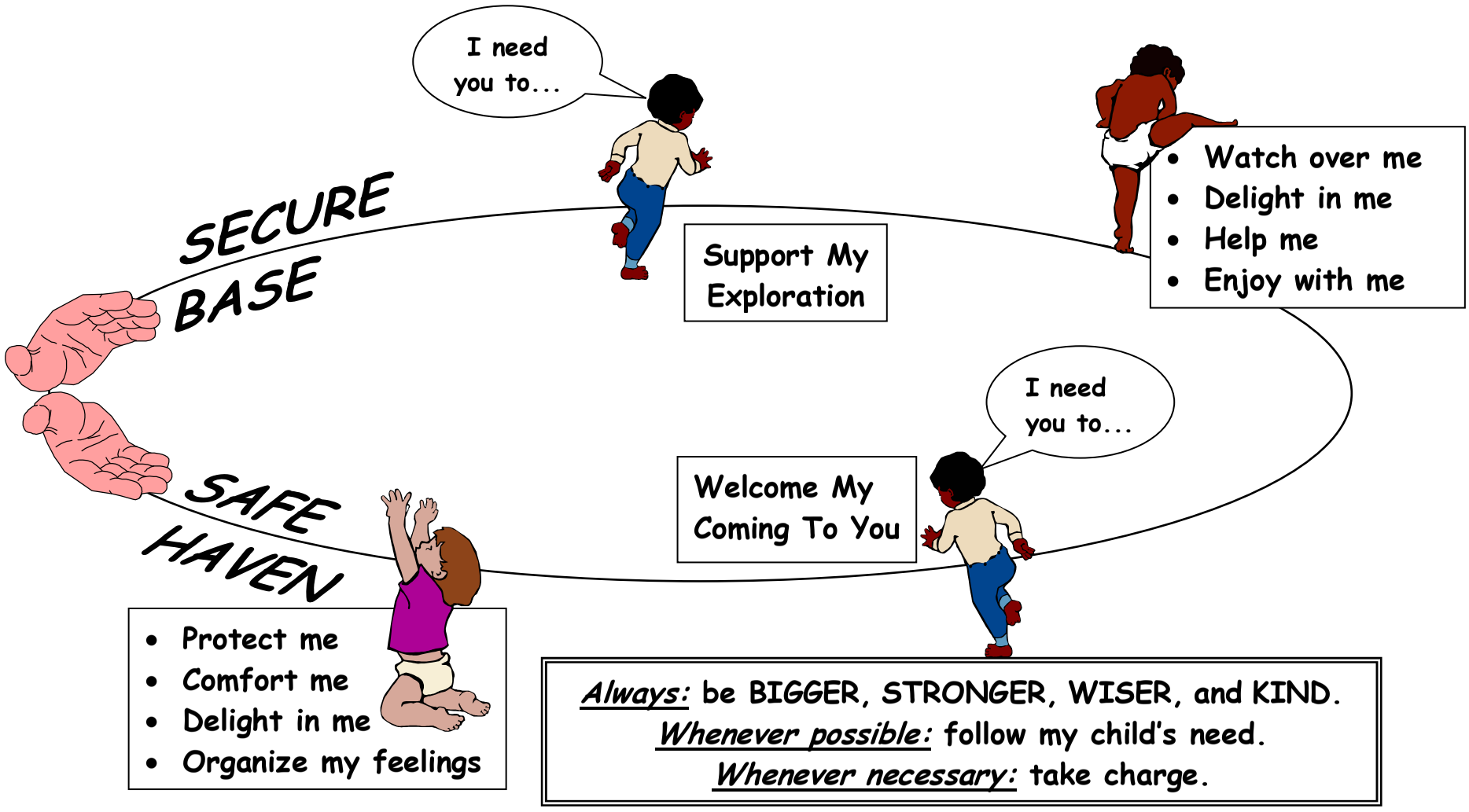
CIRCLE OF SECURITY

PARENT ATTENDING TO THE CHILD'S NEEDS



Always: be BIGGER, STRONGER, WISER, and KIND.
Whenever possible: follow my child's need.
Whenever necessary: take charge.

Traveling Around the Circle of Security

(To be used in conjunction with the Circle of Security graphic)

"Let's use the idea of Secure Base as a starting point for taking a tour around the Circle of Security. We will start with what we call the top half of the circle. When children feel safe and secure their curiosity kicks in and they want to learn about the world. However, before they set off to explore, children need a sense that their parent is supporting that exploration (see "Support My Exploration" on the Circle). "Support My Exploration" is one of the two transition needs on the circle. Even young children watch their parents very carefully to figure out what is safe and what is dangerous. Since they depend so much on their parents to protect them while they explore, young children also watch to see if their parent is paying attention to them for that protection. Young children don't actually think about this–remember, they are wired to do this automatically! Over time, they remember what parents have indicated is safe and what is dangerous. Support for exploration is often a combination of the history of that parent's support for exploration, as well as an immediate cue of safety.

"With support from their parent, children head out for grand adventures. They may wander across the room or behind the couch. As they get older, they can travel farther and stay away longer. And here's one of the most important points –as they are exploring, children need their parent just as much as they do when they are in their parent's lap. Even though what children need from their parent changes as they travel around the circle, it is important to remember that children need their parent all the way around the Circle.

"When the child is exploring, it is usually the parent's job to watch out for danger or be there in case something happens (see "Watch Over Me" on the Circle). Although the

parent may be barely aware of this, and the child may seem preoccupied with play, if the parent becomes unavailable, the child's exploration ends.

"Sometimes children need more than having the parent watch over them. At times children need help exploring (see "Help Me" on the Circle). This requires the caregiver to provide the necessary help without taking over (children need just enough help to do it by themselves). This is called scaffolding and usually requires the parent to continue to follow the child's need rather than taking charge.

"At other times, children simply want their caregiver to enjoy with them (see "enjoy with me" on the Circle). These shared moments provide children with a sense that the caregiver is attentive, available and attuned. It also makes children feel they are worthy of such attention.

"At all times, children need to know that no matter what they are doing, their parent finds delight in them, for no other reason than their simply being alive. Hence, during moments of exploration – moments that often have to do with building autonomy and mastery – a child will look back just to make sure the parent is delighted "(Delight in me"). This delight doesn't have to do with "what I just did" but "that I just am." Such moments do much to build a well-engrained sense of self worth in the child.

"When children have explored long enough or become tired, frightened or uncomfortable, they are no longer interested in exploring. Or if children get into an unsafe situation, parents need to take charge and end the exploration. Either way children suddenly have a new set of needs that require a response from their parent.

"We are now talking about the bottom half of the circle. Unless they are very frightened, the first thing children need on the bottom half of the Circle is a sign from the parent that they are welcome to come back to the parent. "Welcome My Coming to You"

is the second transition need on the circle. (See "welcome My Coming to You" on the Circle.) Like support for exploration, a children's sense that they are welcome to come back is a combination of a history of support, as well as an immediate cue.

"Children sometimes cue their parents for protection (see "Protect Me" on the Circle). Providing protection from clear and immediate danger is a basic part of parenting that we clearly understand. However, children are sometimes frightened and need to be soothed even when, to the adult, there is no clear danger.

"Sometimes the child is not in danger but needs comfort (see "Comfort Me" on the Circle). Although most parents understand the idea of comfort, not all parents have experience of either comforting or being comforted and so they struggle giving comfort to their children.

"Sometimes children need help organizing an internal experience that is overwhelming (see "Organize My Feelings" on the Circle). Most parents understand that their children need help organizing their external world or their behavior, but for many parents, it is a new idea that children need help organizing their internal world. Children's need for internal organization may come from being tired, hungry, disappointed, startled, sad, frustrated, etc. Whatever the cause, children need their parent's help because they are still too young to do it alone. It is through the repeated process of parents helping their children organize internally that children learn how to manage feelings both by themselves and in relationship."

Cooper, Hoffman, Marvin, and Powell – 2004 *circleofsecurity.org*

Building a Secure Attachment for Your Baby

- **The Name of the Game is Delight**: Babies are "hard-wired" to experience joy with their caregivers in the early months of life. Researchers are finding that mutual joy is the basis for increased brain growth. A baby feels more secure knowing that "Life is good, because my parent enjoys life when s/he is with me."
- **Every Baby Needs a Holding Environment**: Babies soak up affection and love through their skin. Gentle touch shares the tenderness that every infant requires. Playful touch encourages joy. Holding your baby not only provides pleasure and reassurance, it is essential in helping to soothe and organize difficult feelings.
- "**The Eyes Have It**:" Gaze into your baby's eyes from the first day of life, and pay close attention to when your child wants to look back. At about six weeks, your child will regularly focus in on your eyes and read what they are "saying." Lots of pleasurable eye contact will translate into a feeling of reassurance and connection for your baby.
- **Whenever Possible, Follow Your Child's Lead**: Security of attachment requires a caregiver who is sensitive and responsive to her/his child's needs. Your willingness to answer subtle requests for attention, comfort, holding, exploration, and discovery (with you nearby) will provide an increased sense of security for your child.
- **You Can't Spoil a Baby**: Contrary to those who may be saying that you will harm your child if you are "too responsive" to her/his needs, it isn't possible to spoil a baby in the first 9-10 months of life. Researchers are finding that the most responsive parents actually have children who are less demanding and more self-reliant as they grow older.
- **Stay With Your Child During Difficult Feelings**: Young children often have upset feelings (anger, hurt, sadness, fear) that are too difficult to manage on their own. When your child has an intense feeling, stay with her/him until the feeling has been worked through. Your child will be learning basic trust: "Someone is here with me when I am in difficulty and pain," and "I can count on a good outcome to follow a difficult experience."
- **Talk Out Loud about Feelings**: From your child's earliest days, talking out loud about feelings (your child's and your own) will begin to help your child to eventually label feelings and realize that they can be shared. As your child gets older, s/he will realize that intense feelings can be named (mad, sad, glad, and afraid) and discussed with another, thus ending a need to act them out.
- **"Mistakes Happen (You Only Need To Be "Good Enough")**:**"** Perfection is impossible in parenting. In fact, it isn't even recommended. A child who knows that everyone in the family makes mistakes, and that they will eventually be worked out, will feel more secure than a child who thinks everything has to be right the first time.
- **Be Bigger, Stronger, Wiser, and Kind**: At the heart of secure attachment is a child's recognition that s/he has a parent who can be counted on to lovingly provide tenderness, comfort, firm guidance and protection during the inevitable difficulties of life. If the truth be told, all of us have this need some of the time, no matter what our age.

COS for Parents & Professionals Regarding Caregiving in a Time of Disaster and Crisis

Circle of Security Project
www.circleofsecurity.org
Glen Cooper, Kent Hoffman, Robert Marvin, & Bert Powell

Here's how we hope the Circle of Security Website might be helpful for parents and children whose world has been turned upside down in a time of disaster and crisis:

1. Take a look at three specific downloads: a) The *Circle of Trust*, b) the *Circle of Security*, and c) "*Traveling Around the Circle*." Each download will give you specific information about the importance of primary caregivers in the emotional life of their children, most especially in times such as these.
2. Read the following brief synopsis regarding the importance of a primary caregiver in helping children in crisis deal with feelings of fear and helplessness.
3. Read the "Summary of Circle Related Themes in a Time of Crisis for Parents and Professionals"

Helping Children of All Ages Deal with Feelings of Fear and Helplessness

- One of the biggest problems for children of any age in the face of a traumatic event will center on how they deal with their sense of fear and helplessness.
- The worst danger isn't that children experience fear. The worst danger comes when fear is not recognized and accepted by a safe and secure caregiver.
- A child's sense of fear, when it is unattended to by a caregiver, moves in the direction of terror.
- The child's sense of helplessness, when unshared and unregulated by the caregiver, moves in the direction of despair.
- Terror (unregulated fear) and despair (unregulated helplessness) become overwhelming for children primarily because they doesn't feel like they can be shared with and organized by someone who is bigger, stronger, wiser, and kind. ("I'm all alone in this worry and weakness with no one with whom I can share it.")
- Hence, the goal is to find a way to give caregivers a sense of clear direction and sound encouragement in offering themselves as a resource for the management of fear and powerlessness.
- The *Circle of Trust* was designed to offer parents and professionals direction and clarity about how essential parents are to their children in a time of trauma and crisis. Attachment research fully supports how valuable parents are in circumstances where it may appear that they themselves are without usefulness and value.

- More than anyone else during a time of disaster, a child's primary caregivers are the center of that child's world and are *the* resource who can make all the difference.
- Offering predictable daily routines that a child can count on becomes a valuable resource, especially when these routines are sponsored by a trusted caregiver. (Bedtime rituals, morning rituals, etc.)
- Finding examples of specific things, events, and people for which to be grateful in the midst of great difficulty can become a resource for a family in crisis.

Summary of Circle of Security Related Themes in a Time of Crisis for Parents and Professionals

In a time of crisis, central among the capacities that children will be looking for will be:

1. The caregiver's ability to take charge and be firm, yet kind and caring (bigger, stronger, wiser, and kind),
2. The caregiver's choice to consistently soothe her/his child(ren), focusing on each child's clear (or hidden) cues of distress,
3. The caregiver's decision to consistently be available for protection, comfort, and organization of any feelings that a child (themes on the bottom of the Circle of Security)
4. The caregiver's recognition that only as the child is feeling safe on the bottom half of the Circle will s/he begin to venture out on the top half of the Circle in the direction of exploration and play
5. The caregiver's recognition that the child will inevitably return again and again to the bottom half of the Circle, with seemingly "unreasonable" and "endless" needs for reassurance. This is to be expected, because the child will be wanting
6. The caregiver's realization that underneath most of a child's problems and meltdowns is a simple but sometimes-difficult-to-understand request for reassurance,
7. The caregiver's willingness to simply be available, rather than thinking that specific problem solving skills, is needed.

Best Practice Next Practice

Family-Centered Child Welfare

A publication of the National Child Welfare Resource Center for Family-Centered Practice, a service of the Children's Bureau

Winter 2004
Mental Health in Child Welfare
A focus on caregivers

in this issue

Frontline Worker from Mars

Stranded on this planet for a few months, a caseworker from Mars stopped me in the hall one day. The Martian asked, "How do you keep your children safe?"

It didn't take me long to reply. I said, " Well, we hire a group of 24-year-olds, we give them a month of training, we send them to look at incredibly complex and deeply disturbing, distressed families for a few hours a month, we tell them to make life or death decisions, and if they are wrong, remind them that something terrible will happen in the family and that they will be publicly crucified. That's how we do it."

"What?" the Martian asked. "You do what?"

"That is what we do to keep children safe. We isolate frontline workers," I explained. "We send them out there fearful and confused, to make huge decisions about which they *know* they do not have the knowledge base, the evidence, or the expertise," I said.

"They must constantly say to themselves, 'Oh, dear God, I know what I am doing, I know what I am doing, I know what I am doing.' There is nothing more dangerous in this world than the person who thinks they know what they don't know and has power over others."

The Martian was astonished. "Are all important decisions made this way, in isolation?" he asked. "It's a terrifying notion."

"Oh, no," I said. "In our judicial system we have juries of 6 to 12."

—Harry Spence, Commissioner, Massachusetts Department of Social Services

Mental Health Issues in the Child Welfare System

This issue of *Best Practice/Next Practice* is the second of a two-part series on mental health issues for families in the child welfare system. The first issue, Summer 2003, focused on the significant number of children identified by the child welfare system for safety concerns who also demonstrate signs of developmental delays and/or emotional or behavioral conditions. In addition, the Summer issue described the experience of those who are placed in care, for which the separation experience and the multiple placements further compromise their social and emotional development. This Winter 2004 issue focuses on another key player for

families in the child welfare system: caregivers, especially frontline workers and supervisors who often are expected to function directly or indirectly to ensure the healthy development of children in the child welfare system. The child welfare system and the state, especially when assuming custody, becomes responsible for the care, education, nurturing, and healthy development of the child.

The demands upon the child welfare system are great. Frontline workers and supervisors carry a great responsibility. As explained to the Frontline Worker from Mars, they are expected to perform difficult interventions and make skilled judgments that have the power to shift the trajectory of a child's or family's life. Workers become the only connection between troubled families and the system that is designed to help them. The public expects that workers will mitigate often deep-rooted consequences of poverty, isolation, mental illness, inadequate education, and other complex issues.

These expectations, however, are not matched with adequate salaries and supports such as appropriate training and supervision. In addition, many state child welfare systems are burdened with staff shortages, high caseloads and turnover rates, and a range of administrative challenges. Workers operate under a punitive system of accountability in meeting minimal safety and permanency needs of the children under their watch—cases of maltreatment in the system often are front-page news. The workers' feelings about the families with whom they work can have a profound—usually unexamined—impact on their work. Their mental health and emotional wellness frame workers' actions and interventions, but they often have difficulty separating their own needs, problems, feelings, and thoughts from those of the families they serve. Seldom can they allow themselves to *feel*, to ask for support, or obtain mental health interventions for themselves. These professionals are in double jeopardy: staff at risk, helping families and children at risk.

In the words of a former associate commissioner of the Children's Bureau, Carol Spigner, "The child welfare system suffers from the same lack of support that many of its vulnerable families suffer." Nevertheless, and despite these ongoing challenges, child welfare staff work hard to improve children's and families' lives. They are the key to improving mental health outcomes for children and families in the system.

The healthy emotional development of children and families within the child welfare system is truly a responsibility of many systems—health, behavioral health, early childhood care and education, early intervention, education and special education. All these systems need to work with the child welfare system to fulfill its part in getting children and families the supports and interventions they need.

Spurred in part by the federal Child and Family Services Reviews, momentum is growing to improve the outcomes of safety, permanency, and well-being of children in the child welfare system. This current interest in improving child welfare systems can highlight the importance in providing supports to staff to meet the program improvement plan goals.

In addition, the work of *Systems of Care*, a collaboration of community-based, culturally sensitive, and family-based interventions, show there is currently strong interest in programs and strategies to enhance the quality, coordination, and accessibility of supports and interventions for families with children who demonstrate severe emotional disturbances. As states develop and fund system of care communities, there are opportunities to incorporate strategies related to child welfare's role in enhancing the well-being of children. Child welfare staff and advocates should be part of the deliberations on what strategies to undertake to ensure the mental wellness of the children they serve.

Drawing on the work of the National Child Welfare Resource Center for Family-Centered Prac-

tice and several other agencies, this issue highlights family, staff, program, and multidisciplinary perspectives on effective practices that can help address mental health concerns in children and families in the child welfare system. Our emphasis is on issues not typically defined as part of the mental health agenda, but integral to improving the outcomes for children and families: providing training and supervision as well as emotional and other supports to staff and caregivers such as biological, foster, kin, and adoptive families of vulnerable children. Perhaps more workers could then feel empowered, as Trevor John in New York City (see box), and become an agent for positive change for families.

Why … does a frontline social worker like Trevor John love what he calls "grunt work"—a job that repeatedly brings him face-to-face with heartbreak, anger, and cruelty?

"I'm an agent for change—that's the gratification I get," said John, 31, a New York City social worker since 1997.

"I'm the one who puts the first foot into that family's home — we're the first responders when something goes wrong with children. Within three or four weeks, you're engaged with that family and you begin to see a change."

John, who grew up in New York, works for the Administration for Children's Services in a program that tries to help troubled families stay together, rather than remove children and place them in foster care.

"They used to call us baby snatchers," John said. "But now we have more preventative services. I've gotten thank-you letters; one family sent me a photo of their child graduating from first grade."

John joined the New York City agency as it was still struggling with aftershocks of one of its worst horror stories—the 1995 beating death of 6-year-old Elisa Izquierdo. The city conceded that child welfare officials knew Elisa was at risk for abuse but did not adequately monitor her case.

New York City's record has improved since then. Initiatives like John's Family Preservation Program have boosted the morale of social workers and enabled the city to cut by almost half the number of children moved from their own families into foster care.

Since the Elisa Izquierdo tragedy, New York City's Administration for Children's Services has sought to improve its performance and its social workers' morale by emphasizing teamwork and encouraging creative, community-based approaches to problems.

"People used to be afraid to make the wrong decision," the agency's commissioner, William C. Bell, said. "If they did, the caseworker and the supervisor were fired, but the system would stay the same. Now," Bell said, "if you're doing your best, you're going to be supported."

Trevor John, who is working toward a master's degree with financial help from his agency, said the new approach had given him and his colleagues more confidence.

"You don't have that sense of being thrown out to the wolves," he said. "Now, you have six or seven collective ideas, and you feel more secure in making a decision."

Aspects of the job remain difficult—especially when John encounters an infant or toddler who has been beaten or sexually abused.

"You learn to cope, you learn to deal with it, but you don't get used to it," he said. "To make an impact on our country, to help shape the future, you have to work with these children and their families," he said. "Regardless of how people feel, we're there to help."

Adapted from "Social Workers Embattled but Not Embittered," by David Crary, Associated Press Writer, and published in the Los Angeles Times, *January 4, 2004.*

Adult Disorders

The following DSM-IV Axis I and Axis II diagnostic categories represent an overview of conditions that child welfare workers encounter.

Substance-Related Disorders

Between 80 and 90 percent of child welfare cases are estimated to involve substance abuse. Many symptoms and behaviors of individuals who are abusing substances are similar to other mental disorders, so it is important to determine whether the presenting symptomology is substance induced. Substance-related disorders are associated with maladaptive use, abuse, or dependence on one or more substances, including alcohol, legal or illegal drugs, and effects of toxins. Individuals who use one or more substances may experience adverse social, behavioral, psychological, and physiological effects. Symptoms may include delusions, hallucinations, depression, irritability, anxiety, euphoria, mania, sexual dysfunction, restlessness, and sleep problems. It is also possible for an individual to have both a substance disorder and a mental disorder, as is the case for 15 percent of all adults.

Anxiety Disorders

Anxiety disorders are characterized by a heightened state of arousal or fear in relation to stressful events or feelings. The frequent experience of worry and apprehension is more intense and longer lasting then the anxiety experienced by the average person in everyday life. Symptoms are expressed in three ways: cognitively—symptoms include fears, intrusive thoughts, obsessions, dissociation, and numbing; somatically—symptoms include motor tension, the startle response, autonomic hyperarousal, rapid shallow breathing, increased heart rate, and/or other physical sensations; behaviorally—symptoms can include hypervigilence, avoidance of evocative stimuli, apprehensive self-absorption, compulsions, rituals, and compensatory behavior.

A common anxiety disorder is Acute and Post-Traumatic Stress Disorder. Those who have faced an extreme trauma may develop the disorder within the first month after experiencing trauma. Common symptoms include nightmares, flashbacks, numbing of emotions, irritability, and being easily distracted.

Mood Disorders (also known as Affective Disorders)

Individuals show a noticeable disruption of mood that is outside the bounds of normal fluctuations of sadness or elation. Mood disorders are characterized by depression, mania, or both symptoms in alternating fashion. The abnormal mood may impair the client's social or occupational functioning. Various mood disorders are characterized by the intensity of the abnormal mood, its duration, the impairment it produces, and the accompanying behavioral, cognitive, or physical symptoms. Common mood disorders child welfare workers encounter include:

Depression. Characterized by an unusually sad and dejected mood, diminished interests, weight loss or gain, insomnia or hypersomnia, agitation or psychomotor retardation, lack of energy, feelings of worthlessness or guilt, difficulty in concentration and decision making, and at times, suicidal attempts or preoccupation with death.

Mania. Characterized by an unusually and persistently elevated, expansive, or irritable mood, inflated self-esteem or grandiosity, decreased need for sleep, excessive talking, distractibility, psychomotor agitation or increased goal-directed activity, and risk-taking behavior. Hypomania is a less severe variant of mania.

Major Depressive Disorder. Characterized by one or more significant depressive episodes.

Dysthymic Disorder. Chronic, low-grade depression, lasting two or more years for adults, and one year for children and adolescents.

Bipolar Disorder. Characterized by dramatic mood swings, severe changes in energy and behavior, from mania to depression, with periods of normal mood in between.

Schizophrenia and Other Psychotic Disorders

Individuals are characterized as having a profound disruption in cognition and emotions, which affect their language, thought, and sense of self. Their perceptions of reality are strikingly different from the reality seen and shared by others around them. Symptoms include psychotic manifestations, such as hallucinations, delusions, disorganized speech, and loss of ego boundaries. In addition, individuals may demonstrate marked disorganization in their personal care, social relations, and job performance.

Factitious Disorders

Individuals attempt to assume the role of a sick person who is in need of help by intentionally producing physical or psychological symptoms. The motivation is the psychological need to assume the sick role, which differs from acts of malingering. In malingering, the goal is to avoid environmental circumstances (i.e., going to work, taking responsibility) by intentionally producing physical or psychological symptoms.

Dissociative Disorders

The distinguishing feature of this class of disorders is a disturbance of one's sense of personal stability due to a disruption of the normally integrative functions of memory, consciousness, sense of personal identity and/or perception of reality. This can lead to amnesia, feelings of depersonalization, or multiple distinct personalities in the same individual. This disorder is associated with individuals who are overwhelmed by intense pain or trauma and are trying to protect themselves from their distressing thoughts and feelings. Five essential dissociative symptoms are amnesia, depersonalization, derealization, identity confusion, and identity alteration.

Eating Disorders

Eating disorders are characterized by severe disturbances in eating behavior and body image. Individuals may excessively restrict food intake or engage in binge eating. This is usually followed by compensatory behavior that includes excessive exercise, purging through self-induced vomiting, or the misuse of laxatives or diuretics. These disorders can be life threatening. The majority of eating disorders occur in adolescent and young adult women. Core symptoms include a distorted body image, inability to control food intake to maintain a healthy body weight, and fluctuation of self-evaluation that is dependent on perceived body shape or weight.

Impulse Control Disorders Not Elsewhere Classified

Difficulties in impulse control can occur in many disorders, such as substance abuse, conduct disorder, and attention deficit disorder. In this class of diagnoses, the focus is on disorders of impulse control (intermittent explosive disorder, kleptomania, pyromania, pathological gambling and tricotillomania) that are not addressed in other mental disorders. The essential features can include giving in to an urge or impulse to perform a harmful act, an inner sense of tension or arousal prior to performing the harmful act, and a sense of relief, gratification, or pleasure while committing the harmful act.

Personality Disorders

Personality Disorders are characterized by long-lasting patterns of maladaptive behaviors and modes of thought that begin in adolescence or childhood. It often interferes with normal interpersonal relationships, and produces functional impairment or subjective distress. These patterns of behavior are markedly different from the expectations of the individual's culture, are pervasive, and stable over time.

Common personality disorders encountered by child welfare workers include:

Borderline Personality Disorder. Characterized by instability in mood, self-image, and personal relationships. Some symptoms include marked mood swings with periods of intense depression, irritability, or anxiety; inappropriate or uncontrolled anger; recurring suicidal threats or self-injurious behavior; unstable personal relationships with extreme black-and-white views of people; and frantic efforts to avoid abandonment. Occurs mostly in young women.

Narcissistic Personality Disorder involves a pervasive pattern of grandiosity (in fantasy or behavior), self-centeredness, and lack of empathy.

Dependent Personality Disorder. Characterized by a pattern of submission with a persistent need to be taken care of by others.

Antisocial Personality Disorder. Characterized by a pattern of disregard for the basic rights of others. Central features can include deceitfulness, aggressiveness, and lack of remorse. This disorder begins in childhood or early adolescence and continues into adulthood.

Adjustment Disorders. Characterized by significant distress due to a recent identifiable, psychosocial stress (financial difficulties, becoming a parent). The level of distress in response to the stressor is excessive. Symptoms develop within three months and clear up within six months of the removal of the stressor. Adjustment disorders are subdivided into subtypes according to the symptoms displayed.

What Does the CFSR Tell Us?

Mental Health in Child Welfare

The federal Child and Family Services Review (CFSR) rates two basic elements for mental health well-being: the first one concerns whether mental health needs were adequately assessed, and the second concerns whether mental health services were adequately provided. Reviewers assess that mental health needs are met or services provided as "significantly," "partially," or "not at all." In at least 90 percent of the cases reviewed during an on-site review, these elements must be demonstrated "significantly" for a state to be in substantial conformity with the federal guidelines. Items are often rated as "Area Needing Improvement" when reviewers determine that assessments or services were provided partially or not at all.

Common concerns among the 2001 and 2002 reviews of 32 states indicate the scarcity of mental health services for children, the questionable quality of mental health services, and the lack of routine mental health assessments even when there was an adequate reason to conduct such an assessment.

Trends—Who Receives Mental Health Services

Nearly all states assess and provide some amount of mental health services for children in foster care with the belief that children entering care need services due to the trauma of removal and adjustment to a new environment. There is, however, a general lack of mental health services for children who are not in foster care. Mental health services for in-home child protective services cases are spotty.

Linda Mitchell, Senior Child Welfare Specialist for the Children's Bureau, in her presentation at the 2003 Annual Meeting of State and Tribal Child Welfare Officials pointed out, "Children receiving in-home services were much less likely to have their mental health needs met and addressed than their physical health needs and were much less likely to have their mental health needs met than children in foster care."

Few services exist for adolescents and youth in transition from residential care to community-based placements, and for children with mental retardation or developmental disabilities.

Quality and Accessibility

The quality of and access to mental health services varies from state to state and from county to county. Inconsistencies include lack of progress reports and documentation of treatment or therapy, shortage of providers, extensive waiting lists, and geographical distances, especially in rural areas, that make access to services very difficult. Many areas lack treatment for sexually abused children.

Some of the findings of the CFSRs with regard to mental health services include:

- All 32 states reviewed to date will need to enter into program improvement plans to strengthen the quality of needs assessment and service delivery to children and families. This is a critical issue since caseworkers often fail to identify important needs of children, including mental health needs, when they develop case plans and provide services.
- Thirty one of the 32 states reviewed failed to achieve positive ratings on the indicator in the CFSR that addresses the provision of physical and mental health services.
- Access to services is one of the weakest areas of performance identified among the 32 states reviewed. Most often, the more specialized services, such as children's mental health services and substance abuse treatment, are among the services that are lacking or inaccessible due to wait lists, location, and so forth.

Joan Ohl, Commissioner of the Administration on Children, Youth and Families, remarked at the Annual Meeting, "A common theme in the final reports is a lack of sufficient access to children's mental health services and to substance abuse treatment services. This is especially true in the rural areas where access of services present barriers both to the successful and timely outcomes for children and families."

Family-focused services are often unavailable. Often only a child will receive mental health services, and other issues and concerns within the family are not adequately addressed. Often there is not adequate treatment for adults and youth who are perpetrators of sexual abuse, substance abuse treatment services for families, counseling and treatment for domestic violence, or respite care.

Frequently, the reviews show, mental health issues were either not identified or identified but with little or no follow-through. This shortfall occurred most often in in-home service cases.

Who Pays for Care?

Funding of mental health services is a critical area. Managed care and Health Maintenance Organization policies can restrict treatment for mental health. In Florida, however, Title XXI funds enable children of parents without health coverage to receive medical and mental health care at a minimum costs and the TANF program provides alcohol, drug abuse, and mental health services.

An over-burdened mental health system and difficulties in securing payment for non-Medicaid-eligible children often make assessment and services to children in-home and out-of-home placements.

Yet most of those in child welfare are keenly aware of the shortcomings when it comes to mental health in child welfare. What the CFSR process allows us to do is assess these shortcomings and begin a process of systemic change to address these problems.

The Reviews also identify exceptional programs that do exist and that show promise and encouragement. The CFSR points to strengths within each state and helps states develop plans for improvement. Modeling and adapting these programs and ideas would help close some of the gaps between. For example, to address providing care to both children in out-of-home placements and those in-home, New York's case records reflected that the mental health needs of children in foster care, as well as in-home care, were identified and services were provided based on available resources. Mental health screenings were provided to the children regardless of whether they were in foster family care, in a residential facility, or in their homes.

North Carolina has worked to change its delivery of services. Soon it will offer a System of Care approach that is based on the needs of the child, not the existing services as well as informal supports and community resources.

To see all the reviews completed to date, visit http://www. acf.hhs.gov/programs/cb/cwrp/staterpt/index.htm.

A System of Care: Meeting the Mental Health Needs of Children in Foster Care

by Anita W. Marshall, MSW, LCSW

Each year, about three million children and their families nationwide come to the attention of the child welfare system through child abuse and neglect reporting systems. Two-thirds of these allegations are not substantiated, which often terminates the child or family's contact with the child welfare system. Yet, about 3 percent of these children are placed in out-of-home care.

More than 500,000 children reside in some form of foster care. Children may be removed from their homes for a variety of reasons that include severe abuse and neglect, the child's chronic serious problems, and an unmet need for mental health care. Parental problems, such as abandonment, physical or emotional illness, alcohol or substance abuse, domestic violence, AIDS, incarceration, or death, may also precipitate removal.

The Adoption Assistance and Child Welfare Act of 1980 mandated increased efforts to maintain children in their own homes. Consequently, children often enter the foster care system only after in-home services have been unsuccessful. As a result, the children in out-of-home placements frequently have more physical, developmental, and psychological problems than their peers who do not have a history of abuse or neglect.

Vulnerability of Children in Care

Research shows that children in foster care have higher rates of chronic medical, mental health, and developmental challenges than children from similar socioeconomic backgrounds who have not been in foster care, even though most children do not enter foster care because of a mental health diagnosis. *The Surgeon General's 1999 Report on Mental Health* indicates that one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year, and that 5 percent of all children experience "extreme functional impairment." In contrast, the Child Welfare League of America estimates that between 30 to 70 percent of children in foster care have a serious emotional disturbance. In addition, children in foster care are coping with the events that brought them

Because serious emotional disturbance is usually not a presenting problem at the time of placement, it may not be recognized until the child experiences a crisis after placement. Children in care frequently struggle with:

- Having undiagnosed serious emotional disturbances
- Blaming themselves and feeling guilty about removal from their parents
- Desiring greatly to return to their parents despite previous maltreatment
- Feeling unwanted if there are other children in the foster home
- Feeling insecure and uncertain about their future
- Being ambivalent about attaching to foster parents
- Anticipating rejection after multiple placements or while awaiting adoption

into care, such as extreme abuse and neglect and exposure to inappropriate adult behavior including drugs, crime, and domestic violence. At the same time, they are enduring the personal grief and trauma that accompany the loss of family and friends. These circumstances make them extremely vulnerable to serious emotional disturbances.

Children in care have a high incidence of behavior problems, academic delays, and problems in peer relationships that negatively affect their placements, options for permanency, and long-term social adjustment. These vulnerable children need interventions to build or restore their self-esteem and prevent poor social outcomes as children mature. To achieve these goals, effective interventions and treatments must be provided.

Systems Challenges

These children and youth often find themselves involved with several social systems: foster care, mental health, and their own families. All three systems share the same ultimate goals: to enable children to live safely with their families, attend and make progress in local schools, participate in the social and cultural life of their communities, and develop the skills to live independently as young adults and contribute to society.

Foster care sees these goals through the mandates of child safety, permanence, and well-being. *Mental health's* vision is characterized by the fulfillment of age-appropriate developmental-intellectual, emotional, and social milestones in the child's family, schools, and community. *Families* want their children to be successful and to belong. Families want to be asked what they know, what they think will or will not work, and what support or resources they may need for their child and family to reach those goals. Yet in spite of the connections between these goals, foster care, mental health, and families face numerous systemic challenges that require an uncommon level of collaboration to resolve. A system of care approach can effectively meet the mental health needs of children and families involved in the foster care system.

Why Use a System of Care Approach?

System of care is emerging as a promising practice. Congress passed legislation in 1992 creating the Comprehensive Mental Health Services for Children and Their Families Program. The program has funded 85 state and local communities to build systems of care. The core values and principles that drive systems of care are already visible in many localities and human services systems. This is an enormous feat in just 10 years given the many adaptive and practice changes needed to partner multiple complex systems into single focused entities focused on children with serious emotional disorders and their families. During the next decade or two, these collaborative efforts will evolve into institutionalized partnerships as individual communities share their learning and successes.

The Child Welfare League of America (CWLA) and the Academy of Child and Adolescent Psychiatrists (AACAP) have incorporated the values and principles of system of care into their strategic plans. The Children's Bureau has also found strong

Challenges in the Foster Care System

- Staff turnover hinders the ability to meet the special needs of children and youth who have serious emotional disturbances. New staff often receive inappropriate training or insufficient supervision to support the child, the foster parent, and the biological parent. When a child is oppositional or aggressive both the foster parent and child need adequate support. Otherwise, a disrupted placement and another rejection for the child results.
- The growing needs of seriously emotionally disturbed children and youth and the inconsistent availability of the foster parent training and supports results in high foster parent turnover. Placement disruption, inconsistent treatment, and increased trauma in the child results.
- Foster parents need to be considered partners in the planning and treatment of children in their care.
- The legislatively mandated focus and media attention on the safety needs of children increase the child welfare professionals' anxiety and takes time away from attending to the emotional and/or trauma needs of the children for whom they are responsible.
- Increased mental health challenges of children require training to ensure earlier recognition and intervention. Younger children who display aggressive and/or sexually inappropriate behaviors are an increased challenge to staff and foster parents who have limited training and supports.
- Access to mental health services for referred children and youth is limited.

Challenges in Mental Health System

- Fewer child and adolescent mental health professionals, especially psychiatrists, are available to work with children in foster care. This shortage is complicated by systemic budget cuts and low insurance rates of reimbursement.
- Mental health professionals working with foster care staff may not understand the child welfare system's mandates; the roles of individual workers; judicial time frames; the variance of roles across differing services components, such as guardianship, family reunification, and permanency planning; and the rights retained by parents with children in foster care.
- Opportunities to identify children who are showing early signs of serious emotional disturbances are limited. Children entering foster care are not routinely screened for mental health needs but are referred only after they display problematic behavior.
- Coordinating and integrating care with multiple systems is difficult due in part to different mandates and values.
- Mental health providers often receive referrals with insufficient information to appropriately assess for treatment.
- Multiple and disrupted placements, missed appointments, lack of communication with mental health providers, and discontinuation of treatment after the child is reunified with family contributes to the lack of continuity of mental health care.
- Many mental health providers need more training to work with an increasing population of preschool sexually abused and/or sexually aggressive youngsters.
- Many mental health professionals need more training in effective and/or evidence-based interventions.

Challenges in Families

- Although 70 percent of children in foster care return to their families, these families are seldom seen as team members in their children's treatment while in care.
- Families are not routinely included in information gathering, such as their child's previous behaviors and demonstrated needs; previous treatments, both effective and ineffective; family history; and treatment preferences, including issues about drug use.
- Within both the foster care and mental health cultures, families are not usually seen as partners and therapeutic allies.
- Youth in care are seldom involved in decisions about their care, such as treatment options, medications, education about psychotropic drugs and alternatives, and transitions prior to discharge from foster care.
- Often family members have unmet mental health needs.

collaboration and good results in communities where systems of care exist. This observation, based on the first two rounds of the Child and Family Services Reviews, is specifically relevant to meeting the mental health needs of children in foster care.

Using Evidence-Based Practices

Systems of care have always been concerned about the quality and effectiveness of community-based treatment interventions. Using practices that have been proven effective preserves limited funding and other resources and respects the right of parents and children to receive the most effective services. Using proven practices also ensures the most positive outcomes with a focus on flexible, individualized, and integrated care.

ORC MACRO, the national evaluator of the Comprehensive Mental Health Services for Children and Their Families Program, identified the five most prevalent DSM-IV diagnoses of children referred by foster care:

- Mood Disorders and Depression
- Oppositional Defiance Disorder
- Post-Traumatic Stress Disorder
- Adjustment Disorder
- Conduct Disorder

The Surgeon General's Report on Mental Health (1999) and the California Institute on Mental Health in Evidence-Based Practice in Mental Health Services for Foster Youth (March 2002) document the overall effectiveness of cognitive behavioral therapies to address these diagnostic issues. However, they highlighted three evidence-based interventions that are effective with foster youth:

- ***Multisystemic Therapy (MST).*** A home- and community-based intervention developed for adolescents that addresses their conduct-related mental health needs by intervening in all of the systems that impact youth, including family, school, peers, and neighborhood. This intervention also focuses on building skills within their family.
- ***Treatment Foster Care.*** Foster parents provide the primary mental health intervention in their homes. Mental health training, consultation, and clinical support are provided.
- ***Intensive case management and wraparound services.***

These three interventions share these common system of care values: providing treatment in community settings, regarding parents as partners, and showing sensitivity to culture. In random studies of these interventions, the outcomes addressed many of the barriers facing systems as they serve children in care who also have serious emotional disturbances. MST trials reflect fewer placement changes, decreased aggressive behavior, and fewer arrests for children in the juvenile justice system. Treatment foster care trials reflected more rapid improvement, decreased aggression, and better post-discharge outcomes for children who received treatment foster care than for those who did not receive the service. The combination of intensive case/care management and wraparound resulted in less restrictive placements and increased functioning for youth receiving the intervention than for those that did not.

A review of long-established system of care communities that focus on children referred by child welfare—both child pro-

tective services and foster care—reflect broad and expansive outcomes for children and their families. These communities all use the interventions described as well as combinations of them. These interventions are provided in nontraditional settings; are provided by parents, professionals, and paraprofessionals (except MST); are less expensive than institutional interventions; and are transferable to mental health, child welfare, education, and juvenile justice settings.

System of care communities in Wisconsin, Florida, Indiana, and West Virginia that reflect a population of 33 percent to 52 percent of children from child welfare indicate even broader outcomes for children and families owing to the flexibility and individualized application of these interventions. Their experience includes:

- Significant reductions in inpatient hospitalizations
- Long-term and ongoing mentoring and supportive relationships between treatment foster parents and natural parents
- The development of free respite opportunities between parents needing relief and natural helpers invested in the families' and children's success
- Increased referrals of juvenile and family court judges into system of care communities
- Measurably reduced strain on caregivers
- Decreased placement disruptions
- Increased options for services, both in range and in accessibility, by using nontraditional community facilities at nontraditional business hours, which also reduces stigma and increases compliance
- Increased mental health screening of children and youth as they enter the foster care system
- Increased cross-systems understanding and support of child welfare mandates
- Community-based interventions specifically developed to support the child welfare mandate of child safety

Communities decided to develop systems of care for many different reasons including court class action suits, local media pressure, funding reductions, legal or programmatic mandates, and the continual insistence of families and well-meaning citizens for change. As noted earlier, our goals for these children include the opportunity to live safely with their families, attend and make progress in local schools, participate in the social and cultural life of their communities, and develop the capacity to live independently as young adults and contribute productively to society. Although a system of care is not a panacea, it is a model to help children, families, child welfare, and mental health achieve these goals. The vulnerable population discussed here requires a coordinated, integrated, collaborative, culturally competent, strengths and community-based, family-driven approach as part of an overall strategy for success.

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National Child Welfare Resource Center for Family-Centered Practice

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The Case Planning Flow Chart

Relationship	Assessment	Goals / Desired Outcomes	Action Steps	Implementation	Tracking/Adjusting
A cooperative relationship between the worker, the family, and the team which enables and supports a client's efforts to make positive changes in behavior and life situation.	A mutual process of gathering pertinent data about family needs, concerns, resources and strengths. Data is used to identify causal and/or contributing factors (underlying needs) to family problems and concerns and to formulate conclusions about *why* problems exist.	Goals and desired outcomes are statements of desired end states. Goals are broad statements of direction. Desired outcomes are concrete, measurable, observable ends designed to reach a goal and eliminate the assessed needs or problems.	The plan lists the necessary tasks and activities to achieve goals and objectives. The plan identifies who should perform the task, where, how and within what time frame (when).	The implementation of the plan requires that all parties initiate the agreed upon tasks and activities.	Each component of the plan is reviewed to determine its current relevancy and the success of interventions. Revisions are made as needed to goals, desired outcomes and action steps.
Work with families is dependent on the existence of a professional helping relationship. The client must be *engaged* in a change process. Teaming helps ensure the best outcomes for the family.	Assessment provides the rationale for all case goals and desired outcomes.	Goals and desired outcomes describe what should be done.	Gives direction to casework activities. The plan should be agreed upon by the team.	The implementation of tasks and activities must be monitored and modified as necessary.	Resolution of problems results in termination of casework activities.

GUIDELINES FOR CASE PLANNING

- At least one desired outcome and a corresponding list of action steps is required for each identified risk.

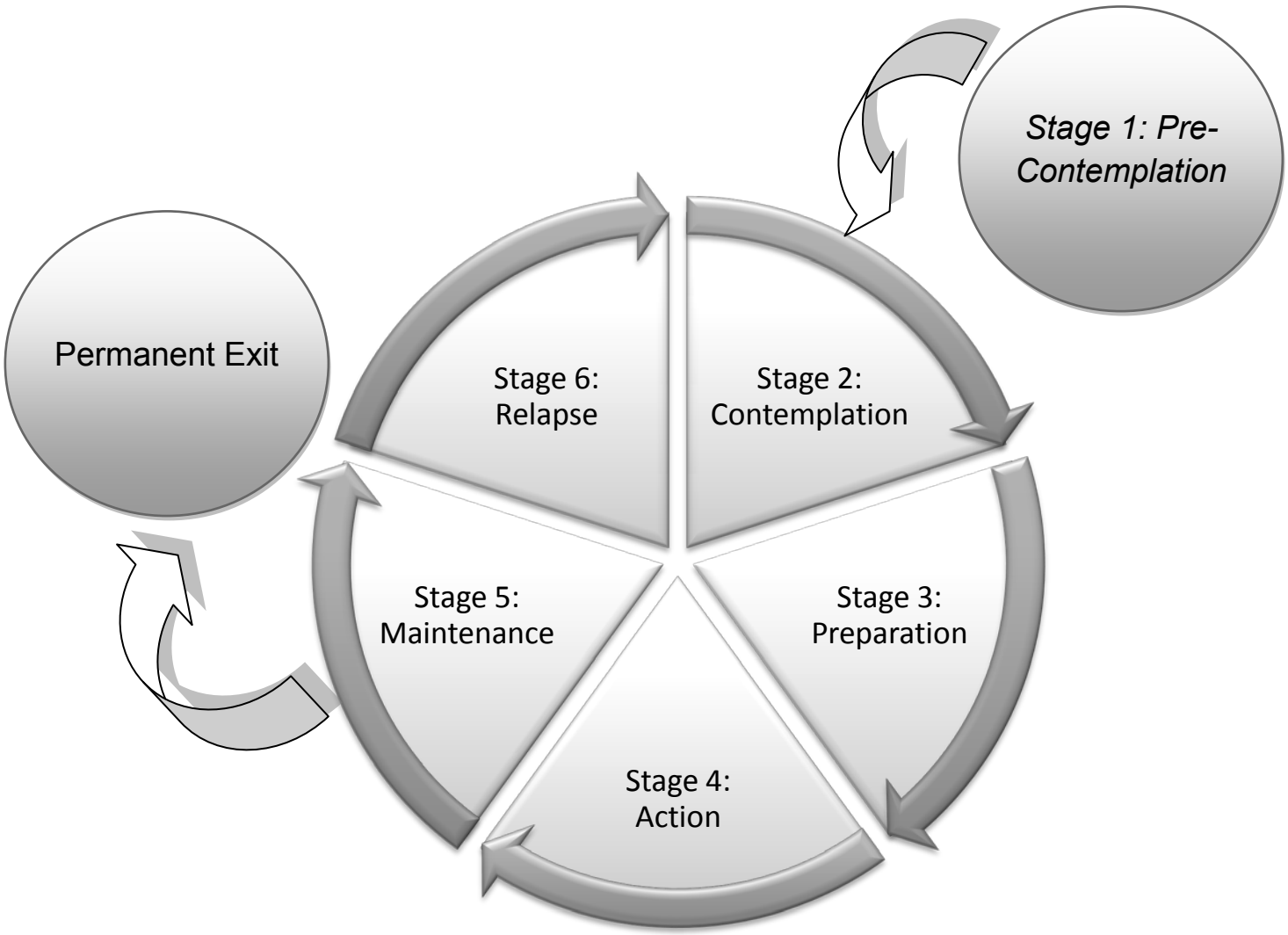
- The list of action steps should be complete. It is a task analysis of all the activities that will be required by the family, service providers and agency to lower risk and satisfy concerns about child safety, permanency and well-being.

- Best practice suggests prioritizing the desired outcomes, developing and listing them in the order of priority. The outcome(s) connected to the highest levels of risk and the areas of concern that will assure safety and permanency are typically listed first, followed by those that will assure well-being. This is one suggested listing of prioritizing objectives:

  - What will reduce the risk of harm?
  - What will assist the safe return of children in substitute care to their home?
  - What will assure the successful long-term development of the children?
  - What addresses multiple outcomes at the same time?
  - What meets a client's request for service?
  - What builds toward success?
  - What will reduce barriers to assuring safety, permanency and well-being?
  - What will facilitate the coordination and cooperation between multiple service systems involved with the family?

- Families need to understand that the plan identifies the **changes** that need to be made to assure child safety, permanency, and well-being. Without these changes being successful and permanent, DCS will be required to continue involvement with the family and/or assure safety, permanency, and well-being outside the immediate family. The worker's role is as a change agent—he/she must understand the change process and stages of change and develop skills to help families make and sustain desired changes.

Wheel of Change



Prochaska & Diclemente's Six Stages of Change

Six Stages of Change

Description	Indicators
Stage 1: Pre-Contemplation	
This is the entry point of a person into the change process. The individual has not even considered the prospect of change and is unlikely to perceive a need for change. It is usually someone else who perceives a problem. At this stage, a person is not likely to respond positively to anyone (family or professional) being confrontive or demanding change.	• Total resistance to doing anything • No willingness to meet, talk to a professional, or get assessed • Angry at any indication from another that there is a problem • Blaming others • "Everything is okay" statements • Willingness to work on other things, but not the specific problem • Refuse to let a professional in and work with him/her • Lack of awareness
Stage 2: Contemplation	
Once the person has some awareness of the problem, then the person enters the stage called Contemplation. It is an ambivalent state where the individual both considers change and rejects it. If allowed to just talk about it, the person goes back and forth about the need to change without justification for change.	• Saying one thing, doing another • Rationalizing, minimizing • Anxiety rises while trying some things that do not work • Both talking about change and arguing against it
Stage 3: Preparation	
The person is ready to change. This is a window of opportunity when the person resolved the ambivalence enough to look at making change.	• Admitting the need for change • Accepting negative ramifications of their behavior • Asking for help • Starting to look at alternatives
Stage 4: Action	
The person engages in particular actions that intend to bring about change.	• Starting to work out a plan • Making changes in behavior • Asking for professional help, or using professional help to make their plan more successful
Stage 5: Maintenance	
The person identifies and implements strategies to maintain progress, and to reduce the likelihood of slips or full relapse into old behaviors.	• Making the long-term life changes needed to "actualize" the changes made in the action stage • Focusing less on refraining from old behavior and more on a "recovery" lifestyle
Stage 6: Relapse	
The person has a slip, or returns to behavior at a level higher than acceptable to either the person or family. At times, the person might slip and not regard it as serious enough to be concerned, yet someone may be at risk. A professional needs to help the person holistically look at the situation.	• Repeating behavior that they are trying to change • Engaging in different, but equally problematic behavior. • Feeling shame about behavior

The Stages of Change: Worker Tasks and Skills

Pre-Contemplation	Contemplation	Preparation	Action	Maintenance	Relapse
• Build a relationship. • Diffuse the crisis. • Assess safety concerns. • Show empathy and caring. • Provide needed services in areas other than the specific risk. • Assess and affirm the individual's strengths and capacity to change if he or she wishes to do so. • Provide information and feedback on the possible risks of behavior to raise the awareness of the possibility of change. • Listen for windows of opportunity where the person talks about problems, concerns and need to change. • Provide specific information.	• Help tip the balance to favor change. • Evoke reasons to change and risks of not changing. • Continue to strengthen the client's self-efficacy. • Strategically use open-ended questions, affirmations, and summarizing. • Have the person voice the problem, concern, and intention to change. • Have the person self-assess values, strengths, and needs.	• Facilitate the development of a vision for their future. • Provide information on all available options. • Explore all available options, and the benefits and consequences of each. • Help the person set specific goal(s). • Help the person develop the plan. • Help the person choose strategies to use, resources needed, and potential barriers to the plan.	• Introduce and practice coping strategies to avoid, change, replace, or change a client's reactions to triggers and conditions leading to problem behavior. • Suggest methods, provide support in trying them out, and help evaluate the effectiveness of those methods. • Keep steps small and incremental • Teach skills. • Access resources for the specific target behavior. • Reward small steps of progress. • Assess success. • Make necessary changes in planning as the person continues to progress.	• Assist in sustaining changes accomplished by the previous actions. • Help the person to develop the skills and self-efficacy to build a new life. • Build relapse roadmaps. • Prepare crisis plans for when a relapse might happen. • Review warning signs of a possible slip or relapse. • Help the person connect to other support systems for a healthier lifestyle	• Assist in processing the emotions resulting from the slip. • Help the person understand what happened to lead to another slip. • Help the person process the experience and use the slip as a learning experience. • Review the plan and commitment to continue. • Adjust the plan as needed. • Implement the plan (as adjusted).

CHILD & FAMILY TEAM MEETING PROTOCOL

Type of CFTM	Person Responsible for Building, Preparation, and Maintenance of Team Members	Time Frame CFTM Must Occur	Purpose of the CFTM "Decision to be made at the CFTM"	Who Facilitates the CFTM *1	Team Leader Presence *2	Other Comments
Initial CFTM	CPS or FSS Case Manager or Family Service Worker or Team Leader	Whenever there is an imminent risk of a child coming into custody (to prevent removal if possible) If a child has entered custody, this should take place within 24 hours; if that is not possible, prior to the preliminary hearing The Initial CFTM must take place no later than 7 calendar days after placement for all children or youth who enter custody. Initial CFTMs that take place prior to custody to prevent removal can be considered as the Initial meeting if they occurred within 7 calendar days prior to the custody date.	Assess all the safety and risk factors and determine how the child's safety can be maintained in the least restrictive, least intrusive manner possible. If the child was removed on an emergency basis, the CFTM must determine if a plan can be developed to allow the child to safely return to his parent's home w/services or if other kinship/community placements are available for the child. If a plan is developed, DCS would pursue divestment of custody at the preliminary hearing. If DCS is to maintain custody, be sure to address the following matters: Identify relatives, kin or other persons with meaningful pre-existing relationships with the child that might be considered for potential placement or visitation; complete a family diagram; and make efforts to ensure that siblings are placed together. Verify names, addresses and any other information regarding all legal, birth, and putative fathers. Assess the appropriateness of temporary placement, and discuss how to minimize any possible trauma to the child as a result of removal. Provide TennCare appeals rights information for DCS placements that are TennCare funded. Develop a plan to obtain child's clothing and other items that child will need in current placement. Discuss any medical or behavioral health issues for the child, as well as any other immediate case-related issues or concerns of the team members. Set up an immediate visitation schedule for child with parents, siblings and other family members and arrange for a schedule of contacts between the FSW and the family. Encourage the family to identify support persons, both formal and informal, who can become part of the Child and Family Team. Explain the purpose of permanency planning and schedule the Initial Permanency Planning CFTM to be held within 30 days.	Trained Full-Time, or Back-up Facilitator	Required	We recognize that time constraints may limit full preparation and development of a team. At the least, the case worker must ensure that families understand the decision to be made at the meeting and are encouraged to bring extended family and/or other support persons with them. The Team Leader for the case is required to be present at all Initial meetings. In the event the assigned Team Leader is unavailable, another Team Leader or FSW3 can serve in his or her place. In order to ensure the facilitator's objectivity, the facilitator should not be directly involved with the case. If placement in custody were a result of CPS involvement (this could be either investigation or assessment staff), the CPS case manager would be responsible for the preparation of team members. If the placement in custody did not involve CPS, the Social Services case manager would be responsible for the preparation of team members. If an Initial CFTM is utilized for children who do not enter care as a result of a safety issue, but through a court adjudication of unruly and/or delinquency, the Family Service worker or the Team Leader would be responsible for the preparation of team members. Information gathered in the Initial CFTM should be synthesized and entered into the Functional Assessment as outlined in DCS Policy 11.4, Functional Assessment Process. When a potential removal Initial CFTM results in a plan to prevent placement, and it turns out that the child enters custody several days later despite the team's efforts, it may be necessary to reconvene the team in order to address issues related to meeting the medical/behavioral needs of the children, minimizing trauma, getting clothing, family visitation, etc., and preparing for the Initial Permanency Planning CFTM. If the CFTM took place more than 7 days before the child entered custody, there must be an Initial CFTM held to address these custody-related issues. If a decision is made to place the child, the CANS should be completed and consulted to help identify the best placement. Whenever there is a CFTM, DCS must ensure that parents and other team members are informed of the child's TennCare Appeal rights and provided a sample copy of the Notice of Action form.

1

*1 – A trained Full-time or Back-up Facilitator is someone who has completed the Advanced Facilitation Training and been certified to facilitate. This person provides an objective voice, so it should not be someone directly involved with the case.
*2– This refers to the Team Leader or FSW3 that has the primary responsibility for the supervision of the case. The DCS Supervisor is expected to participate in a CFTM for each case under his/her supervision no less than every 6 months.

CHILD & FAMILY TEAM MEETING PROTOCOL

Type of CFTM	Person Responsible for Building, Preparation, and Maintenance of Team Members	Time Frame CFTM Must Occur	Purpose of the CFTM "Decision to be made at the CFTM"	Who Facilitates the CFTM *1	Team Leader Presence *2	Other Comments
Initial Permanency Planning CFTM	Family Service Worker	This CFTM must take place and the Permanency Plan completed and forwarded to legal within 30 calendar days of entering custody.	Establish a Permanency Plan Goal and review placement appropriateness/options. Provide TennCare appeals rights information for DCS placements or recommended services that are TennCare funded. Address issues that created risk for the child, building on the outcomes of the Initial CFTM. Affirm strengths identified in the first CFTM and identify new strengths in the family. Assess the concerns, issues and underlying needs of the family/child. The plan should be based upon assessments made through the Functional Assessment, CANS, SDM, EPSDT, mental health assessment or other evaluations. Examine the long-term view for the family and child. Develop concrete action steps with target dates and persons responsible. Complete the permanency plan and provide copies to all members of the team. Continue to engage the family and their support network in the plan.	Family Service Worker or Team Leader	Required	Full preparation of the family and team for participation in this CFTM is expected. There should be as many team members involved in this meeting as possible, to help craft a comprehensive plan that will utilize all of the resources on the team. The FSW should come to the meeting with all demographic information already on the plan, so the meeting can focus on identifying goals, needs, action steps, etc. The Team Leader for the case is required to be present in Initial Permanency Planning CFTM's, to ensure that appropriate preparation has been provided, to assist in the development of a meaningful, realistic plan for the family, and to mentor the Family Service Worker. In the event the Team Leader is not available, another Team Leader or FSW3 can participate in his or her place. Please refer to DCS Policy 16.31-BA, Permanency Planning for Children/Youth in Department of Children's Services Custody for the timelines and requirements for permanency plan development and reviews. For youth who are 14 years of age or older, there shall be an Independent Living Case plan developed in conjunction with the Permanency Plan, in compliance with DCS Policy 16.58, Independent Living Case Plan. For youth whose initial placement is in a YDC or DCS group home, the classification/IPP CFTM shall be done within fourteen days of the date of placement. This meeting can also serve as the time when the FSW completes the Permanency Plan. Whenever there is a CFTM, DCS must ensure that parents and other team members are informed of the child's TennCare Appeal rights and provided a sample copy of the Notice of Action form.

2

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CHILD & FAMILY TEAM MEETING PROTOCOL

Type of CFTM	Person Responsible for Building, Preparation, and Maintenance of Team Members	Time Frame CFTM Must Occur	Purpose of the CFTM "Decision to be made at the CFTM"	Who Facilitates the CFTM *1	Team Leader Presence *2	Other Comments
Progress Review CFTM	Family Service Worker	Teams should be convened every 3 months to review the progress on achieving permanency. If no other type of CFTM has taken place during a 3 month period, a Progress Review CFTM must take place.	Review the child and family's progress towards permanency. Identify the remaining barriers to permanency and develop plans to remove those barriers. Assess the effectiveness of services and whether revisions to the plan or additional action steps are needed. Make an alternate or concurrent plan for permanency, if applicable. Emphasize the importance of achieving permanency for children in as timely a manner as possible. Ensure all team members understand the impact of prolonged separation and uncertainty upon children. Prepare the child and family team for finalizing a permanency decision at the twelve (12) month CFTM.	Family Service Worker (with 1 year or more of experience), or Team Leader	Required if the FSW has 1 year or less of experience	Full preparation of the family and team for participation in this CFTM is expected. A CFTM to review progress on the Permanency Plan can be conducted whenever there are changes needed or progress is not being made in a timely fashion. It is recommended that the Team Leader participate in all permanency plan progress review CFTM's; however, TL's can exercise judgment in deciding whether their participation is required, based on the experience of the FSW, the complexity of the case, and the availability of other supports, such as a FSW 3 or other regional staff. For any family service worker with less than 1 year of experience with DCS, there must be a Team Leader or FSW 3 participating in permanency plan progress review CFTM's. Anytime the team is convened, there should be a review of the progress being made toward achieving permanency - whether services are being provided, are effective and all responsible parties are doing what they agreed to on the plan. This requires the FSW to follow up on all referrals and obtain reports from service providers prior to the progress review CFTM.

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CHILD & FAMILY TEAM MEETING PROTOCOL

Type of CFTM	Person Responsible for Building, Preparation, and Maintenance of Team Members	Time Frame CFTM Must Occur	Purpose of the CFTM "Decision to be made at the CFTM"	Who Facilitates the CFTM *1	Team Leader Presence *2	Other Comments
Revised Permanency Plan CFTM	Family Service Worker	Any time the Permanency Plan needs to be revised. This has to occur before the Permanency Plan has expired, and no less often than 12 months from the date of custody.	Revise the Permanency Plan - this includes goal changes, adding action steps, and revising time frames. The process for development of the revised plan should be similar to the process for developing the initial plan, with the full participation of the family and team. The revised permanency plan should reflect an updated assessment that addresses the needs and utilizes strengths that have been identified since the Initial Permanency Plan was developed. Permanency Plan revisions should be done whenever they are deemed necessary by the Family Service Worker and/or other team members. This has to occur no less often than annually from the date of custody. In addition to the basic steps of the Initial Permanency Plan CFTM, the following needs to be considered: If progress is being made and the goal is return to parent, begin planning for the child's safe return home and revise the plan accordingly. If no progress is being made toward return to parent and a goal change is being considered, explain to the family the reasons for the proposed goal change. Consider alternative options for permanency, such as permanent guardianship, adoption, developing concurrent goals, etc. Explore with the family the possibility of termination of parental rights or voluntary surrender, if applicable. Establish a plan for needed Independent Living/Post Custody support, if applicable. The Permanency Plan and action steps included should reflect the chosen Permanency goal(s).	Family Service Worker (with 1 year or more of experience) Team Leader, or Trained Full-time or Back-up Facilitator	Required if the FSW has 1 year or less of experience	Full preparation of the family for participation in this CFTM is expected. The family should not hear about changing the goal from reunification to adoption, for example, for the first time in the context of a CFTM. Emotionally charged issues need to be raised and processed with the family prior to the meeting as part of preparation. Permanency specialists should be encouraged to become part of any child and family team when progress toward reunification is not proceeding and other permanency alternatives need to be explained and explored with the family. It is recommended that the Team Leader participate in all permanency plan revision CFTM's; however, TL's can exercise judgment in deciding whether their participation is required, based on the experience of the family service worker, the complexity of the case, and the availability of other supports able to participate, such as a FSW 3 or other regional staff. For any family service worker with less than 1 year of experience with DCS, there must be a team leader or FSW 3 participating in Permanency Plan Revision CFTMs. Whenever there is a CFTM, DCS must ensure that parents and other team members are informed of the child's TennCare Appeal rights and provided a sample copy of the Notice of Action form.

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CHILD & FAMILY TEAM MEETING PROTOCOL

Type of CFTM	Person Responsible for Building, Preparation, and Maintenance of Team Members	Time Frame CFTM Must Occur	Purpose of the CFTM "Decision to be made at the CFTM"	Who Facilitates the CFTM *1	Team Leader Presence *2	Other Comments
Placement Stability CFTM	Family Service Worker	Within 15 days of any change of placement – preferably prior to any change of placement, and no longer than 15 days after a move has occurred. If a private provider or DCS resource parent requests a CFTM to preserve a placement, DCS must convene a CFTM as soon as possible – it must be scheduled within 3 working days and take place within 5 working days of the request. .	To reduce the number of disruptions of children/youth in custody and to minimize the trauma when a placement disruption cannot be avoided. Review progress in current placement and determine if the current placement is still appropriate to meet the child's needs, and is the least restrictive, least intrusive placement that can meet those needs. If the current placement can be maintained, develop a plan to stabilize the current placement - this may include additional services to support the child's needs, providing respite or other supports to the caregiver(s), etc. If the current placement is not appropriate and/or cannot be maintained, develop a plan for the transition to an alternative placement in the least traumatic manner possible. If an unplanned change in placement has already occurred, explore ways the team can help to strengthen the present placement and prevent any future disruptions. For planned changes of placement, the CFTM should focus on such issues as how to make the transition successful; what services may be needed; how the child can maintain meaningful connections with people that are important to him or her; and what supports are necessary to help the child adjust to a new setting. Provide TennCare appeals rights information for DCS placements that are TennCare funded.	Trained Full- time or Back-up Facilitator for potential disruptions, <u>unplanned</u> changes of placement For <u>planned</u> changes of placement, such as a move to an adoptive home or to a lower level of care, the FSW (with 1 year or more of experience) or the Team Leader can facilitate the CFTM. If this placement change was planned during a Progress Review CFTM, an additional CFTM may not be needed.	Required if the FSW has 1 year or less of experience	For disruptions, preparation for this CFTM may be limited if there is an urgent nature to the placement move. In these situations, preparation may be limited to ensuring families understand the decision to be made at the meeting. Families should be encouraged to bring extended family and/or other support persons to these CFTMs. It is important that youth be engaged in this CFTM and efforts must be made to avoid shaming or alienating the youth in the process of discussing the issues related to the potential disruption of a placement. In order to ensure the facilitator's objectivity, the facilitator should not be directly involved with the case. In order to make the best placement decision, caregivers are critical team members to include in Placement Stability CFTMs. The Placement Team Coordinator should be consulted and efforts should be made to include the Placement Specialist in the CFTM. If the current placement cannot be stabilized, the CANS should be updated and consulted to assist in identifying the best placement. For changes of placement that are planned moves toward permanency, such as moving into an adoptive home, a move to reunite siblings, or to a lower level of care, representing progress, there should be full preparation of the team. A facilitator may not necessarily be required, unless there are difficult issues or conflicts on the team. It is recommended that the Team Leader participate in CFTM's related to placement stability; however, TL's can exercise judgment in deciding whether their participation is required, based on the experience of the family service worker, the number of disruptions or issues involved, and the availability of others able to participate, such as a FSW 3 or other regional staff. For any family service worker with less than 1 year of experience with DCS, there must be a team leader or FSW 3 participating in Placement Stability CFTMs. Whenever there is a CFTM, DCS must ensure that parents and other team members are informed of the child's TennCare Appeal rights and provided a sample copy of the Notice of Action form. For youth a Youth Development Center, this policy does not supercede DCS Policy 12.9 Emergency Administrative Transfers Between Youth Development Centers that allows the superintendent to move a youth on an emergency basis without a CFTM. However, a CFTM should be convened no more than 7 calendars days after the placement.

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CHILD & FAMILY TEAM MEETING PROTOCOL

Type of CFTM	Person Responsible for Building, Preparation, and Maintenance of Team Members	Time Frame CFTM Must Occur	Purpose of the CFTM "Decision to be made at the CFTM"	Who Facilitates the CFTM *1	Team Leader Presence *2	Other Comments
Discharge Planning CFTM	Family Service Worker	Within 30 calendar days prior to the beginning of a trial home visit, release from custody or exit from care.	To make sure that all safety and risk issues that resulted in custody have been adequately addressed and resolved. To ensure that there is a concrete plan for any needed services and that they are in place. This includes information about continued health care coverage for those receiving TennCare benefits. To assess that the child and family is ready to proceed with a trial home visit, release or exit from custody. To anticipate and address any issues that could compromise a successful discharge, reunification, or exit from custody. To ensure that there are community supports in place to sustain the child and family after DCS is no longer involved.	Team Leader, Family Service Worker (with 1 year or more of experience), or a Trained Full-Time or Back-up Facilitator	Required	This meeting is critical to ensure that the services and supports are in place to make the discharge successful and prevent re-entry. The CANS should be consulted to assist in arranging for the appropriate services. In order to ensure the facilitator's objectivity, the facilitator should not be directly involved with the case. Be sure the FSW assists the child to maintain or obtain health insurance following their exit from custody. This meeting should also take place prior to closing a probation or aftercare case. The Team Leader for the case is required to be present in Discharge Planning CFTMs. This is to ensure that all safety and risk concerns have been adequately addressed and that appropriate preparation has taken place to ensure a successful discharge. In the event the Team Leader is not available, another Team Leader can participate in his or her place. Refer to DCS Policy 16.51 Discharge Planning.

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CHILD & FAMILY TEAM MEETING PROTOCOL

Type of CFTM	Person Responsible for Building, Preparation, and Maintenance of Team Members	Time Frame CFTM Must Occur	Purpose of the CFTM "Decision to be made at the CFTM"	Who Facilitates the CFTM *1	Team Leader Presence *2	Other Comments
Special Called CFTM	Family Service Worker	As appropriate based on case need. In the event of an emergency, DCS should schedule the CFTM as soon as possible - no later than within 3 days. It must take place within five working days. If it is not an emergency, the CFTM should take place within 7 days. If child is expelled/ suspended from school, the CFTM must take place within 5 days.	To address a specific concern raised by any member of the child and family team. To pull the team together immediately to address any urgent need or emergency situation that may arise. Some examples of these would include: o CFT meetings needed to discuss the child's educational needs, in the event of a change in educational setting is being considered or is necessary; o CFT meetings to develop or update an Independent Living plan for an adolescent o CFT meetings for children that are in full-guardianship without a permanent family to identify the best possible family for achieving permanency, or for referral to the Permanency Focus Team. o 90 to 180 days prior to an adolescent turning 18 and at risk of aging out of custody without achieving permanency. o Reviewing the appropriateness of a goal of PPLA every six months and whenever there has been a disruption from the original PPLA resource home.	Team Leader, Family Service Worker (with 1 year or more of experience), or a Trained Full-Time or Back-up Facilitator	Required if the FSW has 1 year or less of experience	The purpose of this CFTM is to pull together the members of the Child and Family Team necessary to address the situation that has arisen. Depending upon the issue to be resolved, it may not be necessary to convene the whole team; however, the child and family should always be included. Any team member may call a meeting. The Team Leader can exercise judgment in deciding whether their participation is needed, based upon the experience of the family service worker, the complexity of the case, and the availability of other supports able to participate, such as a FSW 3 or other regional staff. For any family service worker with less than 1 year of experience with DCS, there must be a team leader or FSW 3 participating in Special Called CFTMs The use of a Trained Full-Time or Back-up Facilitator is not required, but may be best practice in certain cases, depending upon the needs of the team and the reasons for calling a meeting. If there are questions about the quality of services or particularly difficult conflicts between team members, it is recommended that a facilitator be utilized to conduct the meeting.

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Key Steps in Preparing the Family for a CFTM

- Describe the child and family team meeting process and clarify the specific purpose of the upcoming meeting.

- Explain that the family story of how they became involved with DCS will be told by family members. Help the family articulate their current situation as well as their strengths, needs, concerns, and desired outcomes. Ask what they would like to see happen as a result of the meeting.

- Explain that the focus is on family strengths and needs – review assessment information with the family and determine who can summarize the identified strengths and prioritized needs. Encourage the family to assist in the design of services and action steps.

- Explore with the family who should attend the meeting based on what they can contribute toward the outcomes. Ask who cares about their family and who they would like to invite to the meeting.

- Ask if there are any potential conflicts and explore ways in which difficult situations can be handled. Discuss ways in which the participant can manage their own emotions. Identify what could go wrong and a contingency plan in that event. For example, transportation needs may be discussed.

- Discuss the time and place of the meeting.

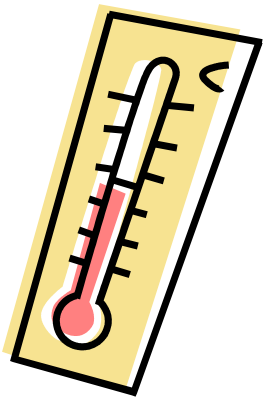
- Explore alternatives for input if a team member cannot attend.

ASSESSING PROGRESS OF FAMILY SERVICE PLANS

Evaluation is directly linked to the Family Service Plan. It asks the following questions:

- **To what degree are the tasks being implemented?** If they are not being well implemented, are the tasks still relevant? If so, what can be done to help with implementation? If not, how do they need to be changed? Are the services being utilized and are they the right services? Are they potent enough? Are the service providers focused on the objectives and goals? Are they providing useful and timely information for the reviews?
- **Are the objectives being accomplished?** In what ways? Is more progress needed? Are the tasks still relevant to these objectives? Are other tasks needed to help achieve them?
- **Are the goals being achieved?** Are they still relevant? Do they need modification? If so, what would need to change or be added in terms of objectives and tasks?
- **Are the issues still relevant?** Are there new issues that have become apparent in the course of the family's involvement with child welfare? If so, are new or modified goals, objectives, or tasks needed? Are the specific safety concerns and risks identified earlier being ameliorated? Are family needs being met?
- **Are the strengths of the family being used?** Has any new information surfaced that adds to family strengths or questions those that were identified? Are the strengths being used to help implement the service plan? Can something be done to improve this?
- **Is the review process timely and does it involve the right players?** Is each player welcomed and encouraged to participate? Is the progress review documented? What follow up is being put in place to support the modifications made in the plan as part of the review? If a child is out of home, is the concurrent plan discussed in each review? Are court dates and other mandatory reviews and timeframes being addressed?
- **Is information about progress being provided along the way** instead of only at the last minute? For example, are parents encouraged to call and leave a message on the worker's or counselor's voice mail when she has successfully used an alternative discipline technique such as time out? Are service providers required to provide written reports in sufficient time to allow the worker to include them in reports to the court? Regular feedback can be quite motivating and can reinforce the partnership between the worker and family. It provides a clear mechanism for informing changes in the FSP.

◎ **Is the information about progress provided in a way that helps people understand it?** For example, is there a way for people to get a visual impression of progress in addition to the narrative? Possible charting methods are:

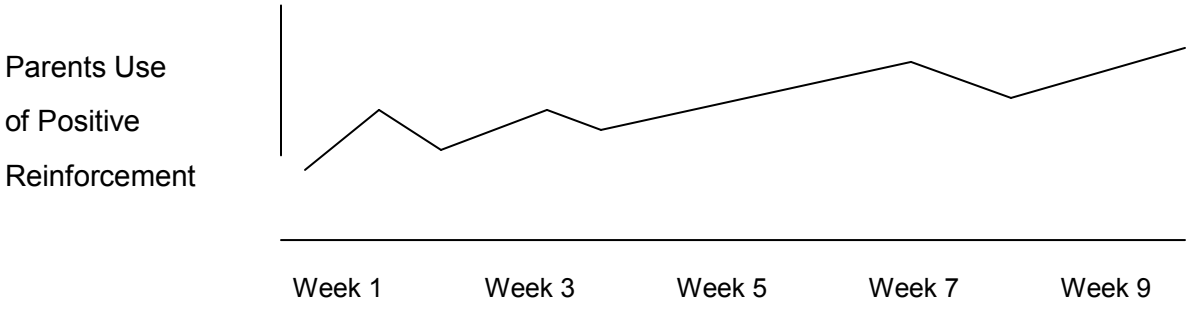


- Draw a temperature gauge with intermediate progress points marked. Use a red pen to document the family's progress toward the case goals.

- Draw a scale, using the idea of "1 – 10". Show progress on the scale by marking dates of when the client (or both the client and worker) thought there was progress.

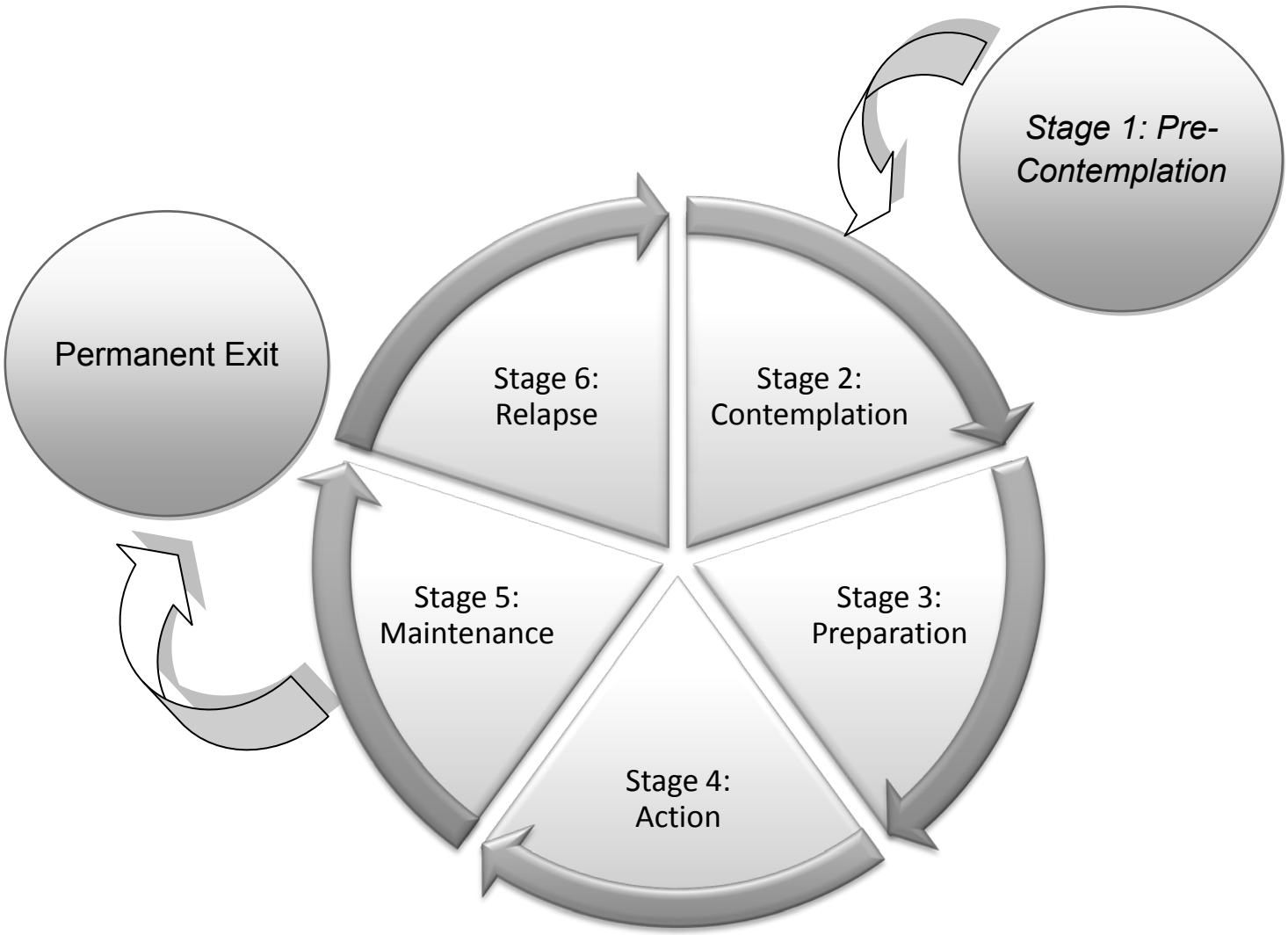
10						
9						
8						
7						
6						
5						
4						
3						
2						
1						
Date	Sept 7	Sept 20	Oct 5	Oct 15		

- Draw a graph with one axis representing time and the other axis representing the behavior change. Measures are plotted on the graph and connected with a line which displays the pattern of change over time. For example, the behavior measured is the number of positive reinforcements the parent uses with the child:



- **Are alternative methods of data collection about progress being used?** For example, videotaping of parent-child interactions is a powerful method for providing feedback to families. The worker views the videotape with the family and points out: what the parents did well; nonverbal expressions by both the child and the parent; and areas for improvement. This feedback method allows parents to see how their behavior affects their children.

Wheel of Change



Prochaska & Diclemente's Six Stages of Change

Six Stages of Change

Description	Indicators
Stage 1: Pre-Contemplation	
This is the entry point of a person into the change process. The individual has not even considered the prospect of change and is unlikely to perceive a need for change. It is usually someone else who perceives a problem. At this stage, a person is not likely to respond positively to anyone (family or professional) being confrontive or demanding change.	• Total resistance to doing anything • No willingness to meet, talk to a professional, or get assessed • Angry at any indication from another that there is a problem • Blaming others • "Everything is okay" statements • Willingness to work on other things, but not the specific problem • Refuse to let a professional in and work with him/her • Lack of awareness
Stage 2: Contemplation	
Once the person has some awareness of the problem, then the person enters the stage called Contemplation. It is an ambivalent state where the individual both considers change and rejects it. If allowed to just talk about it, the person goes back and forth about the need to change without justification for change.	• Saying one thing, doing another • Rationalizing, minimizing • Anxiety rises while trying some things that do not work • Both talking about change and arguing against it
Stage 3: Preparation	
The person is ready to change. This is a window of opportunity when the person resolved the ambivalence enough to look at making change.	• Admitting the need for change • Accepting negative ramifications of their behavior • Asking for help • Starting to look at alternatives
Stage 4: Action	
The person engages in particular actions that intend to bring about change.	• Starting to work out a plan • Making changes in behavior • Asking for professional help, or using professional help to make their plan more successful
Stage 5: Maintenance	
The person identifies and implements strategies to maintain progress, and to reduce the likelihood of slips or full relapse into old behaviors.	• Making the long-term life changes needed to "actualize" the changes made in the action stage • Focusing less on refraining from old behavior and more on a "recovery" lifestyle
Stage 6: Relapse	
The person has a slip, or returns to behavior at a level higher than acceptable to either the person or family. At times, the person might slip and not regard it as serious enough to be concerned, yet someone may be at risk. A professional needs to help the person holistically look at the situation.	• Repeating behavior that they are trying to change • Engaging in different, but equally problematic behavior. • Feeling shame about behavior

The Stages of Change: Worker Tasks and Skills

Pre-Contemplation	Contemplation	Preparation	Action	Maintenance	Relapse
• Build a relationship. • Diffuse the crisis. • Assess safety concerns. • Show empathy and caring. • Provide needed services in areas other than the specific risk. • Assess and affirm the individual's strengths and capacity to change if he or she wishes to do so. • Provide information and feedback on the possible risks of behavior to raise the awareness of the possibility of change. • Listen for windows of opportunity where the person talks about problems, concerns and need to change. • Provide specific information.	• Help tip the balance to favor change. • Evoke reasons to change and risks of not changing. • Continue to strengthen the client's self-efficacy. • Strategically use open-ended questions, affirmations, and summarizing. • Have the person voice the problem, concern, and intention to change. • Have the person self-assess values, strengths, and needs.	• Facilitate the development of a vision for their future. • Provide information on all available options. • Explore all available options, and the benefits and consequences of each. • Help the person set specific goal(s). • Help the person develop the plan. • Help the person choose strategies to use, resources needed, and potential barriers to the plan.	• Introduce and practice coping strategies to avoid, change, replace, or change a client's reactions to triggers and conditions leading to problem behavior. • Suggest methods, provide support in trying them out, and help evaluate the effectiveness of those methods. • Keep steps small and incremental • Teach skills. • Access resources for the specific target behavior. • Reward small steps of progress. • Assess success. • Make necessary changes in planning as the person continues to progress.	• Assist in sustaining changes accomplished by the previous actions. • Help the person to develop the skills and self-efficacy to build a new life. • Build relapse roadmaps. • Prepare crisis plans for when a relapse might happen. • Review warning signs of a possible slip or relapse. • Help the person connect to other support systems for a healthier lifestyle	• Assist in processing the emotions resulting from the slip. • Help the person understand what happened to lead to another slip. • Help the person process the experience and use the slip as a learning experience. • Review the plan and commitment to continue. • Adjust the plan as needed. • Implement the plan (as adjusted).

Interviewing Strategies to Help Clients Stay Invested in the Change Process

- **Express empathy**
- **Use constructive confrontation**
- **Develop discrepancy**
- **Avoid argumentation**
- **Roll with resistance**
- **Shift the Focus**
- **Emphasize Personal Choice**
- **Continued Use of Interpersonal Helping**

Cultural Aspects Impacting the Case Planning Process

1. What are some cultural issues to consider, specific to the development of a case plan? Have you had an opportunity to experience any of these and if so, what did you do?

2. How might your family or a family member of your cultural group have reacted if asked to develop and implement a case plan? What strategies might have been successful in engaging your family?

CHAPTER 8
Case Planning

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

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

Since safety plan considerations are incorporated throughout this manual, this chapter focuses on the case plan process. This entails developing the case plan, involving the family, targeting outcomes, determining goals and tasks, and developing concurrent case plans.

Developing the Case Plan

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

- Identify strategies with the family that address the effects of maltreatment and change the behaviors or conditions contributing to its risk;
- Provide a clear and specific guide for the caseworker and the family for changing the behaviors and conditions that influence risk;
- Establish a benchmark to measure client progress for achieving outcomes;
- Develop an essential framework for case decision-making.

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

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

Involving the Family

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

- Enhances the essential helping relationship because the family's feelings and concerns have been heard, respected, and considered;
- Facilitates the family's investment in and commitment to the outcomes, goals, and tasks;
- Empowers parents or caregivers to take the necessary action to change the behaviors and conditions that contribute to the risk of maltreatment;
- Ensures that the agency and the family are working toward the same end.

Family Meetings

Since the early 1990s, CPS agencies have primarily been using two models—the Family Unity Model and the Family Group Conferencing Model (also known as the Family Group Decision-making Model)—to optimize family strengths in the planning process. These models bring the family, extended family, and others in the family's social support network together to make decisions regarding how to ensure safety and well-being. The demonstrated benefits of these models include:

- Increased willingness of family members to accept the services suggested in the plan because they were integrally involved in the planning process;
- Enhanced relationships between professionals and families resulting in increased job satisfaction of professionals;
- Maintained family continuity and connection through kinship rather than foster care placements.

Family meetings can be powerful events. During the meetings, families often experience caring and concern from family members, relatives, and professionals. Since meetings are based on the strengths perspective, families may develop a sense of hope and vision for the future. The meetings also can show families how they should function by modeling openness in communication and appropriate problem-solving skills.[87]

Targeting Outcomes

One of the decisions resulting from the assessment is what changes must the family make to reduce or eliminate the risk of maltreatment. Achieving positive client outcomes indicates that the specific risks of maltreatment have been adequately reduced and that the effects of maltreatment are satisfactorily addressed.

Agency Outcomes

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

- **Child safety.** The safety of children is the paramount concern that guides CPS practice. In many States, the evaluation of child safety is equivalent to the determination that the child is at imminent risk of serious harm.[88]

- **Child permanence.** Although maintaining a constant focus on child safety is critical, casework interventions also must be aimed at maintaining or creating permanent living arrangements and emotional attachments for children. This is based on the belief that stable, caring relationships in a family setting are essential for the healthy growth and development of the child. This stresses providing reasonable efforts to prevent removal and to reunify families, when safe and appropriate to do so and as specified under ASFA. This also promotes the timely adoption or other permanent placement of children who cannot return safely to their own homes.[89]

- **Child well-being.** The general well-being of children who come in contact with the CPS system also must be addressed, especially for children placed in substitute care. This requires that children's physical and mental health, educational, and other needs will be assessed, and that preventive or treatment services are provided when warranted.[90]

- **Family well-being.** Families must be able to function at a basic level in order to provide a safe and permanent environment for raising their children. Caseworkers are not expected to create optimal family functioning, but rather facilitate change so that the family can meet the basic needs of its members and assure their protection.

Child and Family-level Outcomes

Positive outcomes indicate that both the risks and the effects of maltreatment have been reduced due to changes in the behaviors or conditions that contributed to the maltreatment. The outcomes should address issues related to four domains—the child, the parents or other caregivers, the family system, and the environment—and be designed to contribute to the achievement of the CPS agency outcomes for child safety, child permanence, child well-being, and family well-being.[91]

- **Child-level outcomes.** Outcomes for children focus on changes in behavior, development, mental health, physical health, peer relationships, and education. Sample desired outcomes are improved behavior control (as evidenced by managing angry impulses) or developmental appropriateness and adjustment in all areas of functioning (as evidenced by the child's physical development within range of the chronological age).

- **Parent or caregiver outcomes.** Outcomes for parents or caregivers focus on many areas, such as mental health functioning, problem solving ability, impulse control, substance abuse treatment, and parenting skills. A sample desired outcome is improved child management skills (as evidenced by establishing and consistently following through with rules and limits for children).

- **Family outcomes.** Outcomes for the family focus on such issues as roles and boundaries, communication patterns, and social support. A sample desired outcome is enhanced family maintenance and safety (as evidenced by the ability to meet members' basic needs for food, clothing, shelter, and supervision).

- **Environmental outcomes.** Sometimes outcomes focus on the environmental factors contributing to the maltreatment, such as social isolation, housing issues, or neighborhood safety. A sample desired outcome is utilizing social support (as evidenced by a family being adopted by a church that provides child care respite, support group, and family activities).

Targeting Outcomes for a Family: Case Example

The Dawn family consists of the father, Mr. Dawn, age 34; mother, Mrs. Dawn, age 32; daughter, Tina, age 6; and son, Scott, age 3½. The family was reported to CPS by the daycare center. Scott had lateral bruises and welts on his buttocks and on the back of his thighs. The daycare center reported that Scott was an aggressive child; he throws things when he is angry, hits other children, and runs from the teacher. The center also has threatened not to readmit him.

Through investigation and family assessment, the caseworker learned that Mr. and Mrs. Dawn have been married for 10 years. Mr. Dawn completed high school and is employed as a clerk in a convenience store. He works the evening shift, 4 to 11 p.m., and was recently turned down for a promotion. Mrs. Dawn also completed high school, went on to become a paralegal, and is employed as a legal assistant. Tina was a planned child, but Scott was not. The parents described Tina as a quiet and easy child. They described Scott as a difficult child and as having a temper and not minding adults. Recently, he threw a truck at his sister, causing her to need stitches above her eye, and tore his curtains down in his bedroom. His parents described Scott as unwilling to be held and loved. Both parents are at their wits' end and do not know what to do with Scott. Mrs. Dawn reported that all of the discipline falls on her, and she cannot control Scott.

The home appeared chaotic with newspapers, toys, and magazines strewn all over the living room. There was no evidence of structure or consistent rules. Scott misbehaved during the interview. Sometimes the parents ignored his behavior, and other times they addressed his behavior only when it had escalated to the point that he was out of control. It also appeared that Tina had a lot of age-inappropriate responsibility, for example, making Scott's breakfast every morning.

Mr. Dawn said his mother used severe forms of punishment when he misbehaved. He feels it taught him right from wrong, believing that children need strong discipline to grow up into healthy, functioning adults. He said he often "sees red" when Scott misbehaves and that he yells at Scott or hits Scott with a nearby object.

The family is socially isolated. Mr. Dawn's mother is alive, but they are estranged. Mrs. Dawn's parents are deceased, and her two brothers live hundreds of miles away. Mrs. Dawn has a friend at work, but they do not communicate outside of work. The parents described being very much in love when they met. However, because of work schedules, they have very little time to spend together. Mrs. Dawn describes her husband as often yelling at her and the children rather than just talking.

Targeting Outcomes for a Family: Case Example

The behaviors and conditions contributing to the risk include:

- Father's poor impulse control
- Father's childhood history of abuse
- Father's aggressive behavior
- Lack of structure, rules, and limits
- Inconsistent and inappropriate discipline
- Family isolation
- Inappropriate role expectations
- Poor family communication
- Scott's poor impulse control
- Scott's aggressive and dangerous behavior

Sample parent outcomes may be improved impulse control, child management skills, and coping skills.

Sample family outcomes may be improved communication and family functioning.

Sample child outcomes may be improved and age-appropriate behavioral control.

Determining Goals

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

- ***S*pecific.** The family should know exactly what has to be done and why.
- ***M*easurable.** Everyone should know when the goals have been achieved. Goals will be measurable to the extent that they are behaviorally based and written in clear and understandable language.
- ***A*chievable.** The family should be able to accomplish the goals in a designated time period, given the resources that are accessible and available to support change.
- ***R*ealistic.** The family should have input and agreement in developing feasible goals.
- ***T*ime limited.** Time frames for goal accomplishment should be determined based on an understanding of the family's risks, strengths, and ability and motivation to change. Availability and level of services also may affect time frames.

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

Determining Tasks

Goals should be broken down into small, meaningful, and incremental tasks. These tasks incorporate the specific services and interventions needed to help the family achieve the goals and outcomes. They describe what the children, family, caseworker, and other service providers will do and identify time frames for accomplishing each task. Families should understand what is expected of them, and what they can expect from the caseworker and other service providers. Matching services to client strengths and needs is discussed in Chapter 9, "Service Provision."

In developing tasks, caseworkers should also be aware of services provided by community agencies and professionals, target populations served, specializations, eligibility criteria, availability, waiting lists, and fees for services. With this knowledge, CPS caseworkers can determine the most appropriate services to help the family achieve its tasks. The following text box illustrates a sample outcome, the goals, and the tasks using the case example from earlier in this chapter.

Developing Concurrent Plans

Concurrent planning seeks to reunify children with their birth families while at the same time establishing an alternative permanency plan that can be implemented if reunification cannot take place. In cases such as these, the caseworker needs to develop two separate case plans, although it may seem confusing to work in two directions simultaneously. Concurrent permanency plans provide workers with a structured approach to move children quickly from foster care to the stability of a safe and continuous family home.[92]

Sample Outcome, Goals, and Tasks for the Dawn Family

Outcome: Effective child management skills.

Goal: Mr. and Mrs. Dawn will establish, consistently follow, and provide positive reinforcement for rules and limits.

Task: Mr. and Mrs. Dawn will set consistent mealtimes, bedtimes, and wake-up times for the children.

Task: Mr. and Mrs. Dawn will work with the caseworker to set specific, age-appropriate expectations for their children.

Goal: Mr. and Mrs. Dawn will use disciplinary techniques that are appropriate to Scott and Tina's age, development, and type of misbehavior.

Task: Mr. and Mrs. Dawn will identify those components of Scott's behavior that are most difficult for them to manage and the disciplinary techniques they can use to help him control his behavior.

State of Tennessee
Department of Children's Services

Administrative Policies and Procedures: 16.31

Subject:	**Permanency Planning for Children/Youth in the Department of Children's Services Custody**
Authority:	TCA 37-2-403 and 404; 37-2-408 and 409; 37-5-105 and 106; TCA Section 4-17-02 Amendment; 37-1-166; 36-1-113; 37-1-174; 37-1-801; 37-4-201-207; P.L. 109-239; and P.L. 109-239 section 471 (a) (15)
Standards:	DCS 5-201, 5-202, 5-203, 5-204, 5-401, 5-402, 5-500, 6-507 A
Application:	To all Family Service Workers, Provider Agency Staff, and Supervisory Staff

Policy Statement:

Permanency planning is the process that guides the efforts of child welfare agencies to ensure that all children in custody attain a permanent living situation as quickly as possible. By federal statute, all state child welfare agencies must identify a permanency goal and develop a plan that specifies what must occur in order to achieve the goal, what services will be provided, and the timelines for achieving the goal. Through regular reviews, this process continues throughout the course of the child's custodial experience and is used by the courts, Department and significant others to measure progress toward securing a safe, stable and permanent home for the child. A written permanency plan must be developed in collaboration with the child and family during a Child and Family Team Meeting (CFTM) for all children/youth adjudicated dependent/neglect or unruly under 18 years old and for all children/youth under 19 who have been adjudicated delinquent that are in the custody of DCS. Staff from DCS will partner with families, their support systems, and private provider staff to ensure that best practice, timelines, and professional standards are met to the maximum extent possible.

Purpose:

Children whose lives are disrupted by removal from their families are at increased risk for trauma, developmental delay and other problems. The longer a child is separated from family and remains in a temporary placement, the greater these risks become. Permanency planning requires service providers to consider the negative impact of placement and separation on children and to work diligently to find permanent, safe homes for children in care, in a timely manner. All service providers must recognize that time is of the essence for children, and must maintain a sense of urgency to achieve a permanent living situation for every child as soon as possible.

Procedures:

A. Scheduling and Timeframes	1. The Permanency Plan must be developed in the context of the Initial Permanency Planning Child and Family Team Meeting (CFTM), in which

DCS staff collaborate with the family and other members of the team on the development of a plan that will address the problems that necessitated the child's entry into foster care. This plan will specify the changes required to return the child home safely; identify the services that need to be provided to the parents and the child to ensure a successful reunification; and, determine the appropriateness of the child's placement.

2. The Initial Permanency Planning CFTM shall be held within thirty (30) calendar days of a child/youth's placement in custody. Letters and telephone participation should be encouraged for those parties not able to physically attend.

3. The Permanency Plan must be completed and submitted to the regional legal counsel no later than thirty (30) calendar days of a child/youth entering state custody. Maximum effort must be made to include all mandatory participants; however, a lack of response or participation shall not prohibit the development of the Permanency Plan. In the event that the parents cannot be located or refuse to meet with the worker, the DCS Family Service Worker (FSW) shall document all efforts made to locate the parents and to ensure that the meeting takes place. If a previously absent parent is located, reasonable efforts and engagement of that parent shall occur and shall be evidenced on the permanency plan.

4. Parents who are incarcerated must also be engaged and have the opportunity to participate in the development of the Permanency Plan unless the court has determined that reasonable efforts are not required. The Family Service Worker must consult with the regional legal counsel prior to the development of the Initial Permanency Plan to determine if it is appropriate to pursue this option.

5. Whenever the Permanency Plan goal needs to be revised, a Permanency Plan Revision CFTM should be convened to begin planning for the child's safe return home if progress is being made and the goal is to return the child home. If little or no progress is being made toward returning the child(ren) to the parent and a goal change is being considered, the team shall discuss the reasons for the proposed goal change and consider alternative options for permanency, such as guardianship, adoption, or the addition of a concurrent goal.

6. Every effort shall be made to schedule the CFTM by talking with all parties and agreeing on a time for the meeting as quickly as possible. Staff must be available to participate in CFTM's at times that accommodate the birth family and resource families, even if this falls outside of the traditional workday hours. Whenever possible, staff should schedule the Initial Permanency Plan CFTM at the conclusion of the Initial CFTM.

7. For Initial Permanency Planning CFTM's, if not scheduled in advance by agreement, the FSW will give adequate notice to all child and family team members, preferably at least seven (7) calendar days in advance of the CFTM if the scheduling is done by telephone or in person, and ten (10)

	calendar days in advance if notice is by mail. The Family Service Worker (FSW) should document all contacts for scheduling the child and family team meeting in TN-Kids case recordings. 8. An individualized permanency plan must be submitted by the Department and approved by the court within sixty (60) calendar days of the date that a child first enters state custody.
B. Development of a Permanency Plan	1. DCS staff must engage families in an ongoing assessment of how their strengths and needs will impact the safety, permanency and well-being of the child(ren) involved. The information gathered from this ongoing assessment process shall guide the participants in the Initial Permanency Planning CFTM in determining an appropriate plan of intervention with the child/youth and his/her family. 2. The Permanency Plan shall establish realistic goals for the family (including those parents that are absent or yet to be located), the child/youth, and/or the department necessary to achieve permanency in a timely manner. It shall be built upon the child and family's strengths, address the child and family's needs, and designate timeframes for the completion of actions that will help the child and family to achieve permanency and stability as soon as possible. It will specify what must be completed by the parents, child/youth and the Department to facilitate the timely achievement of the child's permanency goal. Permanency planning decisions must consider/address interstate or inter-jurisdictional placements as part of the planning, as appropriate. 3. Designated timeframes for the completion of actions must consider the negative impact of separation and loss upon children and reflect the importance of achieving permanence as soon as possible. In most cases, plans with a six month achievement date are preferred to ensure that permanency is achieved within the required time lines. 4. Time periods for achieving permanency goals shall be specific to the unique circumstances of the child and family and not dictated by the scheduling of administrative or periodic reviews or meetings. 5. The Permanency Plan should be developed with participants in the context of the Initial Permanency Planning CFTM. It is expected that the FSW will discuss permanency planning with the family prior to the CFTM, providing an orientation to permanency planning and beginning some discussion of the goal. The FSW should come to the Initial Permanency Planning CFTM with much of Sections 1, 2, 3, 4, 6, 7, 9 and 10 completed on the Permanency Plan. Information that is entered on the Permanency Plan prior to the Initial Permanency Plan CFTM will be gathered from the Initial CFTM, Non-Custodial Permanency Plan, Family Functional Assessment, CANS, FAST, YLS, medical and mental health records, school records and interviews with team members. Preparing these sections in advance will allow the participants to spend the meeting time to further explore the strengths and needs of the family, agree upon the goal(s), develop the desired outcomes, and identify the action steps to be taken. This should make the meeting more

	efficient and enable participants to focus on an inclusive, collaborative planning process. See "Instructions for the Custodial Permanency Plan." 6. The Permanency Plan may be a handwritten draft, but is considered complete at the conclusion of the CFTM. Significant changes or alterations to the goals or tasks on the plan can only be made by convening another CFTM or by court order at the Permanency Plan ratification hearing. Minor changes that do not affect the content of the document, such as grammatical or spelling errors, may be made following the meeting. *7.* Detailed information regarding plans for parent/child visitation and a schedule of visits should have been developed during the Initial CFTM and recorded on form ***CS-0747, Child and Family Team Meeting Summary.*** In addition, details regarding visitation should be placed in TNKids case recordings. *8.* The Interdependent Living Plan is a section of the Permanency Plan which is completed for all youth in state custody aged fourteen and older. It is the responsibility of the FSW to develop the Interdependent Living plan along with the Permanency Plan and maintain the same review and update schedule. (See 16.51 Interdependent Living Plan.) To finish the Interdependent Living section, the ACLSA must be completed prior to the Permanency Planning CFTM (See Attachment 1 Ansell Casey Life Skills Assessment /Protocol.). The assessment results will be used along with the team members' input to develop outcomes and action steps. 9. Parents shall have the opportunity to sign a completed, handwritten or typewritten permanency plan at the conclusion of the Initial Permanency Planning CFTM. If a completed typewritten permanency plan was not available for the biological parents to sign by the conclusion of the Initial Permanency Planning CFTM, one shall be presented to the parents for discussion and signature. A permanency plan must be submitted by the department and approved by the court within 60 calendar days of the date a child first enters custody (see Section A-7 of this policy). The FSW will review form ***CS-0745, Criteria and Procedures for Termination of Parental Rights***, with every parent and provide them with a copy. 10. In the event parents have signed a handwritten copy at the conclusion of the CFTM and it is later typed, case managers must bring both the handwritten copy and the typed copy to the court hearing, where the family can review it along with the attorneys to approve the language in the typed plan and sign it, if agreed upon.
C. Participation	1. Participants involved in the Initial Permanency Planning CFTM are the same as those who should be involved in all CFTM's – the family, their support systems, community partners, and DCS staff (including DCS specialty staff and YDC Staff/Treatment Team Members). The greater the participation of the child and family team, the more likely that individualized service plans will be developed. At a minimum this CFTM should include the parents, DCS Team Leader, and DCS Family Service Worker. The following persons shall be Child and Family Team members as appropriate: contract agency worker;

guardian ad litem (GAL); court appointed special advocate (CASA); resource parents; and the child's parents or other relatives or trusted family friends, as identified by the family. Inclusion and notification must be made in accordance with DCS Policy 31.7, Building, Preparing, and Maintaining Child and Family Teams.

2. Children and youth who are at least 6 years of age and older should be involved in the planning process to the extent that they are capable of participating. All children 12 and over should be prepared and included in the Permanency Planning CFTM. Younger children may also be able to participate in the meeting, according to their maturity level and ability to understand. Arrangements should be made to escort younger children out of the meeting and provide supervision when the discussion of sensitive or difficult topics must take place. Usually it's best to include the child in the beginning of the meeting to get his/her understanding of the situation, explore the child's needs and adjustment to placement, etc., and then excuse the child for discussions regarding the treatment needs of parents. Exceptions to this policy must be clearly documented in the case record, with an explanation for why the child's participation would be contrary to his/her best interests.

3. The DCS supervisor assigned to the case shall participate in the Initial Child and Family Team Meeting, the Initial Permanency Planning Child and Family Team Meeting, the Discharge Child and Family Team Meeting, and any CFTM if the FSW has less than one year of experience. For all other Child and Family Team Meetings, the supervisor shall make a decision about his or her participation based on the complexity of the case, the availability of other supports such as a trained, full time or back-up facilitator, and the experience of the FSW. In the event that the assigned DCS Supervisor is unavailable, another Supervisor or FSW III can attend the meeting in his/her place. Please refer to the (CFTM) Child and Family Team Meeting Protocol for the expectations of Supervisory participation in CFTMs.

4. Particular attention shall be paid to the wants and desires of adolescents when identifying Permanency Plan tasks and goals. While the Department is ultimately responsible for the decisions made in the CFTM, actively involving youth in decision-making is crucial to achieving positive outcomes. The FSW must carefully explain all of the permanency options to adolescents and help them to understand how important achieving permanency is for them. Youth should be encouraged to bring someone with them to the Permanency Planning CFTM, if that would help them feel more comfortable participating. If an adolescent does not attend the CFTM, or it is determined that it is not in his or her best interest to attend, the reasons should be clearly documented in TN-Kids Case Recordings.

5. If an identified child or family member does not attend a CFTM, the FSW must document the stated reasons for non-participation and the efforts made to accommodate them in TN Kids Case recording. The Department shall conduct diligent searches (DCS Policy 16.48, Conducting Diligent Searches) as soon as DCS becomes involved with the family, but no later than 30 days

	after the child enters DCS custody and every three months thereafter. If there are any unidentified parents, or the Department does not know their whereabouts, diligent searches must be conducted throughout the life of the case. Efforts to locate parents must be clearly documented in the case record. 6. The incarceration of a parent will not be a barrier to their participation in the CFTM and permanency planning process. By law, DCS must create opportunities for all parents to participate in the plan and to meet their parental responsibilities. This may be accomplished by having meetings where they are located, or by arranging for them to participate by telephone.
D. Permanency Goals to consider for the Child/Youth	DCS shall establish a planning process for all children in DCS custody that; ♦ initially will seek to work intensively with the child's parents and other appropriate family members to allow the child to remain safely at home, if appropriate; ♦ in those instances in which removal from the home is necessary, will work intensively with the child's parents and other appropriate family members in a collaborative process to return the child home quickly under appropriate circumstances consistent with reasonable professional standards; and: ♦ if return home is not appropriate or cannot be accomplished safely within a reasonable period of time, will assure the child an alternative, appropriate permanent placement as quickly as possible. 1. **<u>Return to Parent</u>** is the preferred goal, if the conditions that led to the child's removal can be remedied and it is safe for the child/youth to return to the home. The goal of return to parent is to be utilized when the parent(s) is/are working to resolve the issue(s) that led to the removal of the child/youth. AFSA requires supervisory approval to continue a goal of return to parent beyond certain timelines: a) For any child who has a permanency goal of return to parent for more than 12 months, the FSW, with written approval from the Team Leader, shall include in the record written explanation justifying the continuation of the goal, and identifying the additional services necessary or circumstances which must occur in order to achieve the goal. This justification should be presented to the court at the Permanency Hearing. b) No child shall have a permanency goal of return to parent for more than 15 months unless there are compelling circumstances and reason to believe that the child can be returned to the parent(s) within a specified and reasonable time period. These must be documented in the record

and approved by the FSW's Team Leader within the record. These should also be presented to the court at the Permanency Hearing. AFSA does permit an exception to this when the child is placed with relatives and in a stable situation.

2. **Exit Custody to Live with Relative** is to be utilized when the child/youth is unable to return to the parent(s) and they will achieve permanency through a legal relationship with a relative or other person with a significant relationship with the child. Relatives should be fully informed of all of the permanency options for children in their care as described in DCS Policy 16.59, Disclosure of Legal Options and Available Services for Relative Caregivers. Department staff should be prepared to support the permanency option preferred by the relative caregiver. Legal custody is transferred from the department to the relative/caretaker. This is when an adult (relative or non-relative), who has a significant relationship with a child, is willing to petition for custody of that child. An order from a juvenile court judge is needed to obtain legal custody. The parent's rights are not terminated and the court order generally outlines explicit guidelines for parental visitation. The order may also include a requirement for the parents to pay child support. Parents do have the opportunity to regain custody at a later date, if they can demonstrate to the court that they have reasonably remedied the conditions that led to the child's placement.

3. **Adoption** is to be utilized when a child/youth is unable to return to the parent(s) and permanency through the creation of a new legal parental relationship is in the child/youth's best interest. This option is appropriate when there are no willing and appropriate relatives for the child to exit custody to or adoption is the permanency option preferred by the relative caregiver. In no way does the termination or voluntary surrender of parental rights preclude the possibility of relative adoption.

   a) When considering the goal of adoption, the child and family team should consider the child/youth's best interests as well as his/her views regarding adoption. The FSW shall also consult with the DCS attorney to ensure legal grounds exist to terminate parental rights and/or to properly attain the voluntary surrender of parental rights. Even if there are sufficient grounds to terminate, state and federal law requires that we continue to make reasonable efforts to work with the parents until the termination trial.

   b) Upon identifying a sole permanency goal of adoption, efforts must begin to free the child/youth for adoptive placement and to recruit and locate an appropriate adoptive family. This must occur without delay, even if the goal is changed to adoption prior to the filing of the petition to terminate parental rights.

   c) Refer to DCS Policy 15.11, Adoption Assistance for the criteria and eligibility for a child to receive adoption assistance.

4. **Permanent Guardianship** Permanent Guardianship is a goal to be utilized only after the goals of Return to Parent or Adoption have been ruled out. For

families and caretakers who are unwilling or unprepared to adopt a child they are caring for, permanent guardianship may be the best option. Some relatives are uncomfortable having the parental rights of a family member terminated. This option also allows for an ongoing relationship between the child and biological family. Once a child has lived with a willing and able adult (relative or non-relative) for at least six months and the family is willing to assume guardianship for that child, an order from a juvenile court judge is needed to obtain permanent guardianship. The biological parents' rights are not terminated, but they are limited. A permanent guardian has the same rights as a parent. The court will establish the plans for parent/child visitation as part of the Guardianship order. The order may also include a requirement for the parents to pay child support. It is possible for parents to petition the court to regain custody, however the standard for regaining custody is more stringent – they must convince the court not only that they have remedied the conditions that led to the placement of the child, but that returning the child to them would be in the child's best interest. Permanent guardianship can last until the child is an adult. Some permanent guardians may qualify for a subsidy to assist with expenses. Refer to DCS Policy 16.39, Subsidized Permanent Guardianship for the conditions and criteria for eligibility.

5. **Planned Permanent Living Arrangement (PPLA)** is only appropriate in very rare circumstances, as this goal generally does not support the child/youth's need for permanency. Staff shall not take a Permanency Plan with a sole or concurrent goal of PPLA (nor a recommendation to change to such a goal) to the Foster Care Review Board or to Court until the Commissioner or his/her designee has approved it. A request can be made by completing the ***Request for Permanency Goal of Planned Permanent Living Arrangement*** **(CS-0681)** and following the procedures attached to the form (Planned Permanent Living Arrangement Protocol). The request for consideration of a sole or concurrent goal of PPLA shall be submitted to the Commissioner through the Executive Director for the Office of Child Permanency or his/her designee.

   a) DCS may assign a permanency goal of Planned Permanent Living Arrangement to a child:

      - for whom an appropriate relative or resource parent has been identified.
      - the caregiver is willing to assume long-term responsibility for the child but has legitimate reasons for not adopting, assuming guardianship or taking legal custody of the child

        and…

      - it is in the child's best interests to remain with that caretaker rather than to be considered for adoption by another person.

   b) With the exception of children placed in approved relative resource homes, no child shall be assigned a permanency goal of Planned Permanent Living Arrangement unless:

	♦ the child is at least 16 years old ♦ DCS has made every reasonable effort, documented in the case record, to return the child home, to place the child with appropriate family members or to place the child for adoption or guardianship and… ♦ the person to whom DCS proposes to assign permanent care giving status has demonstrated a commitment to assuming long-term responsibility for the child. c) Before the request is submitted for approval, the Child and Family Team must meet and make a recommendation for the goal of PPLA. In addition, the Child and Family Team must review the appropriateness of PPLA no less often than every six months. d) After a year with a goal of PPLA, another request for approval is required in order to continue the goal. It is critically important that department staff continues to work with children/youth that have an approved goal of PPLA. The Permanency Plan must reflect ongoing efforts to develop more supportive adult relationships the child/youth can rely upon beyond the age of 18. Plans should include action steps designed to help the child/youth develop additional meaningful relationships and family-like connections with other adults. Strategies should include efforts to involve the child/youth in extra-curricular activities through which such relationships can naturally evolve. There should also be efforts to help that youth reconnect with significant adults from his or her past who may become valuable resources for the future. Failure to document such efforts may result in denial of the request to continue the goal. e) In the event the placement disrupts, the goal of PPLA is no longer valid, as it is associated with a specific caregiver who has made a long-term commitment to the child. Another request is required once an alternative caregiver has been identified and agreed to provide care and support to the child, at least to the age of 18 and preferably, throughout adulthood. Please refer to Planned Permanent Living Arrangement Protocol for a fuller description of the process.
E. Concurrent Planning	**Concurrent Planning** is the identification and active pursuit of more than one permanency goal. Much like in our own families, some of our best planning is achieved when several options are considered. Concurrent planning can help to expedite the achievement of permanency for the child/youth. Family Service Workers must fully disclose all concurrent planning information with parents, resource parents, and other Child and Family Team members regarding timeframes, expectations, services, and court actions. The Family Service Worker must include identification of appropriate in-state and out-of-state placement options as part of the concurrent planning process. This option may be optimal when: a) There is not a clear, singular goal that would reflect best practice standard

	of having children/youth move to appropriate permanency in the most timely fashion; b) A child has had a previous commitment in state custody; c) There is a judicial determination that reasonable efforts are not required; or, d) A youth is in full guardianship, seventeen (17) years old or older, and has no identified adoptive family. This option is intended to assure that the youth has family connections and support as he or she enters adulthood.
F. Reasonable Efforts not Required	1. DCS legal will be immediately consulted if the FSW believes that reasonable efforts to reunite a child with a parent(s) or former legal guardian may not be required. The consultation with DCS legal is critical before deciding that reasonable efforts are not required. If the department desires not to make reasonable efforts, then a motion must be filed with the juvenile court and an order obtained that reasonable efforts are not required. If court determines that reasonable efforts are not required, there must be a permanency hearing within thirty (30) days of the court's decision. If the permanency hearing triggers the filing of a petition to terminate, DCS must file the petition immediately. 2. Reasonable efforts are not required when a Court of competent jurisdiction has found that certain defined felonies have been committed by the parent(s) against the child/youth or another child/youth of the parents. *TCA 37-1-166 (g)* (4) lists those felonies: a) murder of any sibling or half-sibling or other children/youth in the home; b) committed voluntary manslaughter of any sibling or half-sibling/s of the child or any other child residing in the home; c) aided or abetted, attempted, conspired, or solicited to commit such a murder such as voluntary manslaughter of the child or any siblings or half-sibling of the child or any other child residing in the home; d) felony assault that resulted in serious bodily injury to the child/youth, siblings, half siblings or other child/youth in the home. 3. Reasonable efforts to reunify are also not required if the parental rights of the parent to a sibling or half-sibling have been involuntarily terminated. 4. Reasonable efforts do not have to be made if the parent has subjected the child/youth who is the subject of the petition or any sibling, half-sibling or other child/youth residing in the home to aggravated circumstances defined in *TCA 36-1-102 (9*) and the court agrees---abandonment, abandonment of an infant, aggravated assault, aggravated kidnapping, especially aggravated kidnapping, aggravated child/youth abuse and neglect, aggravated sexual exploitation of a minor, especially aggravated sexual exploitation of a minor, aggravated rape,

	rape, rape of a child/youth, incest or severe child abuse. 5. If there has been abandonment or severe child abuse or any of the above felonies committed, DCS must carefully consider if there are compelling reasons to make reasonable efforts to reunite this child/youth with the offender. 6. Other circumstances may exist when it is reasonable to make no effort to reunify the child/youth and parent. DCS legal should be consulted in connection with this determination, i.e., refer to grounds for termination as set out in *TCA § 36-1-113*, though cessation of reasonable efforts to reunify does not necessarily have to occur because adoption is a goal or even a sole goal. Either way, termination protocol must begin immediately. 7. In addition to the above statutory exceptions to reasonable efforts, there are some cases where, after an assessment of the facts and the family situation, DCS may take the position that returning the child to the parent will never be appropriate. For instance, in a severe child abuse case, an assessment of the injuries, circumstances and family constellation may result in the determination that the only viable permanency goal is adoption. It may be reasonable to make no effort to reunify the child/youth and family. After DCS has made that decision and established the goal of adoption, the Court must determine (within thirty (30) days of the decision) that the Department's assessment and decision are accurate and that the actions were appropriate. 8. If the Court agrees with the decision, then the Court would find that the Department's efforts up to that point were sufficient (not that reasonable efforts were not required in the past). If this were the finding, DCS would then proceed with termination of parental rights.
G. Permanency Plan Ratification	1. The Juvenile Court of Venue shall review and approve all Permanency Plans unless the youth is placed in a YDC. Plans developed for children placed at YDCs do not require court approval unless directed by the court. When a youth steps down to a placement from a YDC setting, Permanency Plan ratification and court review must begin. 2. If the parents, child, or any team member disagree with the plan, they shall have the right to present their concerns about the plan to the Court. 3. Notification of the review must be sent to all members of the Child and Family Team, as well as a copy placed within the child's record.
H. Role of the DCS attorney in permanency planning	1. DCS attorneys will be notified and may be invited to participate in permanency planning CFTM's. In cases where the DCS attorney does not participate, legal consultation should be sought by the FSW prior to the CFTM. 2. A DCS attorney shall review all Permanency Plans prior to submission to the court, to ensure that child/youth and family issues, services, and placement issues necessary to establish reasonable efforts findings at the initial and

	later court hearings are addressed. 3. If the content is found to be insufficient or the goal inconsistent with early permanency, the attorney shall consult with the FSW and the team leader. Any significant changes to the permanency plan should be made by reconvening the Child and Family Team or shall be made during the permanency plan hearing at Court. 4. The FSW is responsible for providing a copy of the Permanency Plan to the DCS attorney with either: a) referral/request for a motion to set a hearing; or, b) with the date and place of an already-set hearing.
I. Permanency Plan Reviews and Revisions	1. The child's Permanency Plan shall be reviewed in the context of a CFTM's at least every three months. These meetings must be separate and distinct from any court hearings, foster care review board meetings or other judicial or administrative reviews of the child's Permanency Plan. However, if the Child and Family Team are meeting for another purpose, the progress on the plan can be reviewed at that time. It is not necessary to convene another meeting solely for the purpose of reviewing the plan. The Permanency Plan should be updated if necessary any time a review indicates that revisions are needed. 2. Significant revisions of the Permanency Plan are the responsibility of the assigned FSW and should be completed within the context of a CFTM that includes all significant members of the team. This would include such revisions as a change in goal, adding a relevant party such as a parent or resource family, identifying an interjurisdictional placement, or addressing a newly disclosed need on the part of the child/youth or parent/former legal custodian. 3. Significant plan revisions may be made at any time and shall be made when new issues hindering the accomplishment of the permanency goal(s) are identified, when there is a change in the permanency goal(s), when there must be a change in the time frame/target dates, or when there is a need for changes in services or treatment for the child/youth or family. However, a Court does not have to approve a change or addition in services before such can be supplied to the child or family. A change in the child/youth's placement (or in the needed level of care) may not necessitate a change in the Permanency Plan. 4. Permanency Plans must be updated before the plan achievement date expires, so in most cases this would be at least every six months. Permanency Plans shall be updated no less often than annually. However, it is preferable to achieve permanency in less time whenever possible. Permanency Plans must be reviewed through the quarterly progress review process, so the opportunity to update and refine activities and outcomes will be revisited on a regular basis (see DCS Policy 16.32, Foster Care Review and Quarterly Progress Reports.) 5. As with the original plan, the revised plan must be presented to the court of venue in a hearing and approved by the court in accordance with DCS Policy

	16.33, Permanency Hearings. 6. A parent or other legal custodian who did not agree with the revised plan shall have the right to present their concerns about the revised plan to the court of venue during the hearing.
J. Documentation	1. All Permanency Plans shall contain specific information about: a. How a child/youth's permanency goal will be achieved, b. What services are necessary to make the accomplishment of the goal likely, c. Who is responsible for the provision of those services, d. When the services will be provided, e. The date by which permanency is likely to be achieved 2. The case record should reflect the team decisions, interactions with children, youth and families (birth, foster, and pre-adoptive), interactions with collateral resources, and the efforts towards achieving any/all permanency goals. 3. Efforts being made to achieve the permanency goal(s) should also be clearly documented in the quarterly case reviews. 4. Major treatment issues for the child/youth and family (safety issues identified in the child protective services investigation, drug treatment, sexual offense victim or sex offender treatment, special education, domestic violence, etc.) that are identified during the assessment process shall be noted in the Permanency Plan along with activities necessary to address the issues that brought the child/youth into care. 5. The Permanency Plan shall have clearly defined outcomes and the specific, time-limited action steps that need to be completed to reach each desired outcome. All services documented in the plan as necessary for the achievement of the permanency goal(s) shall be provided within the time period in which they are needed. 6. Specific tasks listed on the Permanency Plan shall include observable, measurable outcomes, as well as the names of the persons responsible for completion of each task. This is to include responsibilities of the family and of the Department and other community resources including cross-jurisdiction resources in provision of services and monitoring progress, as well as the child/youth in regard to his/her needs for safety, permanency and well-being. 7. Federal Law requires that each of the following be documented in the Permanency Plan: a. Efforts made by the Department to prevent removal of the child/youth and

placement into custody.

b. A description of the type of placement, including interstate placements when appropriate, and a plan for assuring that the child/youth receives safe and proper care in the least restrictive, most family like setting appropriate, in close proximity to the parents' home, consistent with the best interest and individual needs of the child/youth.

c. A discussion of the safety and appropriateness of the placement.

d. To the extent available and accessible, the most recent health and education records of the child/youth, including the EPSD&T, IEP and/or psycho-educational when applicable, and the specific steps to be taken to assure health and education progress.

e. For a child/youth ages 14 or above, the plan must also include a written description of the services that will help the child/youth prepare for independence. These services must be appropriate to the child or youth's age and circumstance.

f. For all children/youth, the plan must document the steps the Department is taking to achieve permanency for the child/youth. These steps should support the achievement of the permanency goal within reasonable and appropriate time frames.

8. The participants in the CFTM shall receive a copy of the Permanency Plan immediately following the CFTM. The FSW will review form ***CS-0745, Criteria and Procedures for Termination of Parental Rights***, with each parent and provide them with a copy. The FSW should be sensitive to whether resource parents want their identifying information shared with everyone in the CFTM and be prepared to delete it, if requested.

9. All Permanency Plan information and dates shall be entered into TNKids within 48 hours of the completion of the CFTM where the plan is developed or revised. This time frame is to ensure timely dissemination of the Permanency Plan to TennCare Advocates.

10. For those families who cannot speak or read English, the Permanency Plan document and its content will need to be translated into the language the family speaks and reads. The Regional Fiscal Teams can be contacted when translation services are needed.

Forms:	***CS-0746 Meeting Notification*** ***CS-0745 Criteria & Procedures For Termination Of Parental Rights*** ***CS- 0681 Request for Goal of Planned Permanent Living Arrangement*** ***CS-0747 Child and Family Team Meeting Summary***
Collateral Documents:	Functional Assessment, Copy of Notification Instructions for the Custodial Permanency Plan Planned Permanent Living Arrangement Protocol Attachment 1 Ansell Casey Life Skills Assessment /Protocol Policy 16.51 Interdependent Living Plan Policy 31.7, Building, Preparing, and Maintaining Child and Family Teams Policy 31.7 Attachment: CFTM Protocol Policy 16.48, Conducting Diligent Searches Policy 16.59, Disclosure of Legal Options and Available Services for Relative Caregivers Policy 15.11, Adoption Assistance Policy 16.39, Subsidized Permanent Guardianship Policy 16.32, Foster Care Review and Quarterly Progress Reports Policy 16.33, Permanency Hearings

Glossary:	
Child and Family Team Meeting (CFTM):	CFTM is a philosophy that supports making the best possible decision in child-welfare cases. The quality of decision-making is improved because CFTM includes all of the parties involved in a child's case (child, if age-appropriate, birth parents and their support system, resource parents, DCS staff, community partners and other involved parties), respecting the expertise that each party brings to the table. CFTM's should be characterized by respect, honesty, inclusiveness and work towards building consensus in decision-making.
Trained Full-Time or Back-up Facilitator:	DCS Employee whose role at the agency includes the facilitation of Child & Family Team Meetings and the coaching and mentoring of staff in their professional development on CFTM. The facilitator has completed the core curriculum on Child & Family Team Meetings, the advanced curriculum on facilitating Child & Family Team Meetings, passed the skills-based competency exam and met the minimum threshold for competency on their structured observations. Some regions have trained additional staff in advanced facilitation skills as back-up facilitators, who can facilitate CFTM's, as well.
Family Services Worker:	This is a DCS term used to identify the position previously known as the DCS case manager or home county case manager. This person is principally responsible for the case and has the primary responsibility of building, preparing, supporting and maintaining the Child and Family Team as the child and family move to permanence.
Concurrent Planning:	A method of case planning in which two permanency plan goals are implemented simultaneously in order to ensure the most expeditious permanence for children. Successful concurrent planning requires a clear delineation of roles and responsibilities through the planning process, full-disclosure and support to the Child and Family Team members and is often utilized in cases where the outcome of a sole permanency goal is uncertain.

State of Tennessee
Department of Children's Services

Administrative Policies and Procedures: 31.7

Subject:	**Building, Preparing and Maintaining Child and Family Teams**
Authority:	Brian A. Settlement Agreement; TCA 37-5-106
Standards:	DCS 5-201, 5-202, 5-203, 5-204, 5-401, 5-402, 5-500, 6-507 B
Application:	All DCS Family Service Workers, Provider Agency Staff, CPS Case Managers, and Supervisory Staff

Policy Statement:

Building, preparing and maintaining Child and Family Teams is the model utilized by DCS staff to ensure that families and their support systems are engaged in the planning and decision-making process throughout their relationship with the Department. This team will be convened at certain critical junctures in the case, and it is expected that work with members of the team will be an ongoing process based on the needs of the child and family. DCS will establish working relationships with the Child and Family Team (CFT) that shall be characterized by behaviors that impart respect for human dignity, full disclosure of information, inclusion in the decision-making process, and an awareness of the appropriate use of authority in serving families. Through the use of quality Child and Family Team Meetings (CFTM), accompanied by ongoing work with the child and family team, this model will be utilized to address critical decisions around the placement of children; for the continuous assessment of family strengths and needs; for making permanency decisions and developing individualized case plans; and for conducting ongoing reviews to ensure that plans are being implemented toward achieving permanency for children who are in DCS custody. Staff from DCS will partner with families, their support systems, and private provider staff to ensure that best practice, timelines, and professional standards are met to the maximum extent possible.

Purpose:

Child welfare is a community responsibility requiring a collective approach. The process of building, preparing and maintaining Child and Family Teams ensures that families are included in decision-making and that community supports are engaged to help families meet their needs. The Child and Family Team process is used to engage a group of committed individuals who will work to strengthen the family and help it craft an individualized case plan. This model of practice emphasizes family strengths, mobilizes community resources, and involves all those concerned with the child and family in developing and monitoring plans that will maximize the safety, permanency and well being of the children involved.

Procedures:

A. Engagement of the Child and Family Team	1. From the first contact a family or child has with DCS, they should be engaged with empathy, genuineness and respect. It is important that the child and family are part of a trust-based, mutually-beneficial helping relationship with the DCS worker so that they can be active participants in shaping and directing service arrangements that impact their lives. Collaborative and open casework relationships foster an atmosphere of trust when case managers demonstrate competence and empathy, and communicate a belief in family strengths and resilience. When families are engaged in collaborative and open decision making

	and case planning, they understand their roles in the change process and are better able to develop substantive relationships with case managers and other individuals and agencies with which they work. 2. As risk and safety are being assessed, staff must make every effort to validate the child/family's feelings, elicit their understanding of their strengths, needs, and circumstances, and help them to identify other resources in their family, network, or community that could offer support. These individuals, along with DCS staff, other professionals from community providers, and resource parents should form the foundation of an ongoing, functioning team that will work with the family and DCS to: a) secure the child(ren)'s safety in the least restrictive, least intrusive placement that can meet their needs; b) minimize the trauma associated with separation from family and help the child to maintain meaningful connections with family members and others who are important to him or her; c) contribute to an ongoing assessment of the child and family's strengths and needs; d) develop and support the implementation of quality permanency plans and individual program plans for youth in a YDC; e) ensure that plans are monitored for progress and participate in revising or updating plans as the family/child's circumstances change; f) support the stability of appropriate placements while in DCS custody; and, g) facilitate the timely achievement of permanency for children. 3. Members of the Child and Family Team (CFT) should be actively engaged throughout the department's work with the family. A Child and Family Team Meeting (CFTM) will be convened at certain critical junctures in the life of a case, as well as on an as-needed basis, to help the family and the department work together to achieve permanency for children as soon as possible. The Family Service Worker (FSW) coordinates the efforts of the team to ensure that everyone understands their role and responsibility to help the family achieve their long term goals, or, in the event the family is not a viable resource for the child, to work toward finding a permanent, nurturing home for each child in care.
B. Teamwork and Coordination	1. The FSW has the primary responsibility for building, preparing and maintaining the Child and Family Team. This requires working closely with the family to identify their support systems, extended family members, and community resources that can help the family achieve their goals. The family and child (if age-appropriate) should always be central to the decision-making and planning process of the Child and Family Team. 2. Collaboration among team members from different agencies is essential. Evidence of team functioning lies in its performance over time and the results it achieves for the child and family. The focus and fit of services, authenticity of relationships and commitments, dependability of service system performance, and connectedness of the child and family to critical resources all depend upon an effective Child and Family Team process.

a) Convening the Child and Family Team

i. The development of the Child and Family Team begins when there is any risk that a child may be removed from his or her home. The Child and Family Team is convened to explore the safety and risk issues, assess how to meet the child's needs for safety in the least restrictive, least intrusive manner possible, and examine whether there are other family resources that can care for the child. No child should enter the custody of DCS without the convening of a Child and Family Team Meeting. In the event a child is removed on an emergency basis, or adjudicated by a juvenile court for delinquency and placed into DCS custody, the team should be convened as soon as possible to ensure that placement is the best alternative to keep the child safe; that the specific placement is appropriate to meet the child's needs; that the resource parents or other provider have the information they need to care for the child; and, that a visitation schedule is arranged with the family. At this meeting, DCS staff should explore who else could be added to the team, such as informal supports, extended family, and community providers. All team members should be prepared to participate in a CFTM for the development of the permanency plan and/or the individual program plan.

ii. The development of an individualized, comprehensive permanency plan depends upon a full, functioning team that can identify the child and family's strengths and resources; address their needs; help them articulate their long term view; identify how to resolve the issues that required DCS intervention; generate creative solutions; and, share the responsibility for helping the family and child overcome any barriers to child safety, permanence, and well being. The more participants engaged in permanency planning, the more likely that permanency plans will be tailored to the child and family's specific needs.

iii. The Child and Family Team should also be re-convened periodically for the revision and tracking of the permanency plan, to ensure that plans are relevant, that progress is being made, and that plans are revised as needed to address any new issues that may emerge. The team should participate in a child and family team meeting whenever a change of permanency goal is being considered.

iv. Disruptions in continuity of care are damaging to children. They can result in additional trauma, delayed development, interruptions in education, and interfere with a child's ability to attach and trust others. No child in DCS custody should change a placement without convening a Placement Stability Child and Family Team Meeting. This meeting is to assess whether that placement is meeting the child's needs; what DCS and the team can do to support the placement, if it is appropriate; or, if not, to help identify a more appropriate placement for the child. It is also necessary, when a change of placement has been planned and represents a move toward permanency, for the team to meet and ensure that all of the services are in place to make that placement successful.

- Depending upon the circumstances for a change of placement, it may not be necessary to have the full team involved in these meetings. However, the youth, the family, DCS staff, private

provider staff (if providing care) and the caregivers should all participate to help identify the resources needed to stabilize the child and ensure a successful placement.

- ♦ In the event a placement disruption has taken place without sufficient time to gather the team, it is still good practice to convene a Placement Stability Child and Family Team Meeting to examine the issues that prompted the disruption, to assess how the child is adjusting to the new placement, and whether the child needs additional services or supports to maintain that placement.

v. Before a child is leaving custody or beginning a trial home visit, a Discharge Planning CFTM should be convened to ensure that all the needed risk and safety issues have been resolved and that there are services in place to support a successful transition.

vi. There may be other occasions when the wisdom and support of the child and family team are crucial to ensuring that services are being delivered, that the barriers to permanency are being addressed, the child and family's needs are being met, and that every effort is being made to minimize the damaging effects of out-of-home placement for children.

vii. Please refer to the Child and Family Team Meeting Protocol for more guidance on the critical junctures that require a Child and Family Team Meeting and what should occur at each type of meeting.

b) Preparing and Planning for the Child and Family Team

i. Advanced preparation is essential to a quality CFTM. DCS staff must ensure that families and other team members are prepared for the purpose of the Child and Family Team Meeting and what they can expect to take place. This includes preparing the family and youth for the issues that will be discussed and exploring with them how difficult or sensitive issues could be handled. FSWs should spend time prior to each meeting helping the family/youth articulate their current situation, to identify their strengths and needs, and to explore their desired outcomes. Similarly, other members of the team should be informed of the purpose of the meeting and how they can contribute to the decisions that must be made and the development of action steps that will result from the meeting.

ii. In the course of preparing the family for the meeting, the FSW can gather valuable assessment information to develop or update the Functional Family Assessment.

iii. When a skilled facilitator will be conducting the meeting, the FSW should have a pre-meeting consultation to prepare the facilitator for the meeting and alert him or her to any special issues or considerations needed.

iv. DCS staff shall plan Child and Family Team Meetings for times and locations that are convenient to the family and child(ren)/youth. Efforts shall be made to schedule the meeting to accommodate as many team members as possible. The location of the meeting should be conducive

to the private discussion of family issues.

v. The FSW must also assess any safety concerns, such as domestic violence or other sensitive issues to be discussed in the meeting, when determining an appropriate location and who should be included in the meeting.

vi. Families and community partners should be given adequate notice of non-emergency meetings, preferably ten (10) calendar days in advance if in writing or seven (7) calendar days if notified by telephone. The ***CS-0746, Meeting Notification*** may be used to provide written notice of any CFTM called by DCS staff. Efforts to schedule meetings and accommodate team members should be clearly documented in the case recording section of TN Kids.

vii. DCS should provide services to support the participation of parents and relatives in Child and Family Team Meetings. Such services may include transportation, childcare, interpreter services, and any other services that would facilitate and support the family's participation.

c) Members of the Child and Family Team

i. The FSW, birth parents, and family members form the core of the child and family team. Other members can be anyone identified by the family, as well as service providers or other professionals serving the child or family. Because it is considered the "family's" meeting and confidentiality must be maintained as much as possible, the family must agree to the inclusion of community members and other professionals who may not be directly related to the case. The FSW must engage the family in exploring how a diverse team could help them resolve their issues more quickly and provide more ongoing support outside of DCS.

ii. A diverse team is preferable to assure that the necessary combination of technical skills, cultural knowledge, community resources and personal relationships are developed and maintained for the child and family. Collectively, the team should have the expertise, family knowledge, authority and ability to flexibly mobilize resources to meet the child's or family's specific needs. Members of the team should have the time available to fulfill commitments made to the child/family. Team competence, support, and ongoing involvement are essential.

iii. The goal of the Child and Family Team Meeting should influence who should participate in any particular meeting, but the child and family must always be the centerpiece of every CFTM. DCS must help youth and families to identify individuals that they want to become part of their team, people they can turn to in a crisis and rely upon. The FSW must make every effort to engage extended family and community-based, informal supports that will continue to help the family after DCS is no longer involved.

- **Child/Youth**
  - Children and youth who are at least 6 years and older should be involved in the planning process to the extent that they are capable of participating. All children and youth who are 12 years of age and older should be included and

prepared to participate in the meeting to the extent that is age-appropriate. In some cases, children younger than 12 can participate in the meeting, according to his or her maturity level and ability to understand. Arrangements should be made to escort younger children out of the meeting and provide supervision when the discussion of sensitive or difficult topics must take place. Usually it's best to include the child in the beginning of the meeting to get his/her understanding of the situation, explore the child's needs and adjustment to placement, etc., and then excuse the child for discussions regarding the treatment needs of parents. Exceptions to this policy must be clearly documented in the case record, with an explanation for why the child's participation would be contrary to his/her best interests.

- o Generally, children/youth and families should be involved together in their Child and Family Team Meetings. However, consideration shall be given to issues related to safety or highly-charged emotional issues, which may call for some adaptation to the meeting format. Staff shall assess this issue on a case-by-case basis and provide alternative means of participation if the child/youth's best interest warrants the exclusion of any team members. Careful preparation for the CFTM will help the FSW assess whether special considerations or adaptations are needed.
- o A Child and Family Team Meeting can be very intimidating to young people. Youth should be encouraged to bring someone with them that they trust, who will help them feel more comfortable. Most youth will need frequent encouragement to participate, as well as protection from team members who may tend to focus only on the youth's behaviors or problems.

♦ **Parent/Families (Including legal, biological and alleged fathers)**

- o Unless a parent's rights have been terminated or surrendered, the department must include all known parents, including legal and biological fathers, in the Child and Family Team process. Depending upon the relationships and circumstances of the family, alleged fathers may need to be included, as well.
- o The Department shall conduct diligent searches (Conducting Diligent Searches, Policy 16.48) throughout the life of the case if there are any unidentified parents, or the Department does not know their whereabouts. Efforts to locate parents should be clearly documented in the case record.
- o The incarceration of a parent will not be a barrier to their participation in the CFTM and permanency planning process. By law, DCS must create opportunities for all parents to participate in the plan and to meet their parental

responsibilities. This may be accomplished by having meetings where they are located, or by arranging for them to participate by telephone.

- o Extended family members and other support persons identified by the family or DCS should also be invited to participate.

♦ **Trained Full-Time Facilitator or Back-up Facilitator**

- o These are staff that have completed the Advanced Facilitation Training and have been certified as a skilled facilitator, whether working full-time as a facilitator or serving as a back-up facilitator. The facilitator is primarily responsible for the process of the CFTM, which includes ensuring that everyone participates and is heard; that everyone understands the purpose of the meeting; that all the relevant safety and risk issues are being addressed; and that the team reaches a consensus on the decisions to be made. The facilitator guides the meeting through a logical process, helping to resolve any differences that may arise, and ensuring that by the end of the CFTM, there is a plan of action developed, with the responsible persons and time frames clearly identified.
- o It is mandatory in all regions that a Trained Full-time Facilitator or Back-up Facilitator conduct all Initial CFTMs and all Placement Stability CFTMs.
- o CFTMs held for the development of permanency plans, the review of progress on permanency plans, or the revision of a permanency plan does not require the use of a skilled facilitator, but one may be requested if one is needed. Regions have the flexibility to determine when they will require a Trained Full-time or Back-up Facilitator for CFTMs apart from the Initial and Placement Stability CFTM.
- o Whenever possible, efforts should be made to ensure that the same facilitator who conducted the Initial meeting remains involved with the family for subsequent meetings.
- o A Trained Full-time or Back-up Facilitator is not required to facilitate Discharge Planning CFTMs.
- o In the event there is a Special Called CFTM, the team may request the presence of a Trained Full-time or Back-up Facilitator, or the FSW or Team Leader can facilitate the meeting, depending upon the nature of the concerns and the parties involved.

♦ **Child's Family Service Worker**

- o The Family Service Worker is responsible for working with the family and team to coordinate the resources needed to meet the needs of the child and family. As described above, the FSW helps the family identify who should be included on the team, prepares the team members,

schedules meetings, and maintains contact with team members as needed between meetings, to ensure that the agreed-upon action steps are being taken. During the CFTM, the FSW is primarily responsible for the content being discussed, i.e., the worker must be prepared to explain why the meeting was needed, describe the precipitating events, the current situation, the history of the problem, what strengths have been identified within the family/youth, and the worker's recommendation. In the absence of the FSW, the Team Leader is expected to present the case and the department's recommendations in the CFTM. For youth placed in a Youth Development Center (YDC) the meetings should be arranged and scheduled by the YDC case manager, but the FSW responsible for the case must participate in the CFTM, even if it is by telephone or via video conferencing.

- **Team Leader**
  - The Team Leader (TL) for the case is required to participate in all Initial CFTMs and all Initial Permanency Planning CFTMs. In the event the Team Leader is not available, another Team Leader can participate in his or her place. It is highly recommended that the Team Leader participate in CFTMs convened for the purposes of reviewing the progress on the permanency plan or to consider a change in the permanency goal, since the Team Leader is responsible for ensuring that children and families are moving toward permanency. For any FSW with less than 1 year of experience with DCS, there must be a Team Leader or FSW 3 participating in CFTMs convened for any reason.
  - For more experienced FSWs, a Team Leader can exercise judgment in deciding whether their participation is needed, based on the competence of the FSW, the complexity of the case, and the availability of others who can participate, such as a FSW 3 or other regional staff.
  - The Team Leader must participate in all Discharge Planning CFTMs, regardless of the FSW's level of experience.
  - In the above instances described, when the assigned Team Leader is unavailable to attend the meeting, he/she can send another Team Leader or an FSW-3 in his or her place.
  - The assigned Team Leader must attend a CFTM for every case under his or her supervision no less often than every 6 months.
- **Resource Parents**
  - Resource parents with DCS or a contract agency are crucial members of the child and family team. Every effort should be made to ensure their full participation in CFTM's. For Initial and Permanency Planning CFTMs, this may involve working with the biological family to help them appreciate

	the benefit of the resource parents' attendance. For CFTMs held to preserve a placement or to explore placement options, it is very important to have the resource parents there, if at all possible. ♦ **Other Participants** o Depending on the purpose of the meeting, Child and Family Team Meetings may also involve some of the following individuals: o Specialized DCS staff persons may be needed to support the work of the child and family team. These may include, but are not limited to, Assessment/Non-Custodial staff that may have worked with the family in the past, Education Specialists, Health Unit Members, Juvenile Justice Staff, DCS Legal Staff, Independent Living Staff, MSW Consultants, and Permanency Specialists. Staff should exercise judgment to avoid overwhelming the family with too many professional staff. o Therapists and/or contract agency staff involved in providing services to the child/youth, family, and/or other identified permanency option; o Any former legal custodian for the child; o Court Appointed Special Advocate (CASA) Volunteer; o Community Partners, including education or school staff where the children attend school, and other support persons identified by the Department. Please note that the inclusion of these parties is subject to the parent(s) consent; o Informal supports that are identified by the family or youth as resources; o Attorneys, to include the guardian ad litem and the attorney for the child/youth's parents; o Persons external to the case, such as OJT coaches, observers, or others not directly involved in the case should not be included without obtaining the permission of the family; and, o An interpreter, as needed.
C. Assessing and Understanding the Child and Family Team	1. The Child and Family Team have an important contribution to make to the FSW's ongoing assessment and understanding of the family and child(ren). This is particularly true with informal supports and extended family members, who know and care about the family. The FSW should explore how each team member perceives the strengths and underlying needs of the family, the risk and safety issues presented, and what is necessary for the child to achieve a permanent home that will meet his/her needs. 2. Members of the team should have a shared understanding of the family that is reflected in coordinated efforts consistent with the goals agreed upon by the Child and Family Team. As goals are achieved, the team is engaged in

reassessing the progress made and modifying strategies or services as needed, to address any new information or problems that may arise.

3. The content of a CFTM should be focused around the purpose of that meeting; and the purpose should guide which team members participate. Assessment information should be shared with the family and their views must be incorporated into the FSW's overall assessment.

4. There is a general agenda for each CFTM that should elicit assessment information and the team's insight into the child and family's strengths, needs, and circumstances. Please refer to Stages of a CFTM for a detailed description of a CFT Meeting agenda. Some highlights follow, which demonstrate how assessment and understanding are woven into the CFTM process:

a) Introductions

Participants are introduced and the purpose of the meeting is made clear to everyone.

b) Identify the Situation – The Family Story

i. This includes clearly identifying the current situation; what precipitated the need for the meeting, and what decision(s) need to be made. DCS staff must support the child and parents/caregivers in sharing their story related to their current situation, their concerns, and in defining what they would like to see result from the meeting.

ii. Every member of the team should be invited to contribute to the team's understanding of the immediate situation before the meeting progresses to the next stage.

iii. Check for consensus that the present situation has been fully identified before moving on

c) Assessing the Situation – Identify Strengths/Needs Concerns

i. The family is invited to identify the strengths, resources and capacities they have to help them address the concern(s). Every member of the team is encouraged to contribute to the list of strengths they see in this family

ii. The team must examine and assess all of the safety and risk issues associated with the concerns identified and the impact these issues may have upon the children involved. This should include some discussion of the history of the problem.

iii. The team should review what services have been utilized to support this family and the effectiveness of those services so far. The family should be encouraged to identify any informal supports they have.

iv. The family and team explore what underlying needs may be contributing to the issues or concerns presented. The child/family/caregivers are helped to articulate what they need to address the concerns; for example, to take care of their children at home, or to maintain the stability of the child's placement.

v. Sensitivity and judgment should be exercised when families or youth are reluctant to discuss certain issues in the large group. It is

	good practice to provide alternatives in the event families are not comfortable addressing all of the issues with the entire team present. vi. The FSW should inform the team of his or her recommendation for this situation. 5. Ensuring that the team works through the stages of **Identifying the Situation** and **Assessing the Situation** prepares them to **Brainstorm Solutions** and **Develop a Plan** that will utilize the resources the Child and Family Team have to help the family meet their goals. 6. Effective CFTM's should engage all family and team members in an ongoing process of assessment and understanding of what the child and family needs to ensure that children are in a safe, permanent home.
D. Planning and Long-Term View	1. The child/family should have a single integrated permanency plan developed by the child and family team that works as a comprehensive, dynamic service organizer and is focused by the long-term view for the child and family. The permanency plan specifies the goals, roles, strategies, resources, and schedules for the coordinated provision of assistance, supports, supervision, and services for the child, caregiver, and family. 2. The broader the representation on the team, the more likely that case plans will be developed that are specific to each family's needs, providing a mix of services and supports that will maximize the resources of the Child and Family Team. 3. Please refer to Policy 16.31Permanency Planning for Children/Youth in the Department of Children's Services Custody for guidance on the permanency planning process. 4. In addition, plans should address the desired outcomes and the long-term view for the child and family. The FSW and the team should encourage the family to explore how they want their family to be in the future, beyond the resolution of the immediate safety issues necessitating DCS involvement. There should be a shared vision among the team defining what things must change and the steps it will take to achieve the goals for the child and family to maintain the change once the case is closed. 5. To be acceptable, a child and family permanency plan should: a) be based on the big picture assessments, including clinical, functional, educational, and informal assessments; b) reflect the views and preferences of the child and family; c) be directed toward the achievement of strategic goals and success of the child; d) be coherent in design, balanced in the use of formal and informal supports; e) be culturally appropriate; and, f) be modified frequently, based on changing circumstances, experience gained, and progress made. 6. The written child and family permanency plan defines the outcomes and

	reflects the collective intentions of the Child and Family Team - it describes the path and the process to be followed in order to ensure that children are safe and permanency is achieved in a timely fashion. 7. The Child and Family Team planning process should drive the implementation of strategies, actions, and services.
E. Tracking and Adaptation	1. The FSW is responsible for following up on referrals and tasks assigned to the members of the team to ensure that the services and strategies developed in the plan are being executed in a timely and competent manner. This requires coordination and resource management to ensure that progress is being made. The FSW must maintain regular contact with the family and team to ensure that: a) The strategies, actions, and services planned for the parent/family and child are being implemented in a timely, competent, and dependable manner, consistent with family-centered practice and necessary cultural accommodations. b) Actions, supports, and services linked to change strategies are being provided at a level of intensity and continuity necessary to meet priority needs, reduce risks, facilitate successful transitions, and achieve adequate daily functioning for the parent and child. c) Service providers (e.g., social workers, care staff, teachers, therapists, tutors, mentors) are receiving support and supervision necessary for adequate role performance in conducting the planned change strategies for the parent and child. 2. The FSW reconvenes the Child and Family team for reviews and revisions of the permanency plan when changes are needed, such as services are not being provided as planned, the child or family is not responding well to the services, or new issues have arisen that the team must address. 3. An ongoing examination process should be used to track service implementation, check progress, identify emergent needs and problems, and modify services in a timely manner. 4. The service plan should be modified when objectives are met, strategies are determined to be ineffective, new preferences or dissatisfactions with existing strategies or services are expressed, and/or new needs or circumstances arise. The FSW must play a central role in monitoring and modifying planned strategies, services, supports, and results. Team Leaders should be reviewing the progress on permanency plans with FSWs on a quarterly basis, at the least. Members of the Child and Family Team (including the child and family) should apply the knowledge gained through ongoing assessments, monitoring, and periodic evaluations to adapt strategies, supports, and services. 5. Following a CFTM, the development and progress of the work done with the family is documented, as follows: a) The meeting and outcomes, as well as permanency plans, (if developed), shall be documented in TNKids. b) Additional assessment information gathered from any CFTM should be entered into the Family Functional Assessment by the FSW.

	c) If the child or his/her birth parents did not attend or participate, this must be documented in TNKids, with a description of the efforts that were made to encourage the family's participation. d) For meetings in which a permanency plan is not developed or revised, the ***Child and Family Team Meeting Summary, form CS-0747*** shall be provided to all participants and a copy shall be placed in the case file. The team leader must review and sign off the summary. e) For Initial Permanency Planning CFTMs, a written draft of ***Permanency Plan, form CS-0557,*** should be given to all participants at the close of Permanency Planning CFTMs. Typed copies can be provided to all team members upon completion of the plan in TN Kids. Policy 16.31 Permanency Planning for Children/Youth in the Department of Children's Services Custody for more details about preparing the plan, providing copies for the parents' signatures, and in the event the parents sign a handwritten copy which is later typed, having both versions available at court for the parents and attorneys to review and approve. f) For Discharge Planning CFTM's, the ***Child and Family Team Meeting Summary, form CS-0747*** shall be used to document the discharge plans made and provide the child/family with the contact information for the FSW and TL, in the event they need any additional help to ensure a successful discharge. g) All CFTMs should be documented in the Reviews, Hearings & CFTM icon of TNKids.
F. Child and Family Team Meetings for Delinquent Youth in Youth Development Centers	1. Youth Development Centers have some unique challenges to practicing a child and family team model as envisioned in this policy. Some families may live far from the facility; others may be highly reluctant to be involved in this manner; and, the role of the court may limit some decisions the child and family team can make. Nevertheless, DCS believes that involving families whenever possible is critical to helping delinquent youth succeed in their rehabilitation and to prepare them to return successfully to their families and community. 2. CFTMs are to be conducted at the following critical junctures of a case. Those that require the use of a Trained Full-Time or Back-Up Facilitator (either YDC or regional staff) are **Initial CFTMs** and **Placement Stability CFTMs** when an unplanned move appears imminent or has just occurred (See Child and Family Team Meeting Protocol). **a) Initial CFTM** - The Initial CFTM is held primarily to assist in preventing State's custody, prior to a CPS preliminary hearing or within 7 days before or after the date of custody. For youth entering the YDC, if an Initial CFTM has taken place prior to admission to the facility, another Initial CFTM is not required. All Initial CFTM's are to be conducted by a Trained Full-Time or Back-Up Facilitator (YDC Staff or Regional Staff). A Team Leader must be in attendance at the Initial CFTM.

b) Classification/Individual Program Plan/Permanency Plan Development. The identification of a student's classification, the development of the IPP and the Permanency Plan shall be done in a CFTM. Classification shall be completed within fourteen (14) days of the student's arrival at the center.

CFTMs convened to develop plans do not require a Trained Full-Time or Back-Up Facilitator. However, if the Classification/IPP/Permanency Planning process is being conducted as part of the Initial CFTM, it does require a Trained Full-Time or Back-Up Facilitator.

c) Placement Stability/Unplanned Program Transfer/Disruption- Decisions regarding a disruption, or an unplanned transfer from one YDC facility to another shall be made in a Placement Stability CFTM. These CFTMs require the use of a Trained Full-Time or Back-Up Facilitator. Note: This policy does not supersede DCS Policy 12.10, Transfers between DCS Operated Facilities that allows the superintendent to decide whether a youth should be moved on an emergency basis before a CFTM can be arranged. However, a CFTM with a Trained Full-Time or Back-Up Facilitator should be convened as soon as possible after the move.

d) Placement Stability/Planned Program Transfer - A Placement Stability CFTM is also required for any planned transfer or step-down from the facility, but these CFTMs do not require the use of a Trained Full-Time or Back-Up Facilitator.

e) Discharge Planning/Release - Decisions regarding a release from custody shall be made during a Discharge Planning CFTM to ensure that all safety and risk issues that necessitated custody have been adequately addressed and resolved. This CFTM will allow the team to determine whether necessary supports are in place to support the youth and family once the student has been discharged or released. A YDC Team Leader, Regional Team Leader or CM3 is required to be in attendance at this meeting. This meeting type does not require a Trained Full-Time or Back-Up Facilitator.

f) Progress Reviews/Quarterly Reviews/Staffings – A CFTM should be convened for Quarterly Progress reviews no less often than every three months. These in-depth reviews shall be for the purpose of determining whether the IPP is being implemented to meet the individual needs of the student. More specifically, they are to be utilized to make decisions regarding the student's current status; determine the readiness for step-down; identify the need for increased services or interventions; or, to make changes in the current services or interventions. A Trained Full-Time or Back-Up Facilitator is not required for these reviews.

Staffings are held on a monthly basis on all youth in a YDC to assess that the youth's current goals, objectives and interventions continue to meet the youth's treatment needs.

g) Special Called CFTMs - Any team member, including the youth or the youth's family, may request a CFTM at any point during the life of a case. The need for a Trained Full-Time or Back-Up Facilitator should be determined by the nature of the case and the request. These CFTMs should be recorded as "Special Called" in the Reviews, Hearings & CFTM

icon in TNKids.

h) **Documentation -** With the exception of Permanency Planning CFTMs, all CFTMs should be documented on the ***Child and Family Team Meeting Summary Form, CS-0747***. Each team member is provided a copy of the Child and Family Team Meeting Summary at the conclusion of the meeting. This form will serve as the Discharge Plan for Discharge Planning CFTMs. Other planning-related CFTMs can be documented by the Permanency Plan that is developed or revised during the meeting.

YDC staff will continue to document other internal monthly, quarterly progress, or other administrative reviews according to current policy and practice.

3. Additional Considerations for CFTMs:

a) If interpreter services are required for a CFTM, the YDC residential case manager shall make arrangements as needed.

b) The YDC residential case manager shall inform the youth, family, and family services worker about the purpose of the CFTM and clarify the goal and desired outcome of the meeting.

c) Advanced planning to ensure the participation of families and family service workers is necessary. Conference calls, video conferencing etc. may be used to ensure the participation of families and FSWs when their physical presence is not possible. The Child and Family Team Meeting may proceed when their (FSW or parent/guardian's) participation has been arranged. YDC staff shall document their efforts to secure the participation of the family and family services worker in TNKIDS case recordings.

d) In the event the child and family team cannot come to a consensus decision, the facility Superintendent and Regional Administrator (or his or her designee) shall review the case, confer with the team and make the final determination.

e) In the event that neither the youth nor his or her family participates in a scheduled CFTM, the meeting should not be considered a CFTM. It should not be documented as a CFTM, but rather as an administrative review or staffing. Reasonable efforts to include the youth and family should be documented in TN Kids.

Forms:	***CS-0746 - Meeting Notification*** ***CS-0747– Child and Family Team Meeting Summary***
Collateral documents:	**Child and Family Team Meeting Protocol** **Stages of a Child and Family Team**

State of Tennessee
Department of Children's Services

Policy Attachment: Building, Preparing and Maintaining Child and Family Teams 31.7

Subject:	**Stages of the Child and Family Team Meeting**

The Child and Family Team Meeting Process:

Child and Family Team Meetings should be seen as the family's meeting; they should be engaging and conducted in a way that addresses the relevant issues in the most sensitive, respectful manner possible. What follows are descriptions of the stages of a CFTM that are recommended to help the meeting progress logically; however, the need to engage and include the family and to come to a good decision are the primary requirements of a successful CFT meeting. It is recommended to have flipchart pages already prepared for recording the concerns, the family's strengths and needs, the team's ideas, and the action steps that will be developed by the end of the meeting. This visual tool helps to capture the vital information shared during the meeting and to keep everyone on track. The Child and Family Team Meetings should, to the extent possible, include the following activities:

1. Introductions

The facilitator of the meeting will open the meeting by welcoming all participants and identifying the purpose and goals of the meeting. There are several critical components to this stage of the meeting:

a) Introduction of all members present and their relationship to the family.

b) Establishing Comfort Rules: The facilitator shall help the group to develop and agree upon guidelines or "comfort rules" for the meeting. These are collaboratively developed to help manage strong emotions and to keep the meeting focused on the outcome (e.g., speaking one at a time, using appropriate language and tone, being respectful of differences, etc).

c) A statement should be made to emphasize the desire that the child and family team will be able to come to a consensus decision that will meet the needs of the child and family in the least restrictive, least intrusive manner possible. However, the role of the Department and its responsibility for the safety of children and the timely achievement of permanence should also be made clear to the group.

d) Any non-negotiable issues, such as court orders, State laws, or DCS policies related to the safety and well-being of children, should be made explicit in the beginning of the meeting, as the facilitator helps the group define the scope and limits of the groups' decision-making.

e) There should be a brief discussion of confidentiality and family privacy, which specifies the conditions under which DCS will be unable to keep the proceedings confidential. Participants should be asked to agree to respect the privacy of the family before more information is revealed during the meeting.

Note: While a signed confidentiality statement is not legally binding, some regions may want participants to sign an agreement that they will maintain the confidentiality of the family and what is discussed at the meeting. See collateral documents for an example of a Confidentiality Agreement. The first page can be used to guide the discussion and be given to those that want a copy. After privacy and confidentiality is discussed, each participant can be asked to sign the second page that the FSW can keep in the case record.

f) Participants should be encouraged to ask any questions they have about the process or anything

discussed, so far.

g) It should be emphasized that the family is the expert on their own needs and their own children and that the child and family team process is designed to elicit and build upon the strengths in the family.

2. Identify the Situation - The Family Story

a) The next task is to clearly identify the current situation; what precipitated the need for the meeting, and what decision(s) need to be made. The child and/or family can be invited to share their understanding of this, or the FSW can present this information if the family is uncomfortable beginning. If the FSW presents the situation first, the family should be invited to clarify or comment on anything the FSW presented before moving on. The Family Story will provide more background and history in the Initial and the Initial Permanency Planning meeting - for subsequent meetings, such as Permanency Plan Revisions or reviews, it should be more focused on the current situation, the progress made, and what obstacles remain to achieving safety, permanence and stability for the child.

b) To the greatest extent possible, DCS shall support the child and parents/caregivers in sharing their story related to their current situation, their concerns, and in defining what they would like to see result from the meeting.

c) Every member of the team should be invited to contribute to the team's understanding of the immediate situation before the meeting progresses to the next stage.

d) Check for consensus that the present situation has been fully identified before moving on.

3. Assess the Situation – Identify Strengths and Needs/Concerns

a) Invite the family to identify the strengths, resources and capacities they have to help them address the concern(s). Encourage every member of the team to contribute to the list of strengths they see in this family and list these on flipchart.

b) Ensure that the team fully understands the safety and risk issues associated with the concerns presented; the impact these issues may have on the children involved; and the history of the family as it relates to the current situation. Identify any current stressors that may be exacerbating the problem.

c) Explore what services have been utilized to support this family and the effectiveness of those services so far. Help the family to identify any informal supports they have.

d) Encourage the family and the team to explore what underlying needs may be contributing to the issues or concerns presented. Help the child/family/caregivers to articulate what they need to address the concerns; for example, to take care of their children at home, or to maintain the stability of their placement.

e) Sensitivity and judgment should be exercised when families or youth are reluctant to discuss certain issues in the large group. It is good practice to provide alternatives in the event families are not comfortable addressing all of the issues with the entire team present.

f) The FSW should be prepared to give his or her recommendations on behalf of the department in the case.

4. Brainstorming Solutions

a) The group should generate ideas to address the concerns and needs identified, and be guided to think about how to utilize the family's strengths and resources to meet these needs.

b) Every member of the team should be encouraged to contribute his or her ideas and all ideas should be listed on the flipchart for consideration.

c) These ideas should help the group to develop a plan that will ensure the safety, permanence or

well being of the children. Usually these ideas are in the categories of an alternative placement or custody; providing services to reduce the level of risk; or other actions that will increase safety and stability for the child.

5. Develop the Plan/Reach a Decision

a) Using these ideas, the child and family team will develop a plan to achieve the desired outcomes of the meeting and address the underlying needs of the children and family.

b) To every extent possible, families should play a significant role in development of plans/decisions. The department must remain open to the ideas of families, while maintaining the responsibility for safety, well-being and permanency.

c) When reviewing and assessing the ideas generated, the group should start with the least restrictive/least intrusive idea and ask whether that idea can provide the needed protection and safety. If it can, explore what supports will be needed to make it successful. If it cannot, then the group should move to the next least restrictive/intrusive idea to consider.

d) The group must ensure that any safety concerns are clearly addressed by the plan developed.

e) Once the most pressing safety concerns have been addressed, the group should refer to the list of child and family needs that have been generated and develop a plan to address those needs.

f) The plan that is developed should be specific, with tasks assigned to individuals and target dates for completion identified and recorded.

g) The team should assess what might go wrong with the plan and determine who will notify the Department if a particular step in the plan fails. The team should also discuss a contingency plan, in the event the group's plan is unsuccessful. Otherwise, the team may have to reconvene to devise an alternative plan.

6. Closing/Recapping the meeting

a) The facilitator should review with the group the plan that has been developed by recapping each task, the responsible party for each task and the assigned timeframes.

b) In CFTMs that are held for the purpose of developing a permanency plan, the permanency plan will serve as the written plan for the CFTM.

c) For other types of CFTMs, the plan should be documented on the ***CFTM Summary, form CS-0747*** Note: For Family to Family Sites, staff can use their Casey Summary Report in lieu of the *CFTM Summary Form.*

d) The participating team members at the close of the meeting shall sign the plan, which will be copied and distributed to the meeting participants.

e) The team should schedule any necessary follow up meetings.

f) The facilitator should close the meeting by thanking the team members for participating and acknowledge their contributions.

Children's Bureau
Child and Family Services Reviews
Fact Sheet

History

The 1994 Amendments to the Social Security Act (SSA) authorize the U.S. Department of Health and Human Services (HHS) to review State child and family service programs to ensure conformity with the requirements in Titles IV-B and IV-E of the SSA. Traditionally, reviews focused primarily on assessing State agencies' compliance with procedural requirements, as evidenced by case file documentation. In addition, past reviews did not provide States with opportunities for making improvements before imposing penalties.

Now, however, the focus is on States' capacity to create positive outcomes for children and families and on the results achieved by the provision of appropriate services. On January 25, 2000, the HHS published a final rule in the *Federal Register* to establish a new approach to monitoring State child welfare programs. Under the rule, which became effective March 25, 2000, States are assessed for substantial conformity with certain Federal requirements for child protective, foster care, adoption, family preservation and family support, and independent living services.

The Children's Bureau, part of the HHS, administers the review system, known as the Child and Family Services Reviews (CFSRs).

Purpose

The CFSRs enable the Children's Bureau to: (1) ensure conformity with Federal child welfare requirements; (2) determine what is actually happening to children and families as they are engaged in child welfare services; and (3) assist States to enhance their capacity to help children and families achieve positive outcomes.

Ultimately, the goal of the reviews is to help States improve child welfare services and achieve the following outcomes for families and children who receive services:

Safety

- Children are, first and foremost, protected from abuse and neglect.
- Children are safely maintained in their homes whenever possible and appropriate.

Permanency

- Children have permanency and stability in their living situations.
- The continuity of family relationships and connections is preserved for families.

Family and Child Well-Being

- Families have enhanced capacity to provide for their children's needs.
- Children receive appropriate services to meet their educational needs.
- Children receive adequate services to meet their physical and mental health needs.

The Federal Government conducts the reviews in partnership with State child welfare agency staff; consultant reviewers supplement the Federal Review Team. The reviews are structured to help States identify strengths and areas needing improvement within their agencies and programs.

The Review Process

Each CFSR is a two-stage process consisting of a Statewide Assessment and an onsite review of child and family service outcomes and program systems. For the Statewide Assessment, the Children's Bureau prepares and transmits to the State the data profiles that contain aggregate data on the State's foster care and in-home service populations. The data profiles allow each State to compare certain safety and permanency data indicators with national standards determined by the Children's Bureau.

After the Statewide Assessment, an onsite review of the State child welfare program is conducted by a joint Federal-State team. The onsite portion of the review includes: (1) case record reviews; (2) interviews with children and families engaged in services; and (3) interviews with community stakeholders, such as the courts and community agencies, foster families, and caseworkers and service providers.

At the end of the onsite review, States determined not to have achieved substantial conformity in all the areas assessed are required to develop and implement Program Improvement Plans (PIPs) addressing the areas of nonconformity. The Children's Bureau supports the States with technical assistance and monitors implementation of their plans.

States that do not achieve their required improvements sustain penalties as prescribed in the Federal regulations. All 50 States, the District of Columbia, and Puerto Rico completed their first review by 2004. No State was found to be in substantial conformity in all of the seven outcome areas or seven systemic factors. Since that time, States have been implementing their PIPs to correct those outcome areas not found in substantial conformity. The second round of reviews began in the spring of 2007.

CFSR Outcomes Matrix (February 2002)

Outcome Domain	CFSR Case Outcome	Case Outcome Items	CFSR Aggregate Outcome Measure
Safety	**S1** Children are first and foremost protected from abuse and neglect.	**Item 1**: Timeliness of initiating investigations of reports of maltreatment. **Item 2**: Repeat maltreatment.	**Recurrence of maltreatment** (percent victims with recurrence within 6 months). **Child maltreatment in foster care** (percent maltreated in foster care in previous 9 months).
	S2 Children are safely maintained in their homes whenever possible and appropriate.	**Item 3**: Services to family to protect children in home and prevent removal. **Item 4**: Risk of harm to children.	
Permanency	**P1**: Children have permanency and stability in their living situation.	**Item 5**: Foster care re-entries **Item 6**: Stability of foster care placement **Item 7**: Permanency goal for child **Item 8**: Reunification, guardianship or permanent placement with relatives **Item 9**: Adoption **Item 10**: Permanency goal of other planned permanent living arrangement.	**Foster care re-entry** (percent children re-enter within 12 months). **Stability of placement** (percent children in care less than 12 months with 2 or fewer placement settings) **Length of time to achieve reunification** (percent reunified in less then 12 months) **Length of time to achieve adoption** (percent exiting to finalized adoption in less than 24 months)
	P2: The continuity of family relationships and connections is preserved for children.	**Item 11**: Proximity of foster care placement **Item 12**: Placement with siblings **Item 13**: Visiting with parents and siblings in foster care **Item 14**: Preserving connections **Item 15** Relative placement **Item 16**: Relationship of child in care with parents.	
Well-Being	**WB1**: Families have enhanced capacity to provide for their children's needs.	**Item 17**: Needs and services of child, parents, foster parents **Item 18**: Child and family involvement in case planning **Item 19**: Worker visits with child **Item 20**: Worker visits with parents	None
	WB2: Children receive appropriate services to meet their educational needs.	**Item 21**: Educational needs of the child	
	WB3: Children receive adequate services to meet their physical and mental health needs.	**Item 22**: Physical health of the child **Item 23** Mental health of the child	

PRACTICE IMPROVEMENT IN TENNESSEE

Key Improvements

- There are fewer children in foster care than at any time since the Brian A. Settlement Agreement, without a corresponding increase in children re-entering care. Improved in-home services and the Multiple Response System play a large part reducing the number of children entering care.
- DCS has one of the highest rates of successful adoptions in the country, also contributing to the reduction of the number of children in care.
- DCS now actively seeks permanent homes for every child entering care. Subsidized Guardianship has been added and Planned Permanent Living Arrangements are greatly limited.
- The amount of time that children spend in custody has decreased.
- Only 10% of children entering care are not placed in congregate care settings, ½ the rate of seven years ago.
- The percentage of children placed in emergency shelters or temporary placements has decreased from 9% to 2%.
- 85% of children who enter custody as part of a sibling group are now placed together.
- There are early indications that the number of children who “age-out” of care is decreasing.
- Tennessee now utilizes the “practice model” to guide intervention with families.
- DCS has addressed issues of recruitment and retention of qualified staff by increasing the training capacity, implementing a BSW stipend program, and reduced caseloads and raised salaries for front line staff.
- Services to children and families in their own homes has increased.
- Data collection and management has improved, allowing DCS to monitor and report outcome based initiatives.

Key Challenges

- Data suggests considerable room for improvement in the implementation of the practice model.
- The number of resource parent homes is declining and there are not enough homes available in each region to adequately serve the children coming into care from that region. Resource parent retention is a concern.

- While there has been incremental improvement, placement stability remains a challenge. Twelve percent of children in care have had three or more placements in the previous 12 months.
- Many youth age out of care without a permanent family or the supports they need to succeed. Plans to focus on Interdependent Living Skills are targeted to address this need.
- Family visitation remains at a level that is not sufficient to preserve family bonds, reduce trauma, or promote reunification. Only 22% of children in care are receiving two or more visits per month.
- Access to an array of non-custodial services to families needs to improve.

Basic Principles to Assure Personal Safety

Safety issues have always been a crucial component of social work practice, especially with the recognition that every Child Welfare case has the potential for confrontation. At times, workers unintentionally discount the nature of DCS intervention and the client's view of their role when confronting child protective services issues. Difficulties may occur at any point in the process. Threats and volatile situations, however, are more likely to occur during the CPS assessment process, during crisis situations, and when a significant action is taken (e.g., removal of a child or the decision to take a case to court).

With a worker's safety and well-being as a primary goal in the threatening situations which are confronted on a day-to-day basis, each office should take responsibility for assuring safety for all staff. This includes:

- √ Strengthening the awareness of job-related safety precautions
- √ Teaching work-related, as well as personal self-protection skills
- √ Broadening the understanding of law enforcement's role as it relates to DCS
- √ Familiarizing DCS workers with the importance of attitude and professionalism as it relates to safety.

The first step in ensuring worker safety is to assess the risk of the situation before the initial contact. Before workers conduct the first contact with a client they need to assess the risk to themselves. Questions workers should consider include the following:

- √ Is there a previous history of domestic violence or other violent behavior toward others?
- √ Does the intake report indicate the possibility of a family member being mentally ill, being physically aggressive, or using drugs?
- √ Are there firearms or other weapons noted in the intake report?
- √ Is the family's geographic location extremely isolated or dangerous?
- √ Is this a second or multiple intake report involving the family?
- √ Is the initial contact scheduled after normal working hours?
- √ Are there any vicious animals on or near the premises?

All of the preceding questions can be asked during the initial screening process and should be documented on the intake report. After answering these questions, a decision should be made as to whether or not to call upon law enforcement or another worker for assistance with initiating the contact.

A worker's appearance, verbal and nonverbal statements, and demeanor can impact on the client's response. In confrontational situations, if the worker appears calm (both verbally and nonverbally), has control of the situation without being intimidating, and uses anger reduction techniques, he or she will probably be able to defuse the situation. The following information should provide some direction in these situations.

- √ Remain calm.
- √ Introduce yourself and explain your presence in a supportive, matter-of-fact manner, reassuring the family that your purpose is to assure the child's protection and help the family, and that you are interested in working collaboratively with the family to do this.
- √ Use "talk down" strategies and Interactional Skills to defuse hostility and resistance. Acknowledge the client's expressions of anger or fear, and provide reassurance. Do not challenge the family or make accusatory statements.
- √ Interview the family members in a room that is near an exit. Always be aware of accessible exits to enable you to leave the premises if you must.
- √ Disband groups of people. Eight against one are not good odds. Take the primary “interviewee" to your car, to the yard, or to the porch. Ask to speak to people alone to "maintain their privacy."
- √ Do not behave defensively or threaten the client. Always retain a calm, matter-of-fact and supportive demeanor, regardless of the threat. "I understand how angry you are, Mr. Jones. Most people are. I would be too, at first. Even so, I would like to try to work with you. You're an important part of this family, and I need your help. Let's sit down, shall we?"
- √ Recognize body language indicating potentially volatile behavior.
- √ Recognize signs of escalation and learn de-escalation techniques.
- √ Use law enforcement as back up.
- √ Use the buddy system with another caseworker.
- √ Always tell someone where you are going and approximately when you will be back.
- √ **IMPORTANT**: If "talk down" does not help to defuse the client's anger, and hostility appears to escalate, take steps to leave. In the event of escalating anger and hostility, temporarily discontinue the interview. Tell the client quietly that you'll come back at another time when they aren't so upset. Then leave. Return as soon as possible with police protection. In most circumstances, don't tell the client you're getting the police. It may be interpreted as a threat and provoke an already volatile client to hurt you or the child.

(Adapted from the North Carolina and Pennsylvania Child Welfare Training Programs.)