~~CHAPTER FIVE~~

~~INTACT FAMILIES: ENSURING SAFETY WITHIN THE FAMILY SYSTEM~~

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5.1 Framework for Working with Intact Families

5.1.1 Preface

The family is traditionally seen as the basic foundation of society. Children tend to do best when raised within their family. The act creating DCFS charges the Department with the responsibility of providing direct child welfare services when not available through other public or private child care or program facilities. Illinois state statutes define the program purpose in serving intact families as: "preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing the breakup of families when the prevention of child removal is desirable and possible and when a child can be cared for safely at home." (20 ILCS 505/5(a)(3)(C))

DCFS has established rules and procedures to provide services that are directed toward ensuring children's development, safety and well being in their families' homes and preventing out-of-home placement *(Rules and Procedures, Section 302.40).* In addition, the Department has established rules and procedures to provide culturally sensitive services in the family's primary language. Standards established by the Council on Accreditation provide further guidance in the delivery of quality services to children and families.

DCFS professionals have the authority to intervene in the lives of families. By accepting the authority to intervene, the DCFS professional also accepts the responsibility to intervene. In working with intact families as professionals we hold the following values: ***respect for persons***, ***client self-determination***, ***individualized intervention***, ***competence***, ***candor and confidentiality/discretion***. All recipients of child welfare services have a right to be treated in a manner that reflects these values.

In working with intact families, the primary focus of intervention is on the family system, understanding that the actions of an individual may impact on another and/or the family as a whole. Through working with the family to achieve a level of emotional and physical well being we can begin to predict possible outcomes for the family. When the family shows positive growth and progress, the risk of maltreatment will diminish or be eliminated. Conversely, when a family demonstrates an increase in risk factors for

maltreatment, it becomes necessary to make alternative plans to assure safety and permanency for the children.

The family should be involved as a **full partner** since change is more likely to occur when the family participates in the identification of its own strengths, problems and needs. Family involvement must always extend to the selection of services needed, in order to ensure the family takes responsibility for its own future. Additionally, each family has its own traditions and values that the worker should respect, and aim to understand, while always remembering that a child's health and safety is paramount.

The worker/family partnership and the interventions provided to the family seek ***to provide for the safety, well-being and permanency of the child.*** This outcome is achieved by: ***(1) conducting activities designed to prevent recurrence of abuse or neglect;*** **(2)** ***resolving the problems that brought the family to the attention of DCFS***; **and (3)** ***strengthening and better preparing the family to fulfill its own needs***

Child protective (intact) services are relationship-based work. The relationship between the family and worker is unique. The worker should have a relationship with the family that is in many ways analogous to the relationship that the parents should have with their children. This means that the worker must conduct activities that are:

(1) Directing and limit-setting with the family. These activities focus on identifying with the parents which of their behaviors in relation to their children are unacceptable, how the worker will know whether these behaviors are occurring in the family and being clear with the family about the consequences of continuing unacceptable behaviors.

(2) Conducting at the same time activities that are nurturing and that the family may view as helpful. This involves helping the family identify what their needs are and actively assisting them in obtaining services. For example, if the family is having difficulty enrolling their child in school or obtaining public assistance benefits the worker will actively assist the parents in obtaining these services.

All of these activities will be more effective in helping the family change their behavior if they are done with obvious regard and respect for the family.

The alliance between the worker and the family will assist the family to open itself to outside influences aimed at promoting the family's desired change. The process of

change involves continuous exchanges among the family members and between the family and its environment (outside influences). The family, in order to survive, functions in ways to be self-regulating, self-directing and self-organizing. Research has shown that a family going through disruptive or stressful situations will adapt to the tension of its situation and it is through this process that the family can re-define itself and increase its effectiveness. Therefore the crisis of state involvement is an opportunity for the family to make positive changes.

This guide to working with intact families takes into account the need for the worker and supervisor to comply with a number of Department rules and procedures while at the same time providing interventions that are individualized and therapeutic in nature. This guide will also afford the worker and supervisor the opportunity and ability to view the life of a case from the time in which the decision is made to serve the family as an "intact family", to the point in which the case arrives at a resolution. In a step-by-step fashion, this guide will take the worker and supervisor through the mechanics of casework, explaining what drives each activity, its purpose and desirable outcome.

Each stage of service in working with intact families will encompass the following components:

- Philosophy
- Purpose
- Key Decisions
- Practice (time frames, decision-making, and interventions)
- Goals/Outcomes
- Documentation Requirements

The stages of service in working with intact families are as follows:

- Accepting the Case and Preparing To Serve.
- Assessing Family Strengths and Needs
- Planning Services
- Supporting the Family through Change

- Evaluating Family Progress
- Terminating Involvement and Planning for Aftercare

5.2 Safety First

5.2.1 Philosophy

The primary objective of DCFS involvement with families is to ensure that children are safe from moderate to serious harm from child abuse and neglect. Child safety must be assured before any other intervention objective, such as permanency, is pursued. In fulfilling its primary objective, the Department or purchase of service agency needs to identify the preferred mode of communication of each individual family member and their support network.

Intact services are initiated with a family when the family is presently unable to ensure the safety of the children or when children have been assessed to be at risk of maltreatment without DCFS intervention. DCFS, in partnership with the family, provides for the safety of the children through mobilizing internal and external resources and services to address the safety or risk factors that the family is not yet able to control or mitigate. When CERAP safety plans are in place**,** they must be jointly developed and carefully monitored. The existence of the safety plan enables both the family and DCFS to be free to better understand and change those behaviors and conditions that are contributing to the risk and safety concerns. As the family strengthens and makes the changes needed to meet the essential needs of the children, the need for externally imposed safety services begins to diminish. Ultimately, the successful family will learn to use its own (strengthened) resources to deal effectively with risk factors so that both the family and DCFS can have confidence that the ongoing safety of the children is assured.

However, the existence of a CERAP safety plan does not in itself mean that the children will be protected. Where safety plans exist, they must also be actively managed, continually monitored and evaluated as to its effectiveness, and adjusted as needed. Some families may experience periods of regression during the course of change, making it necessary to re-evaluate the adequacy of the CERAP safety plan. Likewise, enhancement of family strengths and abilities is encouraging but not sufficient to relax vigilance

concerning the safety of the children. Therefore, the caseworker must be continually aware of child safety indicators throughout the course of his/her involvement with the family, and he/she must be particularly aware of critical safety issues for intact families (discussed below).

Completing the CERAP form is not assessing safety; it is documenting the caseworker's assessment of safety at a particular point in time. The most effective assessment is the continuous process of weighing each new piece of information against what the caseworker knows about the family as well as against the caseworker's knowledge of the factors and dynamics of risk and safety. With each new piece of information the caseworker considers the impact on child safety. At any time that some information or observation raises a red flag, or even just seems unusual or out of place, the caseworker must inquire further, assess safety implications, and take appropriate action.

Partnering with a family does not mean abandoning appropriate professional distance in the relationship and the ability to maintain a critical perspective on family behavior. Both of these qualities are essential in enabling the caseworker to fulfill his/her primary duty of ensuring the safety of children.

5.2.2 Critical Safety Issues for Intact Families

Although attention to safety issues is a continuous process, there are certain points in the delivery of services to intact families in which extra attention is called for: (1) transitioning the family from investigation to intact services (transition visit); (2) the first 90 days; (3) managing the CERAP safety plan; (4) maintaining vigilance during periods of family progress; (5) paramour involved families; and (6) dealing with special populations.

- **Transitioning family from investigation to intact services (*transition visit*)**
  Transitioning the family from one caseworker to another presents several situations and conditions that heighten the chance for the child to be in danger. For this reason, during this time, the worker should maintain focus on activities designed to detect continuation of child abuse and neglect. For example, for medical neglect, the worker must ensure that the family is involved in medical services.

  – **Initial family instability:** Particularly at the beginning, families often experience crisis because of stressful conditions or events, multiple family problems

or DCFS intervention itself. The worker must respond by providing the family with the degree of imposed structure and control necessary to ensure that unpredictable behavior is managed and contained. These interventions should occur in the preferred mode of communication of the individual family member and their support network. This imposed structure provides the initial stability that the family needs to begin to engage in the change process. Thorough, continuous and vigilant assessment of safety indicators is especially important at this time.

- **Case transfer:** Sometimes when a case is transferred from one caseworker to another, or from one team to another, it is not clear which caseworker has primary responsibility for the family during the transfer process. This can result in an unfortunate lapse in service to the family, as well as a lack of attention to the safety services in place. To avoid this lapse, **the child protection services worker (CPSW) carries full responsibility for services to the family as well as ensuring that the safety plan for the child is in place and closely monitored until the transitional visit occurs.** Following this guideline will ensure continuity of services for the family and provide an incentive for ensuring the transitional visit occurs in a timely manner. **After the transitional visit occurs**, it is the responsibility of the caseworker to continually reassess the safety of the child and the adequacy of the safety plan as he/she begins the service planning process.

- **First 90 Days**

  - **Lack of family knowledge:** Families and the individuals that comprise them are extremely complex and multifaceted, and it takes time even for highly skilled professionals to gain adequate understanding of their strengths and needs. During this initial time, it is important to be highly vigilant of safety indicators and of the effectiveness of the safety plan. Since the significance of events and conditions in the family may not yet be fully understood, erring on the side of safety

is the best approach. Therefore, the caseworker must be particularly watchful and observant, actively looking for and questioning new information, and possibly implementing a higher level of safety services (based on the risk assessment) that may be needed at a later time.

- **Lack of a trusting relationship:** Building an effective, trusting relationship with the family takes time, patience, skill, and perseverance. It requires that the worker create an atmosphere or relationship that is based on honesty and full disclosure and conveys a genuine sense that they are involved with the family to provide assistance while ensuring the safety of the child. There must be at least a basic level of trust present in order to leave a child-at-risk in his/her own home with a safety plan (if one is in place) carried out by the family. One way to build a trusting relationship is to help the family meet its perceived needs. Until the caseworker and family have more contact with one another and begin to trust one another fully, it is important to develop a service plan that has a higher degree of involvement and/or oversight by external sources, such as DCFS or other service providers.

- **Developing and managing the safety plan (if one is in place):** If the investigation continues to be pending at the time of the transitional visit, the activities and responsibility for any safety plan is the responsibility of the investigating CPSW. The CPSW must share all information about the safety plan with the follow-up worker and the child protection supervisor and follow-up supervisor are to ensure that there is a well-coordinated monitoring plan. Some safety plans fail because they are incomplete, poorly developed or poorly communicated or are not written in the family's primary language. The following six "correct" elements are essential to every effective safety plan:

  - **Correct services:** The safety plan tasks and services must target and control the behaviors and conditions that immediately threaten the child. For example, if the mother is overwhelmed by the child while the father is at work, protective day care would be a suitable service because it would control the key safety factor, the mother's frustration. In this situation, or in any other

situation, a safety task such as " The mother will refrain from hitting the child" is worthless. It controls nothing and in fact is dangerous. The safety task must control the ***cause*** of the potential abuse.

- **Correct mode of communication:** The safety plan must be written in the preferred language of the family, the individuals that comprise them and their support network. For example, the parents have indicated that they prefer services in English; however, the alternative caretaker's preferred language is Polish. In such situations, the safety plan needs to be developed in the two languages.

- **Correct timing:** The safety service must be available ***immediately***. If a waiting list of several days or weeks is involved, obviously the safety service cannot be used. If the family can do without the desired service for days or weeks, then that service is not needed to control for immediate safety.

- **Correct amount:** The safety service must also be immediately available in the frequency and amount required to ensure the child's safety. If protective day care is needed 5 days a week to protect the child but is only available 2 days a week, it cannot be used or it must be supplemented by an additional service.

- **Correct conditions:** The family must be willing and able to participate in the service. Both the service and the family must be stable enough for service consistency and continuity to be assured. Additionally, the family must be stable enough for any external providers to feel comfortable and safe in their home environment.

- **Correct monitoring:** The safety plan must be effectively monitored to ensure that services are occurring and that they are effective. This means frequent contact from the caseworker as well as perhaps additional oversight by providers or other family members.

- **Maintaining vigilance during family progress:** The high level of vigilance for safety issues that occurs during the beginning of involvement with the family should continue throughout the life of the case. As the relationship with the family develops and becomes more of a partnership, and particularly as the caseworker begins to see the family making positive progress, there is a danger that attention to immediate safety can diminish. Until the family's positive steps toward change become permanent behaviors, it is always possible for family behaviors and conditions to regress and endanger the child. Particularly at this stage in the case, supervisory reviews, conferences and/or crisis planning can help to maintain a sufficient level of attention to potential safety factors.

- **Paramour involved families, cases indicated for physical abuse and reunification cases where there has been physical abuse:** A child abused by a parent's paramour is considered to be at a greater risk of harm than a child in a familial abuse case. (See Policy Transmittal 2000.18.) Therefore, during the first three months of a new intact family case, the child victims must be observed for possible injuries (weekly in the case of paramour cases) and, if verbal, interviewed (weekly, in the case of paramour cases). Children are not to be interviewed with either the paramour or custodial parent present. This requirement also applies to open reunification cases once the child is returned home. Permanency supervisors must approve any decrease in the number of monitoring visits.

- **Working with special populations:** Safety issues in special cases (sexual abuse, physical abuse of infants and pre-schoolers, domestic violence, substance abuse, mental illness, developmental delays) should be handled as described in Chapter 1, Section 1.3.2, Core Best Casework Practice.

5.3 Accepting the Case and Preparing to Serve

5.3.1 Philosophy

Assuring a smooth case transfer is a ***shared*** responsibility between investigative and follow-up staff. The transition requires: (1) continuity, (2) communication and (3) a full exchange of information between the prior worker and the new worker. The formal transition (transitional visit) should occur **with and in the presence of the family**. In doing so, there will be a clear and more complete discussion of the circumstances placing the child at risk, with less chance of denial, misunderstanding or misstatement. To be

effective in an intervention, the worker must begin engaging the family in a prompt and positive way from the initial contact onward.

5.3.2 Purpose

The purpose at this initial stage of service is to ensure continuity of interventions. The family must receive services quickly and at the point of need. This process begins after the child protective services worker has conducted the initial CERAP and risk assessment and a decision has been made to open the case. In this stage, the role of the permanency worker who will be serving the family is threefold: (1) participating in the transition of the case from the child protective services worker while maintaining focus on the risk and safety issues identified in the investigation, (2) preparing to engage the family and (3) assisting the family in meeting immediate service needs.

5.3.3 Key Decisions

- Is the child safe and healthy during the assessment and service planning stage (30–45 days)?
  - What are the safety factors/indicators present in the family?
  - Is there a need for special evaluations or additional knowledge to be able to assess safety?
  - Is the current safety plan sufficient to ensure the child's safety?
- What safety responses are needed to keep the child safe for the next 30–45 days?
- Who needs to do what, when, to ensure the child's safety (safety plan)? What type/level of service/intervention is appropriate for this family? (Services to address significant needs in family, length and intensity of involvement, etc.)
- Based on the indicated allegations and initially the identified underlying causes, which of the Intact Protocol(s)(Appendix F) is applicable to the case.

- How can an effective partnership with the family best be initiated and developed?
- How to prepare for the comprehensive assessment process?

5.3.4 Practice

Evaluate and Assign Case to Worker

Immediately upon receipt of a newly referred case, the supervisor reads the case carefully in order to evaluate the following issues:

Key Decisions and Tasks	Methods	Actions and Results
What are the key safety and risk issues in the family?	Review risk and safety assessments, case notes and other documentation to identify the significant risk and safety factors in the family. Consider whether worker has accurately identified all key risk and safety factors and their significance for the child's safety.	Document risk and safety issues that differ significantly from the assessments made by the referring team. Identify specific activities to be conducted by the worker that will detect continuing child abuse or neglect.
Does the existing safety plan (if any) provide adequate protection for the child?	Review safety plan to see if planned actions adequately control all key safety factors. Consider match between safety factors and type of safety responses. Consider availability of services and ability of family to manage/respond to services.	If the investigation continues to be pending at the time of the transitional visit, the activities and responsibility for any safety plan is the responsibility of the investigating CPSW. The CPSW must share all information about the safety plan with the follow-up worker and the child protection supervisor and follow-up supervisor are to ensure that there is a well-coordinated monitoring plan. If the supervisor has a concern that the safety plan may not adequately protect the child, s/he must immediately contact the referring child protective services worker and supervisor, discuss the concerns and reach agreement on the appropriate response: No response needed. Safety plan provides adequate protection;

Key Decisions and Tasks	Methods	Actions and Results
		Further assessment needed. Home visit is made immediately to determine if a change in safety plan is needed. Immediate response needed. Child is in danger and action needs to be taken to ensure his/her immediate safety.
Does this case require any special skills or qualities in the assigned worker?	Identify characteristics and/or conditions in the family that may require specialized training, specialized mode of communication or specialized skills, language or qualities on the part of the assigned worker.	If special skills are called for: Assign to worker on team who has those skills, if possible; Assign to worker on team who can develop those skills with supervision and/or training.
What guidance should be given to the assigned worker?	Considering the type of case, the family needs and the skills of the assigned worker identify any clinical issues the worker should be aware of as well as any actions the worker should take. Considering the type of case, the involved issues and the family's level of cooperation with services, determine whether the case should be referred to the State's Attorney (if not already referred by child protection).	Document guidance provided to assigned worker. If the case is to be referred to the State's Attorney, the supervisor notifies the appropriate DCP supervisor of the intent to request a petition for a court order and work with child protection staff to screen the case with the State's Attorney.
Which of the Intact Protocol(s) (Appendix F) is applicable to the case.	Review investigative file to identify indicated allegations and initially identified underlying causes	Identify applicable Protocols

After reviewing the documents, the permanency supervisor will staff the case with the child protective services supervisor, preferably in person. If that is not possible, a telephone conference is acceptable. Refer to Chapter 4, Section 4.6.4, with regard to the specific items that need to be discussed during this staffing.

Prepare to Meet the Family

To prepare for the transitional visit, the permanency worker thoroughly reads the entire case file in order to deal with the following issues:

Key Decisions and Tasks	Methods	Actions and Results
What are the key safety and risk issues in the family?	Review risk and safety assessments, case notes and other documentation to identify the significant risk and safety factors in the family. Consider whether worker has accurately identified all key risk and safety factors and their significance for the child's safety, specifically focusing on factors such as: age of child/functioning severity of maltreatment acceptance of responsibility for maltreatment previous history proximity to alleged maltreator parent's cognitive ability availability of family support system	Document risk and safety issues that differ significantly from the assessments made by the referring team. Identify specific activities to be conducted by the worker that will detect continuing child abuse or neglect. Identify risk/safety issues that need to be explored further with family in handoff meeting. Identify information that is needed prior to the handoff visit from the child protective services worker and/or from appropriate collateral contacts.
Does the existing safety plan (if any) provide adequate protection for the child?	Review safety plan to see if planned actions adequately control all key safety factors. Consider match between safety factors and type of safety responses. Consider availability of services and ability of family to manage/respond to services.	If there is a concern that the safety plan may not adequately protect child, contact the supervisor immediately, discuss the concerns and decide on the appropriate response: No response needed. Safety plan provides adequate protection; Further assessment needed. Contact the child protective services worker and/or supervisor to discuss concerns and to arrange for a home visit as soon as possible to determine if a change in safety plan is needed. Child is not safe. Immediately contact the CPSW and/or supervisor to discuss concerns and arrange to take immediate action to ensure the child's safety.
What is the best way to initiate a working partnership with the family?	Consider the family's perception of the problem. Consider the following areas in order to arrive at an initial approach to the family:	Identify services that would address the family's concerns. Develop an outline for guiding the initial approach to the family, including:

Key Decisions and Tasks	Methods	Actions and Results
	History: What has been the nature and quality of the family's relationship with DCFS in the current investigation as well as in past interventions? How well has the family engaged with other agencies in the past? Characteristics: What are the family's strengths, interests, opinions, and goals? Cultural: What issues related to the family's cultural identity need to be taken into consideration? Special Problems: What actions or styles of engagement are called for based on the presence of special problems, such as domestic violence, substance abuse, mental illness or developmental disabilities? Court: Is there any current or potential court involvement such as a protective order?	How will you introduce your purposes? Where will you be looking for strengths? How will you draw out family members' concerns, opinions and feelings? How will you address emotions that remain from previous DCFS interventions? What interviewing techniques may work best? How will you develop rapport? How will you demonstrate concern and compassion? How will you support the family in beginning to develop a strategy for meeting the child's needs?
Are there any factors in this case that may cause concern for the safety of the worker?	Consider the following areas in order to determine the presence of any potential threats to worker safety: Family Behavior: Threatening remarks or implications by family, level of tension and hostility in family, previous history of violence towards others, presence of potentially dangerous mental or behavioral conditions. Home Environment: Unsanitary conditions, dangerous objects or home conditions, dangerous pets, etc. Neighborhood: Crime rate, other dangerous conditions.	Take personal safety precautions appropriate to the nature of any potential threats to safety, such as: Make home visits only during daylight hours. Have another caseworker or other professional accompany you on the visit. Discuss potential safety concerns with the family prior to the visit.

Are there any immediate services that might help the family?	Review the case record to see if the family could benefit from immediate services such as concrete services (cash assistance, food, clothing), crisis counseling, protective day care or homemaker services.	Research potential resources and prepare a referral list for the family.

What services, techniques for preventing and detecting recurrence of abuse/neglect, and what frequency of client contact do the applicable Intact Protocols (Appendix F) require?	Review the case record to determine which allegations are indicated and which underlying causes have been initially identified.	Draft a preliminary Service Plan.

Confer with Supervisor

The worker will consult with the supervisor and present his/her conclusions and strategies as to early intervention with the family.

Key Decisions and Tasks	**Methods**	**Actions and Results**
Is the worker's plan for initial engagement of the family appropriate for this family's unique circumstances?	Review the initial engagement approach with the supervisor prior to the hand-off visit.	Modify the approach according to input from the supervisor.
Is the worker's preliminary service plan complete?	Review the preliminary service plan with the supervisor prior to the hand-off visit.	Modify the preliminary service plan according to input from the supervisor.
What special skills or knowledge might you need to intervene effectively in this case?	Consider the following areas: Special Issues: Special knowledge and skills that you may need to review or acquire to deal effectively with special issues such as sexual abuse, domestic violence, substance abuse, mental illness, etc. Self-Awareness: Explore personal beliefs, attitudes and biases that may have an impact upon your ability to deal effectively with this family.	Develop a plan with your supervisor to acquire any special skills or knowledge that may be called for by this case, or to involve other professionals who have this knowledge and skill. Discuss self-awareness issues and the impact they may have upon your relationship with the family. Identify methods for dealing with personal issues so that your intervention with the family can be effective and sensitive to their circumstances.

Conduct Transitional Visit with Child Protection Services Worker and the Family

The formal transition of the case will take place in the presence of the family (caretaker(s) and available household members). During this initial contact with the family, the permanency worker should understand that this is an ideal time to glean

valuable assessment information. The worker should be cognizant of the importance of documenting any and all such assessment information.

Time Frame

The transitional visit must take place, preferably in the family's residence, ***no later than two working days*** following the assignment of the case to the permanency worker. Paperwork that the child protection service worker is required to provide the permanency worker includes the following:

- Case Registration/Case Opening Form,
- A copy of the CANTS 1,
- Hispanic Language Determination form, if applicable,
- A copy of all investigative notes to date, including information about any service referrals,
- A copy of the CERAP signed by the child protection supervisor, and
- A copy of the Risk Assessment Protocol signed by the CPSW.

Outline for Conducting Transitional Visit

I. **Introduction and purpose:** The child protective services worker should introduce all family members to the permanency worker, explain the purposes of the visit, and discuss what will be happening during the meeting.

II. **Review reasons for involvement:** Together with the child protective services worker, talk to the family about the allegations, the findings, and the concern(s) for the safety and well-being of the child. Elicit the family's understanding of the reasons for DCFS involvement and their reaction to the investigation process. Identify and discuss with the family their issues and concerns.

III **Provide the Family with Full Disclosure:** Together with the Child Protection Specialist, explain to the family that the Department must assess the family's need for services and, **with the family,** develop an appropriate service plan for the

family's voluntary acceptance or refusal. This service plan cannot include provisions that are not reasonably related to conditions that have not or may not give rise to an indicated finding of child abuse or neglect. The worker must inform the family that the Department must take appropriate action in keeping with the best interest of the child if the family declines such services. This may include Juvenile Court action that may result in the removal of the family's children.

Advise the family of their rights as clients. Provide a copy of the Department's Service Appeal brochure. Some families may need the worker to read the brochure to them. Openly discuss all information that allows them to make an **informed choice** about the following: (1) the use of service, (2) the range of other services and (3) their right to receive services in their primary language and in a manner which is non-coercive and protects their right to self-determination. Read the "Client's Rights and Responsibilities Form" with the family and allow them to sign this document if they are in agreement. Leave a copy of this form and the Service Appeal Brochure with the family. (See Appendix C)IV. **Review and assess safety and risk issues:** Discuss safety concerns and mitigating family strengths and conditions identified during the investigation.

Gather additional information related to safety as needed and as identified during preparation for the transitional v visit (e.g. role of family members including any part-time caretakers, family members or paramour).

Discuss with the family their understanding of the safety of their children and what they feel may be needed to ensure their immediate and ongoing safety of the children.

Document safety-related information on a new CERAP within 5 days of case assignment. If necessary, develop a new safety plan or modify the existing one.

V. **Review the preliminary service plan with the family:** Explain that services will be provided to help the family overcome the problems that led to the child abuse or neglect and strengthen the family. Inform the family of what actions the worker will take to ensure that abuse or neglect is not recurring and that important underlying causes are adequately controlled. Get the family's input with regard to specific services and activities included in the preliminary service plan. The family must be given a clear understanding of the consequences if they fail to engage in their service plan and the child's health or safety is in jeopardy. Stress that the Department's goal is to help the family achieve the capacity to protect its children without the Department's intervention.

Discuss the stages of intact service delivery and address all questions and concerns the family may have. Include assessment, Child and Family Team, concurrent service planning, service delivery, evaluation of progress and case closing/planning for aftercare. Explain to the family that a Child and Family Team will be developed that will assist with planning and decision-making and will support the family throughout the intervention process.

VI. **Evaluate need for revised or new services:** The focus for the first 45 days is planning for safety and providing the necessary immediate services. The idea is to ensure the children are safe and the family's urgent needs are sufficiently addressed so that further assessment of strengths and needs can take place.

If a safety plan exists, discuss it with the family and jointly evaluate whether it is sufficient to ensure the safety of the children. **Ensure the family understands what actions will take place if the safety plan fails.** Identify any needed changes in safety services and develop a specific plan for providing these services.

Assess the environment with the family to identify any immediate basic needs they may have over the next 45 days. Consider concrete needs (shelter, food, clothing), protective or therapeutic day care, need for Norman assistance, as well as other services such as crisis counseling or homemaker services**. It is important that, in assessing the family's environmental needs, the worker not lose sight of the incident of maltreatment that led to the Department's involvement.**

No service plan shall compel any child or parent to engage in any activity or refrain from any activity that is not reasonably related to remedying a condition or conditions that give rise or could give rise to any finding of child abuse and neglect.

Document new or changed safety services on the CERAP and document immediate services on the service plan and/or a case note. Ask the family to sign the CERAP, and remember to sign it yourself. During or immediately after the visit, arrange for any new services that need to begin.

Encourage the family to openly express their views concerning involvement with DCFS. Help the family identify what they wish to achieve. Assist them with clarifying their goals. Ask the family to identify which services might be helpful in attaining their goals.

VI. **Plan for next steps:** Discuss the next steps in the assessment process, and make necessary arrangements for home visits or other needed appointments.

Summarize what was discussed during this meeting, and review action items and tasks identified during the meeting. The worker must ensure that he/she and the family have a common understanding of the next steps.

Ensure Appropriate Services are in Place

Make all the appropriate referrals and arrangements to initiate and support safety and immediate services (e.g. food pantries, clothing pantries, etc.).

Following are the possible levels of intervention determined by the CPSW:

Level 1 – No Services Needed

Level 2 – Referral for Community-Based Services

Level 3 – Short-Term Intact Services

Level 4 – Regular Intact Services

Level 5 – Intensive Family Preservation Services

Level 6 – Substitute Care

Refer to Appendix A for more information regarding the levels of intervention.

Typically when a case is open by Child Protection and referred for permanency services, the permanency worker will be servicing a case on Level 3 or 4.

Based on information gathered during the assessment, risk and safety issues or changes in the family's circumstances, Intact Protocols (Appendix F) may be added or eliminated and cases can be moved among Levels 3, 4 and 5.

5.3.5 Goals/Outcomes

- There will have been early engagement of the family and a comprehensive assessment of safety/risk to the child in the home.
- Once the CERAP, Risk Assessment Protocol and other case information is reviewed, a decision will have been made by the worker (in consultation with the supervisor), regarding: what additional information is required in order to proceed with enhancing the assessment and initiating early case planning and service provision.
- The permanency worker will have evaluated whether any immediate services put in place by the child protective services worker are meeting or are capable of meeting the immediate service needs of the family.
- The preliminary service plan will be agreed upon and its implementation will be begun.
- A seamless transition will have occurred between the child protective services worker and the newly assigned intact family worker.

5.3.6 Documentation Requirements

- The worker will document: a) the review of initial case file material; b) contacts with the child protective services worker; c) initial contact with family and transition of case; and d) communication requirements.
- Within 5 days of case assignment and within 24 hours of seeing the child, the worker will complete the CERAP to assess and document safety issues.
- The supervisor will document in the case record on a case entry note: (a) his/her consultation with the child protective services supervisor and the newly assigned worker with regard to initial review of case file material, (b) the review of the worker's safety/risk assessment and (c) consultation as to the early disposition of the case.

5.4 Assessing Family Strengths and Needs

5.4.1 Philosophy

The assessment process focuses on increasing family stability and promoting family effectiveness. Assessment is an on-going process throughout the life of a case. The comprehensive assessment addresses the child's safety, risk of continued maltreatment and immediate service needs. Throughout the assessment process, it is essential that a family's strengths be assessed as well as a family's needs. The caseworker and the family engage in a mutual process of finding and putting into easily understandable words the family's, parent's, and/or child's strengths, assets, and resources which directly relate to the child's protection. The family's capacity to productively use these available assets and resources is itself an important strength.

The caseworker's assessment begins during the initial visit. From the time the worker first engages the family in the collaborative casework process, worker and family forge a partnership to jointly determine the crucial strengths of that family and ascertain how they can be used to assure the child's safety and well-being. The worker must remember that it is the safety of the child and family's vision of the future that should shape the process, not the Department's vision. To be effective in an intervention, the worker must begin engaging the family in a prompt and positive way at the initial contact and continue throughout the life of the case. Both worker and family should remember the primary focus is on those needs that are directly related to the child's safety and well-being. The worker assists the family in assuring child safety, but it remains the responsibility of the family to take the needed steps to maintain child safety and prevent future maltreatment.

5.4.2 Purpose

During the early assessment process, the primary focus should be on the safety, permanency and well being of the children in the family. It is important that the worker continue to engage in activities designed to detect whether there is continuing abuse or neglect. The purpose of this early stage is to engage and develop a family-centered and empowering relationship with all household members, including the children as well as the parents/caretakers/paramours. In addition, during this phase of information gathering from the family, the worker begins to develop the Child and Family Team. The importance of an inclusive assessment cannot be stressed enough. Without a thorough

assessment, the worker will not have a clear view of family interaction and family dynamics.

5.4.3 Key Decisions

- What are the child's unmet, essential needs related to safety and well-being?
- What changes does the family need to make to meet the child's unmet essential needs? (How much change is needed? How can the worker know when sufficient change has been made?)
- What strengths and resources does the family have that can enable them to make the needed changes? (What can be built-upon, strengthened?)
- How can the family use its strengths and resources to make and sustain needed changes?
- What are the family's views of their strengths, needs and possible solutions?
- What is the nature and quality of the relationship between the family and caseworker, and how does this affect the family's ability to change and/or the child welfare agency's ability to support and validate change?
- What are the significant factors within the family, community or the service system that may present barriers to successful change, and how can they be overcome?
- With the family, identify potential Child and Family Team members and their mode of communication.

5.4.4 Practice

Plan the Assessment Process

The time frame for completing the comprehensive assessment is only 45 days, so it is important to develop an outline for completing the assessment process for each family. Each family is unique, and the tasks, timeframes and activities for one family assessment may differ significantly from another.

Make an outline of critical tasks

The outline should cover, at a minimum, the following topics:

- What further information is needed and what are the sources of this information? What releases need to be signed in order to access this information?
- What specific areas need to be explored more extensively, such as high risk issues identified during the comprehensive assessment or areas of positive functioning? What sources and methods would be most effective in getting this information?
- What special evaluations are needed to understand this family? When and how can these special evaluations be obtained?
- Who should be interviewed (including family and collaterals)? When should they be interviewed? What interview methods should be used?
- When will the first draft of the written assessment be completed?

Develop a schedule of activities

The result is a plan of key activities and their scheduled dates of completion. This is best developed with the full participation of the family during the transitional visit and/or during the first visit following the transitional visit. Especially intensive contact with families should be planned during the assessment stage because intensive contact will foster early development of the relationship, this is often the most dangerous time for the child and there are many tasks to be completed

Arrange for Special Evaluations

In some cases the worker is able to adequately assess the strengths and needs of the family. This is most often the case when the family presents a low risk profile and when there are few or no indications of special problems that have a significant impact on child safety. For example, an assessment should be obtained for apparent mental health problems, substance abuse and other problems. When there are indications of special problems that may influence the risk and safety of the child, the worker must within 24 hours seek a qualified professional to evaluate the condition and report the results.

If potential special problems that may affect the child's safety are not mitigated by other factors, an effective safety plan must be in place and monitored closely while the evaluation is being completed.

Obtain Copy of Prior Investigations and Service Records

As part of the comprehensive assessment, the follow-up worker must obtain a copy of any prior indicated investigations and service records related to the family. If any of these are unavailable, the worker should document efforts to obtain the records and reasons for their unavailability.

Conduct Family and Collateral Interviews

The worker must make ***at least weekly visits*** to the family for the purposes of gathering information for the comprehensive assessment and establishing a relationship with the family. To maximize time and resources and to demonstrate respect for the family, make every contact with the family purposeful and focused by following these three important steps for every family interview: (1) prepare for the interview; (2) conduct the interview; and (3) follow-up on action items.

Prepare for the interview

Consider the following questions in preparing for the interview:

- What was learned so far?

- What has been the nature and quality of participation and engagement by the family?
- What do you want to accomplish in this interview? (Information gained, information communicated, actions taken)
- What areas of assessment do you plan to cover and specific information do you need to collect in this interview?
- What interview methods will you use to learn information and enhance engagement with the family?

Conduct the interview with the family

Use the following interview protocol:

- **State the purpose:** Begin with all family members (or all persons involved in this particular interview) together. Briefly review the tasks and results of the previous meeting and discuss barriers and any questions or issues from the family. Discuss the objectives of today's meeting, and clearly state what will happen and why. Ask for the family's input and suggestions, and respond to any issues and concerns they may have.
- **Review the safety plan:** Discuss the safety plan with those responsible for implementing the plan to ensure that it is being carried out and that it is providing sufficient protection for the children. If the plan is not being followed, or if new information emerges that poses a new concern for safety, immediately assess the safety of the children with the family and decide what actions need to be taken to ensure safety. If there are changes to the existing safety plan, revise the plan during the interview and have those responsible for the plan sign or initial the changes
- **Conduct the interview(s):** Conduct the interview or series of interviews, as planned and agreed upon earlier.
- **Conclude the meeting:** Reconvene all interview participants and discuss any questions or concerns the family may have. Summarize what was learned and accomplished during the meeting and identify next steps with the family.

Conduct the interview with collaterals

Collateral contacts are important because they provide more information about family functioning, provide an outside perspective on the family and corroborate family statements. Also these interviews can serve to begin to enlist non-family member participants on the Child and Family Team. These contacts must be made with the family's knowledge and written consent. These interviews may be conducted in person or by telephone.

The following non-professional collateral contacts should be made: extended family and other non-family members identified by the client as being important such as clergy, friends, godparents.

The following professional collateral contacts should be made as applicable: medical provider, school personnel, day care provider, mental health provider and others who may have important information about the family and the incident of maltreatment.

In conducting collateral interviews, the worker must use caution not to violate the family's confidentiality by divulging confidential information. The purpose of the interview is to obtain information, not reveal it. It will be therefore important that the worker prepare for the interview by determining what specific information they need to obtain from that collateral, how they will obtain it and why they need it.

Follow-up on action items

- Immediately arrange for any new safety services identified during the meeting.
- Incorporate relevant information into the assessment form.
- Make arrangements for all other services or actions identified during the meeting.

Confer with Supervisor

Frequency of Conferences

During the first 45 days of case opening, the supervisor closely monitors the worker's progress towards assessment of safety, strengths and needs, identification of services, case status and family progress. The worker meets weekly with the supervisor during

this stage to ensure that all critical safety issues are addressed and that the best possible assessment is developed.

Content of Supervisory Conferences

The worker and supervisor should discuss the following areas during supervisory conferences:

- **Child safety:** Current risk/safety factors; appropriateness of the worker's assessment of safety; effectiveness of the safety plan. What is the worker doing to determine whether there is reoccurring abuse or neglect?

- **Progress and quality of assessment process:** Whether timely progress is being made; are correct areas being explored; is sufficient depth of analysis being attained.

- **Nature and quality of relationship with the family:** Level of engagement and partnership; possible strategies to enhance the relationship.

- **Clinical issues and intervention techniques:** Meaning of family dynamics and functioning for child safety and family progress; intervention strategies to deal with difficult assessment or treatment issues;

- **Development of the Child and Family Team**. Identification of potential members.

- **Worker self-awareness and safety issues:** Identification of problematic personal issues for the worker related to this case; identification of potential safety issues for the worker; effective strategies for dealing with these issues.

- **Appropriate level of service:** Based on risk/safety levels and the nature and dynamics of family functioning, what level of service is appropriate for this family. Identify and determine the status of concurrent plans.

Throughout the life of the case, whenever legitimate casework or clinical concerns dictate sharing information with family members or others involved in the case, but it appears that concerns over confidentiality do not allow such sharing, the supervisor must contact DCFS legal for advice as to whether the information can legally be shared.

Prepare Draft of the Comprehensive Assessment

Based on interactions with the family and collaterals, results of any special evaluations, conferences with the supervisor and input from the family, complete the first draft of the comprehensive assessment within 45 days of case assignment. The comprehensive assessment builds upon the risk and safety assessments completed during the investigative process, takes into consideration the family's background and includes at a minimum the following elements:

- Preliminary evaluation of the risk and safety issues that were initially presented;
- Compilation of information about past or current services from this organization or other resources;
- Assessment of the family's strengths, needs, resources and existing support systems for addressing the problem;
- Assessment of psychosocial problems which undermine personal or family stability;
- Assessment of family relationships and of the legal status of minor persons served.
- Re-assessment of the initial services put into place by the child protection services worker, their continued appropriateness or need for revised services.
- Assessment of the child(ren)'s educational, physical/health and mental health needs.

Review Assessment with Family

Meet with the Child and Family Team at the first family meeting within 45 days and review the comprehensive assessment. Fully explain the format and function of the assessment and respond to any questions or concerns the family may have. Ensure that the family understands the assessment and actively elicit their suggestions for additions or changes. There may often be some disagreement concerning assessment conclusions. Since the family is not likely to meet a need that they do not believe in, continue your discussion until agreement can be reached. If it is not possible to reach agreement on one or more points, note this on the assessment and include the family's perspective in the

explanation. Finalize the assessment based on information obtained during the initial family meeting.

5.4.5 Goals/Outcomes

- Continued engagement of the family and joint planning with the Child and Family Team;
- The worker and the family together will have considered the following three basic questions:
  - What does the child need to be safe and healthy in this environment right now?
  - What does this child need to remain safe and healthy in this environment?
  - What actions need to be taken and by whom to assure the child is healthy and safe?

  If in answering these three questions, the worker and family together make a decision that the child does have what he/she needs to remain safe and healthy in their environment, consideration should be given at this stage of service towards moving toward termination of services and closing the case.
- The worker will have completed the comprehensive assessment with the family, which provides the foundation for the development of the service plan.
- Together, the worker and family have been making connections between the achievement of goals and permanency for the children. Thus, at this stage in the process, the worker and the family should be actively understanding and following guidelines for case closing, including the selected date for ending/terminating the relationship between the family and DCFS.

5.4.6 Documentation Requirements

- The worker will document the continued assessment process with the client in case entry notes.
- The worker will document all of the contacts with the family during this stage in case entry notes.
- The worker will document his/her efforts to determine ongoing abuse and the results of his/her efforts in case entry notes.
- The worker will document in case notes re: any additional services that have been put in place with the family.
- The supervisor will document weekly supervision with the worker during this 30-day stage on a case entry note to be maintained in the client's case file.
- The comprehensive assessment will have been completed within 45 days and be documented in the case record.

5.5 Planning Services

5.5.1 Philosophy

Having defined the children's health and safety needs, the family's strengths, and the challenges the family faces in meeting the children's needs during the process of developing the comprehensive assessment, the worker and family are ready to discuss what can be done to meet the children's needs. Protocols related to the presenting problem (allegation) and underlying conditions have been developed and will be an important guide in determining the necessary services and activities that need to be conducted. As in every stage of service in working with intact families, planning a response to the family's needs will be successful only if the family is actively involved from the start and continues its involvement through this phase. It is the responsibility of the worker serving intact families to provide the information, advice, and support necessary for the family to achieve its goals. It is the responsibility of the family to play an active and collaborative role in addressing its own needs. The Child and Family Team facilities full participation by the family.

A family is most likely to participate in (and benefit from) interventions when they participated in defining both the substantive content of those interventions and the method in which the intervention will be carried out. The process of involving the family in this aspect of case management is essentially a continuation of the earlier engagement of the family. Each family member should be consulted with respect to his/her opinion on needs and vision of solutions.

The family's participation in concurrent planning is essential in building their self-sufficiency. In developing the service plan, the caseworker should seek agreement on such things as the factors and conditions that are placing the child's health or safety in jeopardy, the preferred and alternate approaches for addressing those issues, prioritization of goals, tasks to be accomplished, and criteria for measuring outcomes. A belief in the ability of a family to change and a belief that parents want to be good parents are basic to child protective services. Collaborating with the family automatically communicates that those involved with the family believe change is possible.

This partnership between the worker and family is relationship-based and operates on the principle that the ultimate authority for change rests with the person or family who is concerned with the change. It flows out of respect for and commitment to each other. It is facilitated and nurtured by the permanency worker. It is founded on the belief by all parties that life can be better for the family and its members.

5.5.2 Purpose

The primary objective of this stage is to determine what services are needed to help the family provide for the child's safety on their own (i.e., without DCFS intervention).

The service plan is a fluid document that is completed within 45 days of case opening and amended as needed. The identified safety issues, risk issues and comprehensive assessment drive the first service plan. The service plan will be discussed with a supervisor monthly and will be formally reviewed every 90 days at the family meeting. This allows for the review of new information or changes that occur in the family as intervention is proceeding. Additionally, this emphasizes the importance of accountability by the worker and others involved in serving the family. The service plan will be reviewed and a new plan completed every six months. Specifically, the purpose of the service plan is as follows:

- To formalize an approach to address underlying needs by providing direction to the worker and family about what will occur during planned change.
- To emphasize family system outcomes and specific underlying need associated with specific outcomes to focus and direct family change.
- To identify specific measures which can be applied to facilitate family change.
- To prioritize what will be worked on, when, by whom, and for what length of time by the family, the worker and other providers.
- To establish the length of service expected in the case.

5.5.3 Key Decisions

- What is the alternative permanency goal and/or plan in the event that the family does not make progress toward the preferred goal?
- What is the family's level of motivation to change?
- What services/interventions can help this family make needed changes? What efforts should be conducted to detect or control recurrence of the abuse or neglect?
- What providers can most effectively deliver these services?
- What is the optimal order of service delivery?

5.5.4 Practice

- **Meet with family to discuss service needs:** The worker will meet at least weekly during the first 30 days with family members who will be participating in and/or receiving services to discuss family strengths, needs, goals, vision of change, and desired services. The worker and the family will come to an agreement regarding the needs to be met and the services to address them. The

worker and family jointly develop a draft service plan to be finalized at the 45-day family meeting.

- **Develop a draft service plan:** The worker and family will ensure that the service plan contains the following information:
    - Preferred permanency goal and planned achievement date;
    - Alternative permanency goal and/or plan
    - Specific task-based objectives
    - Clearly identified services that delineate who will be providing such services, the frequency of services, and the estimated beginning and ending date for services.
    - Measures that will be applied to judge goal achievement.
    - Service tasks designed to help the family member progress toward achieving a particular goal.
    - Crisis plan(s) to address contingencies such as relapse, regression, domestic violence, home or environmental conditions.
    - Worker's role in determining whether the abuse or neglect has continued or dangerous conditions persist.

    Based on discussions with the family, the worker and the family will draft the service plan to include preferred permanency goal and plan, alternative permanency goal and/or plan, strengths/needs, behavior/conditions that must change, matching providers to service need, etc.

- **Conduct 45-day family meeting: T**he worker will schedule and facilitate the family meeting within 45 days of case opening. Participants in this meeting include the members of the Child and Family Team. (The follow-up supervisor must attend the first meeting; subsequent attendance is discretionary depending on circumstances.) The primary purpose of this family meeting is for the worker and family to:
    - Discuss the information contained in the comprehensive assessment

- Discuss the preferred plan which reflects the services currently being provided as well as any additional services that are needed; discuss the alternative plan which will be implemented if the preferred plan cannot be achieved;
- Determine the anticipated length and depth of DCFS involvement with the family.
- Finalize the service plan unless extraordinary circumstances prevent finalization at this time.
- Share the service plan with the family and get signatures.
- Discuss with the family that the worker will need to engage in certain activities in order to detect or control recurrence of the abuse or neglect.

The worker will advise the family that additional social history information (the expanded assessment) will be collected within 90 days of case opening.

The service plan will be modified to reflect any changes that were identified during the family meeting. Be sure the service plan includes identification of tasks for the alternate plan.

Upon completion, the worker reviews the written service plan document with the family. The worker will also provide the family with notification of their rights as clients and seeks the family's agreement with the written plan. This agreement is formalized by signature of all relevant parties (e.g. parents, children when appropriate, service providers, caseworker).

The supervisor will review the written service plan with the worker to ensure that the identified safety and risk issues are addressed and will finalize this review by signing the plan.

In those situations where the family disagrees with all or part of the document and refuses to sign the plan, the worker indicates this on the document. The family will be invited to document their concerns and objections, will be provided with a copy of the signed document and will be advised of their appeal rights. The family must also be informed of the potential consequences of their failure to engage in their service plan.

Relevant parts of the service plan will be provided to other members of the Child and Family Team.

5.5.5 Goals/Outcomes

- Continued engagement of family.
- Continued monitoring of the family in the service plan.
- The worker and family together will have continued to consider the following basic questions:
  - What does the child(ren) need to be safe and healthy in this environment now?
  - What does this child(ren) need to *remain* safe and healthy in this environment?
  - What actions need to be taken and by whom to assure the child is healthy and safety?

  If in answering these three questions, the worker and family together make a decision that the child does have what he/she needs to remain safe and healthy in their environment, consideration should be given at this stage of service towards moving towards termination of services and closing the case.
- The worker and family will have together completed the service plan which will drive the casework interventions for the next 60 days when the first quarterly family meeting will occur.
- Together, the worker and family in partnership have been working toward achieving the objectives which relate to the successful achievement of the child's permanency goal.
- The measures established in the service plan are established on the basis of minimal standards of achievement. In addition to providing a means for evaluating goal attainment, they should furnish the worker, family, and service providers with direction and content which should be the focus during service provision.

5.5.6 Documentation Requirements

- The worker will document in case entry notes the development of the service plan and the family's participation in the process, as well as obtaining the family's signature on the plan itself.
- The service plan will be documented on the service plan form.
- The worker will document the continued assessment process, participation with the family in the development of the Service Plan and in the evaluation of progress made towards goal achievement from the previous service plan in case entry notes.
- The worker will document all of the contacts with the family during this stage in case entry notes.
- The worker will document any delay of services due to specialized needs and/or communication requirements, as stated in the family service plan.
- The worker will document in case notes any additional services that have been put in place with the family and termination of any services.
- The worker will further document in case entry notes that the family received a copy of the service plans and client rights were discussed.
- The supervisor will document all supervision around the following areas:
  - Review of the service plan.
  - Progress of the family in services as it relates to the plan.
  - Child safety, risk and well-being.
  - Whether frequency of contact and activities specified in the protocols have been waived and reasons why.

5.6 Supporting the Family Through Change

5.6.1 Philosophy

Services will be effective when the client and worker alliance becomes evident. It is important for the worker to remember that the family members and the community play an important role in this alliance. The worker's support for the client is pivotal to accomplishing the steps necessary to meet that client's goals. Once a plan is in place, the work that remains is (1) the provision of services, along with (2) ongoing evaluation of (a) whether there is evidence that the abuse or neglect have continued or that a dangerous underlying condition persists; (b) how the plan is working; and (c) whether both the worker and the family are fulfilling their responsibilities as agents of positive change. The worker's role is never limited to monitoring or overseeing a case. The worker is to act as an agent of change both in relation to the family and to the family's needs. Both the worker and the family are active participants in a collaborative effort and every meeting between them should have a purpose and a substance. The protocols in Appendix F contain service expectations for certain types of cases.

The intensity of the Department's response, both in terms of frequency of visits and substance of services, will vary depending on the level of the children's health and safety needs and the level of risk factors. It is important that the worker, under the guidance of his/her supervisor, view the situation holistically, maintaining a comprehensive overview of both the individuals involved and the family unit as a whole. At the same time, there will always be specific needs for specific families that need detailed on-going attention.

As services are being provided, it is the worker's responsibility to ensure an appropriate prioritization and integration of the various elements of those services. The worker and the family together should have a mutual understanding of the underlying purpose of the DCFS intervention. Resources might include the "natural" supports available to the family such as church groups, the children's teachers and neighbors. The worker and family should decide together which family members will see which service providers, how often, under what circumstances, and how transportation will be provided.

It is also incumbent upon the worker to work with, and to help the family to work with, collateral service providers. The worker's role may include making active collaborative efforts through interagency linkages. The worker must maintain careful communication with collateral service providers to ensure that the family is actively participating in services and is making progress, and that the children remain safe. Throughout this process, the worker should see himself/herself as one of the significant resources for the

family. Whenever the worker meets with the family, there are opportunities for continuing to support that family's efforts to enhance the children's safety and well-being.

5.6.2 Purpose

The purpose of this stage in service is for the worker to: (1) maintain careful communication with collateral service providers to ensure that the family is actively participating in services and is making progress, and that the children remain safe. (2) Ensure that systems are in place and (3) establish connections between the family and needed services, which will further implement the service plan and enhance the likelihood of meeting the family's established goals. As a further support for the family, the worker should continue to engage the family in an ongoing dialogue about safety and well-being issues and how the intervention is affecting the family. In this way, the worker is a catalyst for change.

5.6.3 Key Decisions

- What is needed to support the family through the change process?
- What providers or resources can most effectively deliver the needed services?
- What are the availability, accessibility and affordability of the identified providers?
- How can the worker and family most effectively initiate services with each provider?
- What feedback will be needed from each provider, and how will it be obtained?
- How will the quality and effectiveness of each provider be measured?
- Are safety factors being addressed?
- Is the family making progress and are the identified risk factors being mitigated?
- How will the caseworker know when a service is no longer needed?

- Does the alternate plan need to be implemented?

5.6.4 Practice

- **Ensure the ongoing safety and health of the child:** All the worker's actions must focus on maintaining the safety of the child while the family works on overall goal achievement. Completing the CERAP and the Risk Assessment Protocol at the specified milestone, the worker can use these instruments to discuss ongoing safety and risk. In addition, the worker must conduct the activities designed to detect or control recurrence of the abuse or neglect, as specified in the protocols in Appendix F.

- **Initiate referrals for services and ensure linkage with service providers:** The worker is to make service referrals, based on and identified within the agreed upon service plan. The worker ensures linkage for the family with identified service providers and facilitates initiation of services with providers.

  The process of initiating services involves facilitating communication between the family and the various service providers in order to prioritize and strategize utilization of services. It is important that the worker take an active role in linking families and service providers. This may involve the worker's attendance at the initial intake interview between the family and the service provider. As part of the referral process to treatment providers, the worker must give the provider copies of relevant referral information including redacted copies of indicated investigations. Providers not providing treatment services (e.g., day care or homemaker) need to be given only information sufficient for them to understand and fulfill their portion of the service plan.

  The service plan will be used as a guide to establish the details of service utilization (e.g. the order in which the services are to be provided, how transportation is to be arranged, etc.). This coordinated effort will ensure that all interventions are oriented towards the permanency goal and needs identified for the family. The worker must be sensitive to the work and school responsibilities of family members when services are scheduled. The worker is to discuss with the service provider and family/client agreed upon treatment objectives as they relate to (a) the safety and well being needs of the child and (b) the length of anticipated service and outcome measures.

- **Regular and purposeful family contact (home visits):** During this stage of service, the worker continues to maintain an average of weekly home visits with the family. The purpose of these contacts is for the worker and family to:

  - Maintain communication and rapport between the family and worker.
  - Actively seek and use client/family feedback on the services being provided.
  - Make connections between the achievement of goals and the safety, permanency, and well-being of the children.
  - Evaluate if the alternate plan needs to be implemented.
  - Work with the family to ensure that the family is addressing the child's essential needs.
  - Conduct activities specified in the protocols in Appendix F to detect or control recurrence of the abuse or neglect.

  The worker will advise the client/family as to their rights to service appeal in the event that services are either changed, discontinued or denied.

  For paramour-involved families, during the first three months of a new intact family case, the child victims must be observed weekly for possible injuries and, if verbal, interviewed. Children are not to be interviewed with either the paramour or custodial parent present. During an investigation (subsequent oral reports) on open service cases, the permanency worker shall conduct the weekly monitoring visits, unless other arrangements are made with the investigator. The permanency supervisor must approve any decrease in the number of monitoring visits.

- **Maintain contact with service providers:** The worker will maintain contacts with the provider by phone or in person according to the expectations specified in the protocols in Appendix F. During the intake/referral process the worker will establish the following:

  - Time periods for progress reports

- Pattern of communication, i.e. immediate report of missed appointment
- Staffing scheduled if appropriate

Communication between the provider and worker should flow both ways. It is the responsibility of the worker to keep the provider informed of any changes in the family's circumstances as well as providing him/her with a copy of the part of the service plan that pertains to his/her service provision. When appropriate, the provider will be included in the family meeting.

- **Confer with Supervisor:** Supervisory/worker conferences continue to take place on at least a monthly basis, at which time the service plan and case status/progress is reviewed. This includes a review of the assessment, service plan, any service provider reports, the alternate plan and or other pertinent information. During the conference, the worker and supervisor should consider whether more frequent supervisory conferences are needed.

5.6.5 Goals/Outcomes

- Continued engagement of the family.
- The worker and family together will have continued to consider the following basic questions:
  - What does the child need to be safe and healthy in this environment now?
  - What does this child need to *remain* safe and healthy in this environment?
  - What actions need to be taken and by whom to assure the child is healthy and safe?
  - Does the alternate plan need to be implemented?

If in answering these four questions, the worker and family jointly decide the child does have what he/she needs to remain safe and healthy in their environment, then at this stage of service, consideration should be given to moving toward termination of services and closing the case.

- The client/family is provided with the services that best allow them to consistently move toward the successful achievement of the child's permanency goal.

- Continued monitoring and evaluation of the family's progress.

5.6.6 Documentation Requirements

- The worker documents all of the contacts with the family, including assessment addenda, during this stage in case entry notes.

- The worker documents the progress and impact of the interventions on the service plan.

- The worker documents in case entry notes at least once per month contact with identified service providers. Contact and documentation should focus on the client/family's progress toward successful achievement of treatment objectives as they relate to the safety, permanency and well-being of the child.

- The worker documents the receipt and review of all written treatment reports from service providers in case entry notes.

- The worker and supervisor document the decision to decrease the weekly monitoring visits for paramour involved families during the first three months of case opening.

- The supervisor documents all formal supervision in the case file. In addition, the supervisor should document all supervision around the following areas:

  - Review of the service plan.

  - Progress of the family in services as it relates to the plan.

  - Child safety, risk and well-being.

5.7 Evaluating Family Progress

5.7.1 Philosophy

Recognizing that insuring child's health, safety and well-being in some families requires more extensive interventions due to underlying conditions, the assessment will need to be enhanced or amended as part of the on-going assessment. During the comprehensive assessment, the worker engaged the family and built rapport in a courteous and respectful context. Now the family has had time to move from the crisis period in which they were adjusting to the need for change, and they are at the point where change is possible. The worker has had time to begin building an effective partnership with the family, and now has a belief in the ability of the family to make change. This partnership is the vehicle for change, and collaborating with the family communicates that the worker believes change is possible.

The partnership between the worker and family at this stage of service is characterized by:

- The family's ability and/or willingness to be more open and share information at a deeper, more personal level.
- A general sense of comfort, where there is little reluctance to disagree or minimal fear of demonstrating powerful emotion.
- The worker and family seeking each other out. Parties make themselves available and feel responsible to inform the other when they cannot be available. A sense of disappointment or satisfaction occurs when appointments are missed or are met.
- A prevailing atmosphere of frankness and honesty.
- An understanding and acceptance in provocative or unsettling areas.

5.7.2 Purpose

The specific functions of the assessment include assisting families with: (1) identifying their own needs and desires; and (2) how to best address those needs in ways that assure

that children are not maltreated and are safe. Specifically, the purposes of the assessment are to:

- Engage the family in a collaborative partnership.
- Identify strengths.
- Identify underlying need.
- Identify family system outcomes (that will reduce risk).
- Identify what (individual and family conditions) must change to reach outcomes.
- Evaluate and manage safety.

The assessment is the compilation of information gathered from the family and other relevant sources. It supports the position the worker takes with regard to the family system. This evaluative perspective focuses on involvement with the family to determine how the family is best served. Necessary information which now becomes as important as facts are: *perception, attitude, feeling, meaning, hopes and dreams, all of which are presented from both the family's and worker's perspective.*

5.7.3 Key Decisions

- What significant changes in family circumstances occurred? How do these changes impact child safety?
- What additional/further understanding of family functioning was gained?
- What has the family changed and accomplished during this period? (Progress toward making needed changes, goal achievement.)
- What remains to be changed in order to meet the essential needs of the child? (If nothing, is family capable and willing to meet the safety needs of the child on their own?)
- How has the family participated in services during this period?

- Evaluation of the effectiveness and appropriateness of services provided and of the service providers (this includes a special focus on service effectiveness re: child safety).
- Prognosis – is the family willing and able to make the needed changes in a timely manner?
- What is the nature and quality of the partnership with the family?
- What are the current risk/safety issues in the family?
- Does the alternate plan need to be implemented?
- What would enable the worker to close this case? (Why can't the case be closed?)

5.7.4 Practice

- **Evaluate family progress toward meeting the child's essential needs:** The worker will assess the parents/caretaker's ability to meet the child's essential needs by considering: a) whether the underlying conditions that have been identified as contributing to the indicated maltreatment have been mitigated; b) whether the risk and safety factors identified as contributing to the indicated maltreatment have been mitigated and controlled; c) whether parents are meeting the minimal parenting standards established by the Department (refer to Appendix E) and d) whether the family is making progress in reaching the goals of the service plan. Throughout the life of the case and in every contact with the child, family, extended family, service providers and others, the worker will evaluate whether the child's essential needs are being met.
- **Conduct the expanded and ongoing assessment:** Having completed the comprehensive assessment during the first 45 days of service, the expanded (updated) assessment will be completed within 90 days and will be built upon the comprehensive assessment, incorporating any additional information that was gathered through professional evaluations, worker/family contacts and any other relevant information that is obtained. The totality of the information gathered will form the bedrock for the identification of the family's strengths and needs and ability to meet minimum parenting standards as it relates to the child's safety, health and well being.

- **Conduct quarterly family meeting:** During this process, the Child and Family Team discuss both progress and/or lack of progress as it relates to individual service tasks and achievement of the overall service goal. Specific discussion must address behavioral changes that have occurred or still need to occur to reduce the risk of child maltreatment and ensure the safety and well-being of the children and family. This discussion includes the following elements:

  - Success or failure of family and Team members to carry out their responsibilities specified in the service plan.
  - Changes the family has made to meet the essential needs of the children.
  - Significant events or dynamics that have changed during this period.
  - Changes still necessary to meet the essential needs of the children.
  - Willingness of individual family members to make the necessary changes in a timely manner.
  - Results of the current safety evaluation
  - Need for modification of alternate plan
  - Availability and accessibility of services at the required level needed.
  - Service utilization
  - Evidence of progress or lack of it
  - Focus of the interventions
  - Time frames for required actions
  - Quality and timeliness of provider reports
  - Client satisfaction with service provider

- Evaluate service plan, amend as needed and update as specified in Rule 315

The evaluation is based upon the following methods of measurement:

* Worker observation of behavior, including the results of a current safety evaluation
* Worker interviews, questioning and evaluation
* Review of record entries and other data
* Self-reporting by individuals and families
* Observations and reports from others
* Identification and description of events, situations, accomplishments, etc.

5.7.5 Goals/Outcomes

- Continued engagement of the family.
- The worker and family together will have continued to consider the following basic questions:
  - What does the child need to be safe and healthy in this environment now?
  - What does this child need to *remain* safe and healthy in this environment?
  - What actions need to be taken and by whom to assure the child is healthy and safe?

If in answering these three questions, the worker and family jointly decide the child does have what he/she needs to remain safe and healthy in their environment, consideration should be given at this stage of service to moving toward termination of services and closing the case.

- The expanded assessment will be conducted in a collaborative fashion with the family.
- The worker and family will have evaluated the current services and identified any barriers to services.
- The worker will be engaging the family toward actively pursuing the achievement of the permanency goal.
- Intensified action/process of the family moving toward goal achievement and the progress of the family should be more evident. This is the "crisis is over" stage in the life of a case, where the worker must work to help maintain the family's momentum toward goal achievement.

5.7.6 Documentation Requirements

- The worker will document the continued assessment process with the family in case entry notes.
- The worker will document all of the contacts with the family during this stage in case entry notes.
- The worker will document in case notes any additional services that have been put in place with the family.
- The worker will document in case notes the development of or enhancement to the basic service plan with the family.
- The supervisor will document supervision with the worker during this 60-day stage process on a case entry note to be maintained in the client case file.
- The written comprehensive assessment will have been completed.
- The worker will update the comprehensive assessment at a minimum of six month intervals or whenever significant case circumstances have occurred that suggest the need for an updated assessment.

5.8 Terminating Involvement and Planning for Aftercare

5.81 Philosophy The primary criterion for closing a case and disengaging from the family is the determination that the child is safe and will remain safe without the Department's intervention. In many cases, this will involve the existence of a network that can support the family and assure the child's safety after the Department's involvement has ended. Secondary to assuring safety is the determination that the child's well-being will be maintained by the family without DCFS involvement. The family, worker, supervisor, and in some cases, service providers should all be involved in the determination that the child's safety and well being are assured. In this stage of casework, the worker must continue to support and encourage the family, but there should be increasing emphasis on the family's initiation of their own efforts.

Bringing the working relationship between the worker and family to closure before closing the case is essential and in keeping with best practice. If the worker has had a meaningful partnership with the family, then a great deal has been invested together (e.g. emotions, sharing, trust, commitment, time, effort, joy, sadness, celebration, consolation, etc.). It is likely that a bond exists where the worker and family have become important to each other. Focusing attention, time, and effort in the necessary separation that closing a case brings is important.

5.8.2 Purpose

The purpose of this stage of service is threefold:

- For the worker to disengage from the family and continue to support and encourage the family, while increasing emphasis on the family's initiation of their own efforts. Family contacts during this stage from the worker should continue, but with less frequency. Agency services should be gradually decreased while family self help efforts should be increased.

- Joint determination with the Child and Family Team as to the appropriateness of formal case closure. The worker should discuss and review with the Child and Family Team all critical elements of DCFS intervention, at which time the family should be empowered to express their opinions and feelings, and encouraged to provide constructive feedback to DCFS. One preferred reason for case closure exists – success. "Success" means that previously agreed upon outcomes now exist within a family system, which remove any reason for continued Department

involvement (e.g. the family can and will ensure child's safety, permanency, and well-being).

- Establishing an aftercare plan that will maximize the family's opportunity to succeed. This is a collaborative process that focuses on the family's strengths and is jointly developed with the family.Aftercare plans will often include the intervention of a network that may include extended family members, community based service providers, school personel and others. Such networks may serve two purposes: 1) they may provide support, assistance, and services to the family and 2) they may provide a protective resource to which the child can report new incidents of abuse or neglect. All parties should actively participate, have direct input, and understand the expectations that are created by the plan.

5.8.3 Key Decisions

- Some key decisions that apply to all families include:Has the family ceased its formerly abusive/neglectful behavior ?
- What significant changes in family circumstances have occurred and how do these affect the child's safety in the future?
- Can the family – possibly with the help of an esatblished support network -- meet the essential needs of the child and ensure the child's safety and well-being without continuing DCFS involvement?
- Does the family need further services? (What, why, who?)

Some circumstances which **always** preclude case closing are:

- Any new indicated abuse/neglect report during the preceeding three months or a pending report at the time of closing.
- The presence of a safety plan.
- The presence of a major new stressor affecting the family which includes:

1. the new or prospective birth within three months of case closing;

2. the imminent threat of the loss of the family residence (e.g. eviction).

NOTE: Under no circumstance should any case , where there is an indicated finding of abuse, be closed soley on the basis that the parents or caretakers will not cooperate with services. If the worker has made persistent efforts to engage the family including:

- **the development of a basic service plan,**
- **informing the family of the responsbility of the department to offer services and ensure the safety of the children,**
- **informing the family of possible referral to law enforcement for action**
- **or requesting the States to file a petition in court,**

and the family still refuses, the worker must contact the State's Attorney to attempt to screen the case into court. The worker must continue to try to engage the family and must monitor the safety of the child(ren) while the court petition is filed. The worker must fully document all attempts to contact the caretakers and provide services.

If the State's Attorney's office refuses to file, the worker must document the reason(s) why the case is being refused and also document what necessary information/documentation is necessary to file a petition. If after providing the State's Attorney with the required information or taking the required actions, the State's Attorney declines to file a petition, the worker must continue to attempt to engage the family for a period of at least 90 days. These attempts must include a minimum of twice per month contact with the family. During this period, the worker must continue to monitor the child's safety by maintaining twice per month contact with the child's teacher, day care provider, physician or other professionals who may be able to provide information about the child's immediate safety.

If, after 90 days from case opening, the family continues to refuse all Departmrnt intervention, the case may be closed.

The Intact Protocols (Appendix F) specify required closing criteria for cases involving specific allegations and specific problems often associated with child abuse

and neglect. These criteria are to be considered mandatory. They may be waived by the Manager. When waiving these requirements, the Manger must document the reason(s) for the waiver in the case file.

5.8.4 Practice

- **Confer with supervisor to decide upon the suitability of closing the case:** As the family demonstrates progress in service plan goals and objectives, the worker determines with the family and other service providers, as well as with approval from the supervisor, the readiness of decreasing family case contacts. Before initiating steps to close the case in areas where there is not a paired team model, the worker, his/her supervisor and the child protection supervisor must meet to staff the case, using the following criteria in making the decision for case closing:

    - **Children are safe:** From the on-going risk/safety assessments, judgments can be made about safety/risk in respect to absence of threat, no maltreatment, absence of fear and general sense of security. The worker will conduct a formal safety (CERAP) and risk assessment. This assessment should:

        - Indicate the absence of any threats to harm or;

        - Sufficiently demonstrate that any threats to harm are adequately addressed within the family and/or through extended family or community supports.

    - **Family has achieved case goals.There are no new stressors that significantly impact stability of the family system and, therefore, the safety of the child:** For example, it is not appropriate to close a case shortly before or after a baby is born into the family. Other stressors, such as job changes, financial problems, a move, divorce, other changes in close relationships or the death of a close family member, may create a crisis in the family system that may impact the safety of the child.

- **Family functioning has improved:** Confidence in closing a case and ceasing Department involvement exists when evidence of minimally acceptable family functioning exists. This is evidenced by:

    - Demonstration of ability and commitment on the part of the parents/caretakers or other family members to protect the child

    - The presence of effective protective behaviors within the family

    - Ability of the parents/caretakers or other family members to (a) recognize the continuing presence of, or potential threats to, child safety, (b) acknowledge the need for protective measures, and (c) be accepting and supportive of external sources to assure protection.

    - Improvement in critical family systems outcomes such as:

        Family member functioning

        Family relationships

        Socialization

        Problem solving

        Family maintenance

        Family support

- **Child permanency has been achieved:** Confirming the action to close a case requires the consideration of permanency. Evidence should exist that supports a conclusion of the likelihood of permanence.

Case closing is a critical decision, with the safety of the child being paramount. In cases where there is not a paired team model the closing of an intact family case will be based on collaboration between investigations and permanency divisions. Communication and cooperation between units are key elements to making solid decisions regarding safety and well-being of children. This is especially critical when considering case closing.

The permanency worker, his/her supervisor and child protection supervisor will review the completed pre-case closing safety/risk assessments, the service plan, and the relevant closing requirement set forth in Appendix F during the staffing. The worker and supervisor(s) must then jointly make a decision as to whether or not to close the case. For intact family service cases that are subject to an existing court order, this consultation with and approval by the CPSW supervisor must occur before the court is requested to vacate the existing court order. If the decision is made to close the case, there should be a preliminary discussion between/among the worker and supervisor(s) as to the appropriate aftercare plan for the family. The child protection supervisor will inform the permanency supervisor in writing if he/she agrees with the case closing decision.

If the child protection supervisor disagrees with case closure at this time, the reasons for the disagreement must be in writing. Another staffing date must be scheduled to review the case again for case closure. The permanency worker will continue to keep the case open and serve the family until a decision is made to close the case. At the permanency supervisor's and worker's discretion, the child protection supervisor may be invited to the next family meeting in order to review the issues that prevent case closure.

- **Contact key service providers to discuss the possibility of case closure:** The worker will communicate to the providers his/her assessment of the possibility of case closure, and will request the following:
  - Service provider's feedback in regard to possible case closing
  - Written report of service termination if services are being terminated
  - Recommendations for aftercare
  - Acknowledgement that no significant safety or risk issues remain unresolved
  - If the child is safe and services are no longer needed to ensure the safety of the child, then services may be terminated and the case may be closed.

- **Meet with family to discuss the possibility of terminating DCFS involvement:** The worker will meet with the family to review the service plan and evaluate

progress and goal achievement. Included in this review will be a summary of the work completed in order to recognize the accomplishments of the family. The worker will review risk and safety issues with the family and complete a CERAP and Risk Assessment Protocol. As indicated, the worker and family will jointly identify the need for future services (foundation of the aftercare plan).

- **Decrease frequency of contacts with family:** During visits, the worker encourages the family to make use of its support network while empowering the family to believe in its ability to be independent from DCFS. The worker is positive and affirming, recognizing and acknowledging the family's successes up to that point. The worker elicits the family's own sense of pride in their accomplishments.

  As part of the termination process, for a period of three months following agreement with the family to terminate DCFS involvement, the worker will decrease the frequency of contacts and home visits (minimum of one home visit per month).

  The worker should meet with the family for the purpose of jointly developing an aftercare plan. At this time, it is the worker's responsibility to ensure that the family is aware of: (a) what signs might indicate a need for services in the future, (b) where to go for help, (c) how to access that help, and (d) the necessary links to community resources which have been created. The worker should be aware that separation from Department services and worker support may create anxiety on the part of the family and should be addressed in the following ways:

  - Exploration of the need for continued services from another organization within the community.
  - Assistance with any needed referrals for community services.
  - Ensuring that the family knows that they can request assistance from the Department in the future, as well as how to access such Departmental assistance.

- **Obtain supervisory approval:** A supervisory conference with the worker is to take place in which the worker shares with the supervisor his/her written closing summary as well as the written aftercare plan for the family. Once the written documentation for formal case closing and aftercare planning has been approved by the supervisor, the worker is ready to formalize case closing with the family.

- **Convene final family meeting:** The worker should meet with the Child and Family Team for the purpose of finalizing the mutual experience between the worker and family. This process involves:

  - Acknowledging the family's as well as the worker's feelings.
  - Encouraging the family and having the worker express his/her belief in them.
  - Expressing and accepting appreciation.
  - Reviewing the written aftercare plan, obtaining the client/family's signature on the plan, and confirming linkage to helping resources.
  - Leaving the door open, encouraging contact if needed, with an understanding of boundaries that exist for the good of both the family and worker.

- **Close the case record:** The worker will complete all appropriate documentation and ensure that all necessary reports have been received.

5.8.5 Goals/Outcomes

Evidence will exist, based on the criteria listed for determining case closure, that:

- The family has reached at least a minimal level of achieved desired outcomes;
- The family has reached necessary goals;
- The family has changed behavior so that risk is no longer a concern; and that
- Child safety can be maintained by the family or through external sources.

5.8.6 Documentation Requirements

- The worker documents all of the contacts with the family during this stage in case entry notes. This will include the following practice areas:
  - Disengagement
  - Conducting of safety/risk assessment
  - Decision for case closing
  - Aftercare planning and finalizing case closure
- The worker documents the receipt and review of all written treatment reports from service providers in case entry notes.
- The worker is to complete a safety assessment (CERAP) to aid in making the decision regarding the appropriateness of case closing.
- The supervisor documents supervisory consultation around the critical decision of case closure in the case file. The supervisor also reviews and signs off on the safety/risk assessment.
- The worker is to complete a written closing summary which includes the reasons why DCFS no longer needs to be involved with the family (e.g. goal achievement, family functioning, child safety) as well as the aftercare plan.
- The supervisor reviews and signs the written closing summary and aftercare plan for the family.
- The worker/supervisor is to ensure that a CFS 1425 is entered to formalize case closing with the Department.

Appendix A
Levels of Service/Models of Intervention

Families will receive the level of service that best meets the health and safety needs of the child. Families can move between levels of service during the time that they are served by DCFS. For example, a family may begin at the "short-term" level of service and move to "regular" because of safety issues. With the supervisor, the worker uses the criteria outlined below to help decide the appropriate disposition of the case.

Level 1 - No Services Needed

No services needed is indicated when there is no or low risk to the child and the family is able to manage any risk issues using its own strengths and resources.

Purpose

- To terminate intervention into the family's life as soon as possible.

Outcome

- Safety is ensured and risk is minimized.
- Essential child well-being needs are met.
- Family satisfied with DCFS intervention.

Selection Criteria

- According to CERAP, children are safe.

- Risk assessment indicates no significant risks such as domestic violence, substance abuse, mental illness or developmental delays.
- Minimum parenting standards are being met
- Family has many strengths and resources and is able to deal with challenges and needs without referral to community agencies.
- If abuse or neglect was indicated, it was an isolated incident of low severity or there is no access to child by perpetrator.
- There is no juvenile court involvement.
- No history of serious or chronic maltreatment.

Assessment Protocol

- Complete CERAP and Risk Assessment Protocol.

Service Plan

- No safety or service plan needed.

Length of Service and Frequency of Contact

- One visit with family to terminate intervention.

Services and Resources

- None.

Level 2 – Referral for Community-Based Services.

Referral for community-based services is indicated when there is low risk to the child and when the family is able to use community resources for support without further intervention by DCFS. These cases are usually not open but the worker is responsible for ensuring that the family has been linked with community services.

Purpose

- To link the family with the community services and resources that the family needs to deal effectively with their challenges and needs.
- To prevent future child abuse or neglect.

Outcome

- Safety is ensured and risk is minimized.
- Essential child well-being needs are met.
- Family satisfied with DCFS intervention and support.

Selection Criteria

- According to CERAP, children are safe.
- Risk assessment indicates family does not have significant problems such as domestic violence, substance abuse, mental illness or developmental delays; or if any of these problems are present they do not threaten child safety, and the family has sufficient strengths and resources to deal with them through extended family and/or community resources.
- Minimum parenting standards are being met.

- Family may be facing some challenges and needs, but these are not of an overwhelming nature and they do not endanger the child's immediate safety.
- The family has many strengths and resources and is able to deal with these challenges and needs through involvement with extended family and/or community resources.
- If abuse or neglect was indicated, it was an isolated incident of low severity, or there is no access to child by perpetrator, or the family displays remorse and accepts responsibility for the incident and is willing and able to change with community support.
- No history of serious or chronic maltreatment.
- There is no juvenile court involvement.
- Presence of a protective and reliable parent.
- The services and resources needed by the family are available and accessible in the community.
- Family has demonstrated that they can follow through with all needed services.
- Family willing and able to make necessary changes to assure safety, permanency and well-being.

Assessment Protocol

- CERAP
- Risk Assessment Protocol

Service Planning

- No safety plan needed, but may use the Risk Assessment Protocol to document needed community services for support.

Length of Service and Frequency of Contact

- The worker should remain involved with the family only long enough to ensure that family is connected with appropriate community resources for support, usually an average of 30 days.
- Some Level 2 cases will be open for DCFS services when services cannot be provided by a community referral. The worker will then follow requirements for a Level 3 short-term intact cases.
- Frequency of contact as needed to ensure that the family has been linked to community services.

Services and Resources

- Referral and connection to community resources.
- Verification that the family has followed through with referrals.

Level 3 – Short-Term Intact Services

Short-term services are indicated when there is risk to the child and when services can successfully mitigate the risk factors in an average of 75 days.

Purpose

- To ensure the safety of the children while DCFS services are being delivered.
- To enable families to resolve minor to moderate challenges and needs that are contributing to risk and safety concerns for the children in a short time frame.
- To engage the family with external community resources and extended family support.

- To equip families to effectively utilize strengths and resources to ensure the safety of their children on their own.

Outcome

- Safety is ensured and risk is minimized.
- Essential child well-being needs are met.
- Family satisfied with DCFS intervention and support.

Selection Criteria

- According to CERAP, the children are safe. No safety plan is or should be in place.
- Risk assessment indicates that family behaviors and conditions contributing to the risk to the child are of a relatively minor nature and can be effectively mitigated. Types of cases that usually are appropriate for short-term services include: environmental neglect, temporarily hospitalized parent, minor abuse or neglect (minor lack of supervision, over-discipline, minor medical needs, dependency due to short-term incarceration of parent, minor risk of harm.)
- Minimum parenting standards are being met or, if not, the parents are capable of meeting minimum parenting standards on their own after short-term intervention by DCFS.
- Family is facing challenges and needs that may have an effect upon risk and safety, including special problems such as domestic violence, substance abuse, mental illness or developmental delays. However, these are not of an overwhelming, chronic or severe nature and the family has sufficient strengths and resources to deal with them with the assistance of DCFS short-term intervention.
- If abuse or neglect was indicated, it was of low to moderate severity.
- No history of serious or chronic maltreatment.
- There is no juvenile court involvement.

- The services and resources needed by the family are available and accessible in the community.
- Family has demonstrated that they are capable of making needed changes.

The following cases are not appropriate for short-term services:

- Families newly indicated because of the birth of a substance exposed infant
- Families indicated for any abuse of a child age six or younger
- Families indicated for failure to thrive/malnutrition
- Families in which a paramour is indicated as being responsible for any abuse allegation

Assessment Protocol

- CERAP
- Comprehensive assessment
- Specialized evaluations as needed to determine prognosis and/or assess need for services

Service Planning

- Use of the CERAP to ensure the safety of the children and to plan for any short-term services that the family may need.
- Service plan that addresses the risk factors and services needed to mitigate the risks.

Length of Service and Frequency of Contact

- Services must be completed in an average of 75 days. If a longer period of service is needed, the case could be reclassified as a Level 4 – Regular Intact Services.
- Frequency of contact should be an average of weekly. The expectation would be that there would be more frequent contact during the assessment period and during crises and taper off during the termination period (the last month). Supervisors can diminish the frequency of contact but must document the reason in the case record.

Services and Resources

- Short-term interventions, such as homemaker, protective day care, crisis counseling, short-term counseling, parenting classes, supportive casework, etc.

Level 4 – Regular Intact Services

Regular intact services are indicated when there is significant risk to the child and when placement is not the necessary safety intervention.

Purpose

- To ensure the safety of the children while DCFS services are being delivered.
- To enable families to resolve moderate to significant challenges and needs that are contributing to risk and safety concerns for the children in a reasonable time frame.
- To equip families to effectively utilize strengths and resources to ensure the safety of their children on their own.

Outcome

- Safety is ensured and risk is minimized.
- Essential child well-being needs are met.
- Parents meet minimum parenting standards.
- Family satisfied with DCFS intervention and support.

Selection Criteria

- According to CERAP, children may be unsafe and in need of a safety plan. The factors threatening safety may be of a moderate to significant nature but can be controlled with a safety plan without a serious threat of child removal.
- Risk assessment indicates that family is facing challenges and needs that have an effect upon risk and safety, including special problems such as domestic violence, substance abuse, mental illness or developmental delays. However, these behaviors and conditions can be effectively controlled during intervention. The family has sufficient strengths and resources to learn to deal with them with the assistance of DCFS intervention, although some families with low risk may also need regular intact services. The family is likely to have multiple and complex child welfare needs.
- There is a need for more than short term (75 days) services.
- Minimum parenting standards are not being met, but the parents seem capable of meeting minimum parenting standards on their own or with community-based services after intervention by DCFS.
- The abuse or neglect that occurred may have been of moderate to high severity, and there may have been a history of chronic or serious maltreatment. If the abuse or neglect was severe, there is no access to child by perpetrator, or the access and/or abusive behavior of the perpetrator can be controlled through intervention.
- There may be juvenile court involvement, such as protective orders.
- All of the services and resources needed by the family may not be available and accessible in the community.

- Parents may not be ready to accept responsibility for the incident and may be resistive and unmotivated to change or to be involved with DCFS. However, there are some indications that the family is likely to be able to change with DCFS support.

Assessment Protocol

- CERAP
- Comprehensive, expanded and ongoing assessments
- Specialized evaluations as needed to assess need for services

Service Planning

- Initial and on-going service planning is always done with the Child and Family Team within the context of the family meeting. Initial service plan must be done within 45 days.
- Following the approval of the first service plan, service plan is reviewed and approved by supervisor quarterly.

Length of Service and Frequency of Contact

- Services will last an average of 12 months.
- Frequency of contact should be an average of weekly. The expectation would be that there would be more frequent contact during the assessment period and during crises and taper off during the termination period (the last month). Supervisors can diminish the frequency of contact but must document the reason in the case record.

Services and Resources

- DCFS child welfare services

- DCFS contractual services
- Community-based services through LAN referral or found through other means

Level 5 - Intensive Family Preservation Services

Intensive family preservation services are indicated when there are significant risk issues in a family and the child is at imminent risk of placement to ensure safety.

Purpose

- Primary purpose is to prevent imminent placement of child.
- To ensure the safety of the children while DCFS services are being delivered.
- To enable families to resolve moderate to significant challenges and needs that are contributing to risk and safety concerns for the children in a reasonable time frame.
- To equip families to effectively utilize strengths and resources to ensure the safety of their children on their own.

Outcome

- Safety is ensured and risk is minimized..
- Essential child well-being needs are met.
- Parents meet minimum parenting standards.
- Family satisfied with DCFS intervention and support.

Selection Criteria

Family has similar profile to families receiving regular intact services with the addition of the following characteristics:

- CERAP indicates that one or more children in the family are unsafe and at high risk of imminent placement.
- Short-term, intensive services will help the parents stabilize the situation.
- Family must have a high motivation to change.
- Family is willing to be involved in this program/level of intervention.
- Situational family crisis has led to behaviors or conduct that directly impacts on the safety of the child.
- Family has little or no support system.
- Family is cooperative with agency services.
- Family has ability to communicate to talk about their thoughts, motives and feelings so they are understood.
- All other less intensive services have been exhausted or not sufficient to avert placement.
- Family needs more intervention than those provided in the regular service intervention.
- No families with serious, debilitating substance abuse or mental health issues unless they are complying with necessary treatment for these conditions.

Assessment Protocol

- CERAP
- Risk Assessment Protocol
- Comprehensive, expanded and ongoing assessments

- Specialized evaluations as needed to assess need for services

Service Planning

- Initial and ongoing service planning is done with the Child and Family Team within the context of a family meeting

- After approval of the initial service plan, service plans are reviewed and approved by the supervisor quarterly.

Length of Service and Frequency of Contact

- Up to six months with a 3 month extension.
- Frequent family contact, at least weekly by permanency worker.
- Family Preservation worker will work with the family up to 20 hours per week.

Services and Resources

- Low caseloads
- Intensive services, immediately available
- Emphasis on one-on-one relationship with family and more in-home services.

Level 6 – Substitute Care

There are severe risks and/or safety issues that cannot be adequately controlled or mediated through service provision and necessitate the removal of the child from his or her caregivers via a juvenile court order. The case will receive permanency services.

APPENDIX C
CLIENT RIGHTS AND RESPONSIBILITIES

Clients have the right to:

- Receive quality services in a respectful manner without discrimination.
- Make an informed choice of services.
- Know the qualifications of staff who provide them with services.
- Receive and understand information and instructions about their service needs.
- Consent to or refuse services before they are provided.
- Know the nature and purpose of services.
- Refuse services with the receipt of information and the consequences of refusal.
- Be informed prior to any transfer or discharge from services.
- Expect confidentiality of information and protection of their child welfare records.
- Receive timely response to their needs along with reasonable continuity and coordination of services.
- Know about charges for services.
- Know how to voice any grievance about their services.
- Receive services based on an individual service plan.
- Be part of the process of updating the service plan when his/her needs change.
- Receive all services at DCFS or be referred to another agency.

Clients have the responsibility to:

- Give accurate information about their mental health, substance use, and domestic violence issues as well as other circumstances which might impact upon the care of their children.
- Assist by making and keeping a safe environment.
- Notify the agency if scheduled appointments need to be changed.
- Notify the agency if there is a change in your living arrangements.
- Work with staff in planning, reviewing and changing their individual service plans.
- Inform staff immediately if they have any concerns or problems with the service they are receiving.

I have reviewed and understand my rights and responsibilities and have been informed that my individual service plan will be developed. Also, I have received and have had explained to me the Service Appeal Process brochure.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

I may be contacted for follow-up information as part of agency program evaluation and quality improvement. This usually constitutes client satisfaction surveys. Any and all information is strictly confidential. A sampling of clients is included in follow-up activities about what has happened positive and negative due to service. If I refuse to be included this will not impact services.

_____ Yes, it is OK to include me _____ No, please do not include me

APPENDIX D: PLANNING FOR FAMILIES IN CRISIS

When dealing with families who tend to experience more than the average number of crises, it is advantageous to both the family and the worker to establish a plan of action to deal with these situations before they arise. Many families that are identified as high-risk (e.g., those in which the stress level is high such as single parents, teenage parents, parents who are mentally ill/mentally retarded, parents who are addicted to drugs/alcohol, etc.) experience frequent crises in their lives. Planning ahead for crises that have a high likelihood of occurring not only empowers the family but also teaches them problem-solving skills. Additional benefits of crisis planning may include decreased subsequent oral reports, placement prevention, enhanced child safety, greater utilization of community resources, improvement in the cooperation of families, less impulsive decision-making, and the beginning of aftercare planning.

Features of Effective Crisis Plans

(Adapted from the Wraparound Planning Training Manual, Spring 1995)

- Effective crisis plans anticipate crises based on past knowledge. The best predictor of future behavior is past behavior.
- Great crisis plans assume the worst case scenario and plan accordingly.
- As you build a crisis plan, always research past crises for the cause, the precipitating factors, and the consequences that followed.
- Effective plans include child and family outcomes as measures of when the crisis is over.
- Good crisis plans acknowledge and build on the fact that crisis is a process with a beginning, a middle, and an end rather than just a simple event
- Crisis plans change over time based on what is known to be effective.

- Clearly negotiated crisis plans with clear behavioral measures help families function in difficult times.
- Behavioral measures need to change over time to reflect progress and changing capacities and expectations of the youth and family.

Practice Guidelines for Building Effective Crisis Plans

- Always build plans that are prioritized for different levels of intensity and severity of crisis events (small crises do not require the same response as big crises).
- Build crisis plans early in the life of the case so they are in place when crisis occurs
- Be sure to ask the child and family what can go wrong with the whole plan as the first step in building the crisis plan. They know best what can go wrong.
- Build a crisis plan for a 24-hour response. Crises seldom occur when it is convenient.
- Build and clearly define roles for family members (including the children as age-appropriate) and natural support persons as they are likely to be most responsive during a crisis.
- Create time for the family, the worker, and the support participants to assess their management of a crisis.
- Establish a rule that no major decisions (except those relating to child safety) can be made until at least 72 hours after the crisis has passed in order to keep the family from overreacting to an event.
- Review the plan that has been developed.

Questions that Workers May Explore when Developing Crisis Plans

- Does the family have access to a telephone?

- Does the family have emergency phone numbers (e.g. police, domestic violence shelters, crisis lines, hotlines)?
- Are there any neighbors who can assist during a crisis?
- Who are the support persons for the family?
- Do they have means of transportation if they must vacate the residence (e.g.
- hidden car keys, money to call a cab, etc.).
- If it is necessary to separate family members during a crisis, are there resources (such as relatives' homes, etc.) for this?
- Assess the various relationships of the family members and how these could impact upon the crisis.

APPENDIX E
MINIMUM PARENTING STANDARDS

Per Departmental Rule and Procedure, "minimum parenting standards" means that:

> "A parent or other person responsible for a child's welfare sees that the child is fed, clothed appropriately for the weather conditions, provided with adequate shelter, protected from severe physical, mental and emotional harm, and provided with necessary medical care required by law. A parent who has abandoned a child, deserted a child for three months, or failed to demonstrate a reasonable degree of interest, concern, or responsibility as to the welfare of a newborn child for 30 days after birth is deemed to have failed to have met the minimum parenting standards. In addition, a parent who is addicted to alcohol, or who is a drug addict, as defined in the Illinois Alcoholism and Other Drug Dependency Act (Ill. Rev. Stat. 1989, Ch. 111-½, par. 635.1-3) and who has consistently failed to cooperate in a rehabilitation program for a period of at least 12 months is deemed to have failed to have met the minimum parenting standards unless the child's safety and well-being have been ensured despite the parent's addiction."

The Department believes this definition correctly supports the notion that public child welfare services should be the least intrusive and as short-term as necessary to assure a child's protection and permanency.

APPENDIX F: IN-HOME PROTECTIVE SERVICES PROTOCOLS

Introduction

Protocols have been developed to guide the activities of Department and POS staff as they provide services to protect children in their own homes. These protocols are organized according to the issues most commonly presented in In-home cases. The first eleven are related to indicated allegations. They are:

- Concrete Need (Allegations: 76, 77, 78, 82)
- Medical Issues (Allegations: 79, 81, 83, 85)
- Sexual Abuse (Allegations: 18, 19, 20, 21, 22)
- Severe Physical Abuse (Allegations: 1, 2, 4, 3, 7, [always]; Allegations: 5, 6, 9, 12, 13, 14, 16 [almost always]; Allegation: 11 [sometimes])
- Moderate Physical Abuse (Allegation: 11 [usually], Allegations: 5, 6, 9, 12. 13. 14, 15 &16 [rarely])
- Neglect resulting in physical injury (Allegations: 51, 52, 53, 54, 55, 56, 57, 59, 61, 62, 63,65 (Parent's who neglectfully allow their children access to prescription medication/illegal drugs/alcohol.)]
- Substantial risk of physical injury (Allegation: 10)
- Mental injury (Allegation: 17)
- Substance misuse (Allegation: 65 Substance Exposed Infants)

- Neglect related to supervision (Allegations: 74, 75, 84)

The remaining five concern the conditions most likely to underlie child maltreatment. They are:

- Alcohol and other Drug Abuse
- Mental Illness
- Developmental Delay
- Domestic Violence
- Poor Parenting Practices Resulting from Lack of Information, Immaturity, Inexperience or Inappropriate Learned Behavior

At least one and usually several of these protocols will apply to every case. Each protocol includes four sections: 1) Activities the worker will conduct in order to detect or control reoccurrence or persistence of the abuse, neglect, or the condition that may have caused it, 2) The services that are most likely to be applicable to address relevant issue, 3) required frequency of contact with children and caregivers, and 4) criteria for case closing.

As the supervisor and caseworker prepare for the transitional visit, the protocols are to be reviewed and those relevant to the case are to be identified. The activities in the relevant protocols are to be considered mandatory. However, supervisors may waive activities or alter the frequency with which they must be conducted based on 1) the specific issues presented by individual cases, 2) the availability of particular resources, or 3) the families' refusal to consent to activities requiring consent. In the event that any of the activities on a relevant protocol is waived, the supervisor must document the fact that it is being waived and the specific reason for the waiver on a supervisory note included in the case record. All activities that are not waived are to be included as components of the service plan.

Throughout the life of the case, whenever a CERAP or risk assessment is completed, the supervisor and caseworker must consider whether any protocols that concern the

conditions most likely to underlie child maltreatment have become relevant or irrelevant to the case. If so, required activities should be added or eliminated accordingly. Protocols related to indicated allegations must be added if new allegations are indicated as the result of subsequent reports during the provision of services. They may not be eliminated until case closure.

Activities included in the protocols are to be considered minimal requirements. Service plans are to include other activities as dictated by the needs of particular cases.

Some of the activities included in the protocols will require the consent of the family. These should be discussed with the family at the transitional visit, at service planning, and whenever activities are being added. Worker must explain to the family the reason for conducting such activities and the potential consequences of their refusal to consent to them.

Concrete Needs

Allegations

Inadequate Food (76)

Inadequate Shelter (77)

Inadequate Clothing (78)

Environmental Neglect (82)

Efforts to detect or control recurrence

Assure that the family has the financial wherewithal to provide for the child(ren)'s concrete needs.

Observation of relevant areas of the environment:

- If inadequate food, observe food in the house. Is the amount and type of food sufficient? Is parent able to prepare meals?

- If inadequate clothing, observe the clothing that children have and observe that the clothes that they wear are appropriate for the weather, condition and quantity of clothing, whether clothing appropriately fits the children

- If inadequate shelter or environmental neglect, observe the home environment for obvious hazards and dangerously unsanitary conditions

Interview the children apart from the caregiver. **Discuss with children** whether relevant concrete needs are being met.

Minimum Frequency: weekly during the comprehensive assessment period (first 45 days); twice per month thereafter

Interview relevant collaterals such as the school or extended family who may have information relevant to the provision of concrete needs.(Requires the consent of the family)

Minimum Frequency: bi-monthly

Interview service providers about whether and how the family's is providing for the relevant, concrete needs to the children.(Requires the consent of the family)

Minimum Frequency: monthly

Services To Address The Concrete Needs

Consult and review applicable Treatment Paths and supporting documentation.

Consider Norman certification and services.

Actively assist the family in obtaining and maintaining adequate food, clothing and shelter:

- For inadequate food, activities include (but are not limited to): locating food pantries, registering children in WIC, helping the family apply for public assistance, teaching the family to budget, provide nutritional education, obtaining homemaker services.

- For inadequate clothing, activities include (but are not limited to): locating affordable clothing (thrift stores, clothing depositories), helping family to care appropriately for clothing, obtaining homemaker services.

- For inadequate shelter, activities include (but are not limited to): housing advocacy, helping family apply for Section 8 and public housing, transporting family to locate housing, helping family to locate shelters, home repair services, obtaining homemaker services.

- For environmental neglect, activities include (but are not limited to): assisting family to arrange for exterminators, cleaning service, obtaining homemaker services

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.

Criteria For Closing

- The children's concrete needs are met

- Parents have demonstrated their ability to meet the children's needs either independently or with the help of established network on an ongoing basis. The parents have demonstrated this ability consistently for three months.

Allegations Related to Medical Intervention

Allegations

Medical Neglect (79)

Failure to Thrive (81)Malnutrition (83)

Medical Neglect of Disabled Infants (85)

Efforts to detect or control recurrence

Ensure that family has a consistent medical provider and that he/she is aware of the reported condition.

Minimum Frequency: within five working days of transitional visit

Contact the primary physician to determine prescribed course of treatment (including medications and equipment) and to arrange for ongoing exchange of information.

Minimum Frequency: within five working days of transitional visit

Contact the medical provider to ensure that the family is keeping medical appointments and is otherwise adhering to medically prescribed treatment and to check on the child's medical progress.

Minimum Frequency: supervisor and worker will develop a plan that will correspond to the expected frequency of prescribed medical interventions. (The plan will be recorded on a case entry note and the service plan.)

If available and indicated, **arrange for nursing services** (DCFS. public health, private visiting nurses or contracted nursing services) to assist the worker in determining whether the child's medical needs are being adequately met.

- For failure to thrive babies, the nurse should weigh and observe them to detect signs of dehydration and other apparent medical problems

Minimum Frequency: supervisor and worker will develop a plan that will correspond to the medical issues presented in the case. (The plan will be recorded on a case entry note and the service plan.)

Observe whether prescribed medications and medical equipment have been obtained.

Minimum Frequency: at every home visit.

HOME VISITS

Minimum Frequency: Weekly

To Address The Medical Needs

- **Consult and review applicable Treatment Paths and supporting documentation.**

- Assist the family with transportation to medical appointments. This may include workers transporting family to medical appointments, especially during the assessment stage.

- Advocate with the Department of Human Services, other third party payors, or private or public programs (e.g., Division of Services for Special Children, charitable organizations) regarding payment of health care costs and provision of equipment.

- Refer for homemaker and/or nursing services if necessary.

- Assist the family to arrange for childcare to enable them to attend medical appointments.

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.

Criteria For Closing

1. The child's primary medical provider verifies that the child's medical and nutritional needs have been met.
2. Medical specialist treating conditions related to the indicated allegations verify that the child's/medical/nutritional/psychiatric needs are met.
3. Parents have consistently demonstrated their ability to meet the child's medical/nutritional/psychiatric needs for a period of six months.

4. Worker has verified that medical providers are aware that the department's case is being closed and that the provider will notify SCR of any future suspicion of neglect.

5. Parents demonstrate an understanding of potential harm if the child's medical/nutritional/psychiatric needs are not met.

Sexual Abuse Allegations

Allegations

Sexually Transmitted Diseases (18)

Sexual Penetration (19)

Sexual Exploitation (20)

Sexual Molestation (21)

Substantial Risk of Sexual Injury (22)

Efforts to detect or control recurrence

Interview verbal children away from caregivers to determine whether (a) there has been repeated abuse or (b) whether or not the perpetrator has had access to the child in violation of any court order, safety plan or service plan. Engage child by clarifying that worker's primary role is to ensure the child's safety and protect the child from further abuse.

Minimum Frequency: at every visit with the child

Be aware of signs that may indicate re-abuse such as runaway behavior or suicidal behavior.

Minimum Frequency: at every visit with the child

Home visits, including unannounced home visits, to detect the presence of the perpetrator in violation of any court order, safety plan or service plan.

Minimum Frequency: weekly (throughout life of case), half of them unannounced

Contact school personnel or other collateral sources who may have relevant information to determine whether family members have reported that perpetrator has had access to the child.

Minimum Frequency: monthly

Contact service providers to determine whether family members have reported that perpetrator has had access to the child, to determine whether clients are keeping appointments, whether parents are receptive, parents' level of resistance, parents' progress and indications that non-offending caregiver is willing and able to protect the child.

Minimum Frequency: monthly

For sexually transmitted diseases, contact medical provider to determine that prescribed treatment has been obtained.

Minimum Frequency: within five working days of the transitional visit. Supervisor and worker will develop a plan that will correspond to the expected frequency of prescribed medical interventions. (The plan will be recorded on a case entry note and the service plan.)

Services To Address The Family's Needs Related To Sexual Abuse

Consult and review applicable Treatment Paths and supporting documentation.

Refer child victim to sex abuse assessment and psychotherapy.

Refer perpetrator for sex offender assessment and sex offender psychotherapy (group, individual).

Arrange mental health services (e.g. counseling, support/education groups) for non-offending caretaker to understand the child's victimization and the caretaker's role in providing ongoing protection to the child(ren).

Provide and assist with advocacy resources for non-offending caregiver (e.g. housing, transportation, and court process).

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.
- There is reason to believe that the alleged perpetrator may have access to any of the children in the home.

Criteria For Closing

1. Non-offending caretaker: a) believes that the child was sexually abused, b) understands his/her role in protecting the child, and c) has consistently protected the child for a period of at least six months.

2. Non-offending caretaker will not allow the alleged perpetrator access to the child as evidenced by (when applicable) divorce action, protective order, and/or cooperation with criminal prosecution.

3. Older children have access to at least one specified adult outside of the home to whom they can report reoccurrence of sexual abuse and specified adult is aware of this role and will assume responsibility to report to SCR.

Severe Physical Abuse

Allegations

The distinction between severe and moderate physical abuse is that in severe physical abuse, the perpetrator cannot have access to the child. This will be determined by court orders or safety plans devised by the CPSW. In situations where, because of decisions made by the State's Attorney or the court, the Department lacks the legal wherewithal to prevent access to the child by the perpetrator, cases indicated for any of the allegations listed in this protocol must be treated as moderate physical abuse.

The following allegations must always be treated as severe physical abuse:

- Death (1)
- Head injuries (2)
- Internal injuries (4)
- Poison/noxious substances (6)
- Wounds (7)
- Torture (16)

The following allegations are most often to be treated as severe:

- Bone fractures (9)
- Sprains/dislocations (13)
- Burns/scalding (5)

- Human bites (12)

- Tying/close confinement (14)

Bone fractures (9) and Sprains/dislocations (13) may be treated as moderate only when the victims are older (over 14), the injury is comparatively minor, the injury was the result of an altercation with a family member and no implement was used.

Burns/scalding (5), Human bites (12) and Tying/close confinement (14) may be treated as moderate only when the sole underlying cause is related to poor parenting as a result of lack of information, immaturity or inappropriate learned behavior.

Cuts, bruises and welts (11) must be treated as severe physical abuse when the child victim is under the age of 2 and the injuries are to the child's head/face or cover extensive portions of the child's body or the totality of the circumstances suggests that the abuse presents an exceptionally high threat to the child's safety.

Efforts to detect or control recurrence

Interview verbal children away from caregivers to determine whether (a) there has been repeated abuse or (b) whether or not the perpetrator has had access to the child in violation of any court order, safety plan or service plan.

Minimum Frequency: at every visit with the child

For non-verbal children, with the parents' consent and participation, observe the child's body to detect signs of ongoing abuse.

Minimum Frequency: at every visit with the child

Conduct home visits, including unannounced home visits, **to detect the presence of the perpetrator in violation of any court order, safety plan or service plan.**

Minimum Frequency: weekly (throughout life of case)take out, half of them unannounced

Contact State's Attorney or correctional personnel **to determine whether there have been any changes in the perpetrator's incarceration status or in bond or probation orders.**

Contact school personnel or other collateral sources **who may have relevant information to determine whether family members have reported that perpetrator has had access to the child.**

Minimum Frequency: monthly

Contact service providers to determine whether family members have reported that perpetrator has had access to the child and to determine whether clients are keeping appointments.

Minimum Frequency: monthly

Ensure that family has a consistent medical provider and that he/she is aware of the reported condition.

*Minimum Frequency**:*** within five working days of transitional visit

Contact the primary physician to determine prescribed course of treatment (including medications and equipment) and to arrange for ongoing exchange of information.

Minimum Frequency: within five working days of transitional visit

Contact the medical provider to ensure that the family is keeping medical appointments and otherwise adhering to medically prescribed treatment and to check on the child's medical progress.

Minimum Frequency: supervisor and worker will develop a plan that will correspond to the expected frequency of prescribed medical interventions. (The plan will be recorded on a case entry note and the service plan.)

Services to address the Child and Family's needs related to Severe Physical Abuse

Consult and review applicable Treatment Paths and supporting documentation.

Arrange mental health services (e.g., counseling, support/education services) to the non-offending caregiver to ensure that he/she is capable of providing adequate protection and care for the child.

Assist the family with transportation to medical appointments. This may include workers transporting family to medical appointments, especially during the assessment stage.

Advocate with the Department of Human Services, other third party payors, or private or public programs (e.g., Division of Services for Special Children, charitable organizations) regarding payment of health care costs and provision of equipment.

Assist the family to arrange for child care to enable them to attend medical appointments.

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or

- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.
- There is reason to believe that the alleged perpetrator may have access to any of the children in the home.

Criteria For Closing

1. Non-offending caretaker: a) believes that the child was severely physically abused, b) understands his/her role in protecting the child, and c) has consistently protected the child for a period of at least six months.

2. Non-offending caretaker will not allow the alleged perpetrator access to the child as evidenced by (when applicable) divorce action, protective order, and/or cooperation with criminal prosecution.

3. Older children have access to at least one specified adult outside of the home to whom they can report reoccurrence of severe physical abuse and specified adult is aware of this role and will assume responsibility to report to SCR.

4. The child's primary physician and medical specialists treating conditions related to the indicated allegation have verified that medical needs are being met.

5. The worker has verified with medical providers and extended family/support network that the case is being closed and that providers will notify SCR of any future suspicion of child abuse and neglect.

Moderate Physical Abuse

Allegations

The distinction between severe and moderate physical abuse is that in severe physical abuse, the perpetrator cannot have access to the child. This will be determined by court orders or safety plans devised by the CPSW. In situations where, because of decisions made by the State's Attorney or the court, the Department lacks the legal wherewithal to prevent access to the child by the perpetrator, cases indicated for any of the allegations listed in this protocol must be treated as moderate physical abuse.

Cuts, bruises and welts (11) may be treated as moderate physical abuse unless the child victim is under the age of 2 and the injuries are to the child's head/face or cover extensive portions of the child's body or the totality of the circumstances suggests that the abuse presents an exceptionally high threat to the child's safety, in which case it must be treated as severe physical abuse.

Burns/scalding (5), Human bites (12) and Tying/close confinement (14) may be treated as moderate only when the sole underlying cause is related to poor parenting as a result of lack of information, immaturity or inappropriate learned behavior.

Bone fractures (9) and Sprains/dislocations (13) may be treated as moderate only when the victims are older (over 14), the injury is comparatively minor, the injury was the result of an altercation with a family member and no implement was used.

Efforts to detect or control recurrence

Interview verbal children away from caregivers to determine whether there has been repeated abuse.

Minimum Frequency: at every visit with the child

For non-verbal children, with the parents' consent and participation, observe the child's body to detect signs of ongoing abuse.

Minimum Frequency: at every visit with the child

Conduct home visits, including unannounced home visits, to deter ongoing abuse.

Minimum Frequency: weekly (throughout life of case) take out, half of them unannounced

Contact school personnel or other collateral sources who may have relevant information to determine whether they have seen signs of ongoing abuse.

Minimum Frequency: monthly

Contact service providers to determine whether they have seen signs of ongoing abuse.

Minimum Frequency: monthly

Services to address the Child's and Family's needs related to moderate physical abuse

Consult and review applicable Treatment Paths and supporting documentation.

Arrange mental health services (e.g., counseling, support/education services) to the caregiver(s) to:

- ensure that he/she is capable of providing adequate protection and care for the child
- help parent(s) learn alternative forms of discipline
- treatment addressing
- help parent(s) understand and manage the child's behaviors that may have precipitated or provoked the abuse
- help parent(s) understand reasonable expectations for the child given the child's developmental level

Arrange for evaluation, mental health services or other services for the child to identify and manage problematic behaviors that may have provoked the abuse.

Assist the parent(s) in locating day care, after-school programs, recreational programs or other opportunities for the parent(s) to have respite, including extended family involvement.

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.

Criteria For Closing

1. The child is not afraid of parent's caregivers evidenced by observation, collateral contacts and private interviews with verbal children.

2. No significant evidence of physical abuse for a period of 6 months.

3. Parents consistently demonstrated non-abusive forms of discipline -- as evidenced by observation, collateral contacts and private interviews with verbal children -- for a period of 3-6 months.

4. Older children have access to at least one specified adult to whom they can report reoccurrence of abuse and the adult is aware of this role and will assume resume responsibility to report to SCR.

5. Major stressors identified in the assessment as contributing to the abuse have been resolved or mitigated.

Substantial Risk of Physical Injury

Allegation

Substantial risk of physical injury (10)

Efforts to detect or control recurrence

Interview verbal children away from caregivers to determine whether there has been repeated abuse.

Minimum Frequency: at every visit with the child

For non-verbal children, with the parents' consent and participation, observe the child's body to detect signs of ongoing abuse

.

Minimum Frequency: at every visit with the child

Conduct home visits, including unannounced home visits, to determine ongoing abuse and to determine whether there are safety hazards (guns, drugs, etc.) in the home.

Minimum Frequency: weekly (throughout life of case) take out, half of them unannounced

Contact school personnel or other collateral sources who may have relevant information to determine whether they have seen signs of ongoing abuse.

Minimum Frequency: monthly

Contact service providers to determine whether they have seen signs of ongoing abuse.

Minimum Frequency: monthly

Other efforts to detect or control recurrence will depend on the underlying cause(s) and other indicated allegations.

Services to address the Child's and Parent's needs related to Substantial Risk of Physical Injurgy

Consult and review applicable Treatment Paths and supporting documentation.

Arrange or provide psychotherapy, counseling or other services to the caregiver(s) to:

- ensure that he/she is capable of providing adequate protection and care for the child
- help parent(s) learn alternative forms of discipline
- help parent(s) understand and manage the child's behaviors that may have precipitated or provoked the abuse
- help parent(s) understand reasonable expectations for the child given the child's developmental level

Arrange for evaluation, psychotherapy or other services for the child to identify and manage problematic behaviors that may have provoked the abuse.

Assist the parent(s) in locating day care, after-school programs, recreational programs or other opportunities for the parent(s) to have respite, including extended family involvement.

Other services will depend on the underlying cause(s) or other indicated allegations.

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment

period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.

Criteria For Closing

1. Parents/caretakers understand and accept their responsibility for the protection of their children as evidenced by their behaving in a consistently and appropriate protective manner for at least 6 months verified by private interviews with children, collateral contacts and worker's observation.

2. The condition that subjected the children to substantial risk of physical harm has been removed or mitigated as evidenced by the fact that no child has been harmed as the result of the condition for at least 6 months.

Neglect Resulting in Physical Injury

Allegations

Death (51)

Head injuries (52)

Internal injuries (54)

Burns/scalding (55)

Poison/noxious substances (56)

Wounds (57)

Bone fractures (59)

Cuts, bruises and welts (61)

Human bites (62)

Sprains/dislocation (63)

Note: While the investigation yielded evidence that one of these injuries was the result of neglect, the worker must remain cognizant of the possibility that the injuries were in fact the result of abuse. If new evidence is obtained suggesting that the injury was the result of abuse, the worker must contact SCR and complete a new CERAP.

Efforts to detect or control recurrence

Interview the child (if verbal) apart from caregiver to determine whether neglect is ongoing.

Minimum Frequency: every time child is seen

With the consent and participation of the parent, observe the non-verbal child for signs of ongoing neglect and injuries.

Minimum Frequency: monthly

Make home visits, including unannounced home visits, to observe the home environment for safety hazards (e.g., unguarded radiators, iron within reach of child) that would cause injury.

Minimum Frequency: weekly

Contact school personnel, extended family members or other collateral sources who may have relevant information to determine whether they have seen signs of ongoing neglect or injuries.

Minimum Frequency: monthly

Contact service providers to determine whether they have seen signs of ongoing neglect or injuries.

Minimum Frequency: monthly

Contact the regular medical provider to determine whether he/she has seen signs of ongoing neglect or injuries.

Services to address the child's and parent's needs relating to neglect resulting in physical injury

Consult and review applicable Treatment Paths and supporting documentation.

Arrange mental health services (e.g., counseling, support/education services) to the caregiver to:

- ensure that he/she is capable of providing adequate protection and care for the child
- help parent(s) understand reasonable expectations for the child given the child's developmental level

Assist the parent(s) in locating day care, after-school programs, recreational programs or other opportunities for the parent(s) to have respite, including extended family involvement.

Other services are dependent upon the underlying cause.

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or

- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.

Criteria For Closing

1. Parents/caretakers understand and accept their responsibility for the protection of their children as evidenced by their behaving in a consistently and appropriate protective manner for at least 6 months verified by private interviews with children, collateral contacts and worker's observation.

2. If the physical injury resulting from neglect required medical intervention, worker verifies from medical providers that proper medical care has been obtained.

3. Any dangerous conditions in the environment that contributed to the child's injury have been removed or corrected.

Neglect Related To Supervision

Allegations

Inadequate Supervision (74)

Abandonment/Desertion (75)

Lockout (84)

Efforts to detect or control recurrence

Home visits, including unannounced home visits, to detect/deter ongoing neglect

- during the home visit the parent/caregiver and the children should be seen/observed
- observe evidence that situations that trigger the neglect continue to exist. For example, mother exhibits signs of being overwhelmed and needing to leave the children, resulting in them being left alone.

Minimum Frequency: Weekly (throughout life of the case) take out, half of them unannounced and at different times of day.

Ensure that the parent(s)/caregiver has an appropriate and consistent care plan in place, including the name, address and telephone number of the substitute caregiver. Plan should also include a back-up or contingency plan in the event hat the primary plan is not viable.

- Contact participants in the child care plan to assure that the plan remains in place, that it is effective and to determine if they have information that the neglect has continued.

Minimum Frequency: Semi-monthly

Interview verbal child(ren) apart from the caregiver to determine level of care, and assess risk/safety provided to the child(ren) by the parent/caregiver.

Minimum Frequency: At every visit with the child

In addition to quarterly family meetings**, interview relevant collaterals, such as school personnel and extended family** regarding relevant information to determine whether there has been repeated neglect

Minimum Frequency: Monthly

Contact service providers to determine whether family members have reported further incidents of neglect as well as ascertaining family's active involvement in services.

Minimum Frequency: Monthly

Services to address the Child's and Family's needs related to Supervision:

Consult and review applicable Treatment Paths and supporting documentation.

Arrange mental health services (e.g., counseling, support/education services) to the caregiver to:

- ensure that he/she is capable of providing adequate supervision, protection and care for the child (ren)
- help parent(s)/caregiver to understand and manage the child's behavior that may have precipitated or provoked the neglect
- help parent(s)/caregiver to understand/learn reasonable expectations for the child (ren) given the child's developmental level
- help parent(s)/caregiver understand the dangers of leaving the child unsupervised.

Arrange for evaluation, mental health services (e.g., counseling, support-education), or other services for the child to identify and mange problematic behavior that may have provoked neglect

Assist the parent(s)/caregiver in locating day care, after school programs, recreational programs or other opportunities for the parent(s)/caregiver to have respite, including extended family involvement.

If available, the worker shall participate in any sessions that may be requested by the service provider

Ensure that appropriate consents are secured for release of information

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.

Criteria For Closing

1. Parents/caretakers understand and accept their responsibility for providing supervision for their children as evidenced by their provision of adequate supervision for a period of three to six months.

2. Parents understand and are able to describe to the worker the degree of independence appropriate for their child, taking into consideration each child's age, development, and special needs.

3. Parents have appropriate specific plans for child care that consider the family's usual schedule and that has been verified by the worker.

4. Parents have potential appropriate resources for child care if an emergency or unusual circumstance arises which have been verified by the worker.

Abuse or Neglect Related to Substance Misuse

Allegation Substance Misuse Services to Address the Needs related to abuse or neglect related to Substance Misuse

Consult and review applicable treatment paths and supporting documentation.

Complete an adult substance abuse screen (CFS 440-5) if one has not been previously completed or the facts of the case warrant a new screen being completed.

Refer parent to an agency listed in the Directory of OASA/DCFS Initiative Providers. If there is not an OASA/DCFS Iniatiative provider in the area, refer the adult to the nearest OASA funded provider for an assessment.
Call the AODA provider for the adult and set up the assessment appointment. Provide the referral information to the adult in writing.

Work assertively and closely with parent and treatment provider to ensure parent is given every opportunity to begin/cooperate with assessment and treatment. If possible, provide transportation to the intial intake appointment to ensure attendance.

Follow up with the AODA treamtment provider to assure that the appointment was kept and to schedule an initial case staffing to discuss joint service planning.

Set up monthly staffings with treatment counselor and client to continually assess progess, determine level of care transitions, and to ensure aftercare plans along with relapse plans are in place.

Provide/refer adults to complete random urinalysis as recommended by treatment provider (Discuss and consider results with supervisor and treatment provider)
Refer extended family members and significant others for alcohol and other drug education programs.

Work with the parent to engage extended family members in providing support to the parent in drug treatment and assisting in parenting responsibilities, if needed.

Assist the parent in locating day care, after-school programs and recreational programs, including the use of extended family, while the parent attends alcohol and other drug treatment, including AA and NA meetings.

When an infant is substance exposed, arrange for home visits by a public health nurse and maintain monthly contact with him/her. Ensure all children receive appropriate medical care.

Assist the family with transportation to medical appointments and other services.

Assist parents in getting their infant a 0-3 evaluation and, if necessary, enrollment in an early intervention program to prevent developmental delays (SEI infant).

Assist parent in getting health care and family planning, including HIV testing and treatment.

Refer family for housing, utilities, furnishings and food as needed. Consider Norman certification and services.

Refer parent to interactive parenting program once recovery has been sustained.

Efforts to Detect or Control Recurrence

Contact substance abuse treatment provider to obtain information about the parent's treatment plan, to share information about the client's treatment, to invite the provider to the family meeting and to request that the service provider advise the worker of the parent's non-compliance with treatment.

Minimum Frequency: at least monthly

Assure that there is a consistent medical provider (for allegation 65) and find out what the child's treatment plan is.

Contact medical provider to determine whether parent is following the prescribed treatment plan for the child.

Contact substance abuse treatment provider to determine parent's compliance and progress with alcohol and other drug treatment requirements.

Minimum Frequency: bi-weekly

Contact other service providers to determine if parent is cooperating and using service appropriately.

Minimum Frequency: monthly

Make home visits, including unannounced visits, to observe the home environment to check for any signs that the parent has resumed using alcohol or other drugs. (Observe behavior of parent, condition of the home, drug paraphernalia or alcoholic beverage containers, strangers in the home, children unkempt or not fed)

Minimum Frequency: weekly

Complete CANTS/LEADS on all adult caregivers in the home or providing childcare.

Minimum Frequency: Whenever additional adults move into the home and at case closure.

Interview verbal children away from caregivers to determine if parent has resumed use of alcohol and other drugs and is able to care for children

Minimum Frequency: weekly

Contact extended family, school personnel or other collaterals sources that may have relevant information to determine whether they have seen signs of alcohol or other drug abuse by parent and parent's ability to care for their children.

Minimum Frequency: monthly

Ensure that the child has a non-substance impaired adult available as a resource in the even that the parent suddenly relapses. For example, extended family members or clergy.

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.
- For SEI child, there is not a consistent medical provider and parent is following the prescribed treatment plan for the child
- There i not a non- substance impaired adult available as a resource in the event that the parent suddenly relapses

Criteria for Closing (In accordance with SAF policy 99.13)

1. The children show evidence of improved care, i.e in the areas of health care, supervision and responsiveness by the parent.

2. There is not risk to the child as indicated by the safety assessment.

3. There have been no additional indicated hotline reports for _____6_____months.

4. The parent has had negative urinalysis reports for the past _____3_____months.

5. LEADS check is free of current drug related charges.

6. The child(ren) have access to at least one specified adult outside of the home to whom they can call for assistance in the event of inappropriate activities related to substance misuse and the specified adult is aware of this role and will assume responsibility to report to SCR if there is reasonable cause to suspect child abuse or neglect.

7. Parents have been fully engaged in the recovery process for the past _____6____months or

    - Substance abuse issues have been addressed and no longer represent risk to the child(ren) or

    - In those cases where the parent does not successfully complete substance abuse treatment, but does provide and meet the physical and emotional needs for the child, and the worker is able to verify the safety and well being of the child(ren).

Mental Injury

Allegation

Mental Injury (17)

Efforts to detect or control recurrence

Observe the interaction between parent and child to look for evidence that child continues to be fearful of parent/caregiver, look for evidence of parent's unrealistic expectations of child, calling the child derogatory names or belittling the child.

Minimum Frequency: every visit

Interview the children apart from the caregivers to discuss the nature of the parent's interaction with the child.

Minimum Frequency: every visit.

Interview relevant collaterals such as extended family or school personnel, who may have information relevant to the current treatment of the child by the perpetrator and/or information about the child's current functioning as it relates to inter-family relationships or school performance.

Minimum Frequency: within 5 days of transitional visits and monthly thereafter.

Interview service providers to determine consistency in attending services and/or ensuring that child attends services, progress in treatment and to determine if they have any knowledge that the abuse/neglect is continuing.

Minimum Frequency: within 5 days of transitional visit if referral has been made prior to the transfer of the case. (If the referral has not been made then the worker shall make the referral and shall speak with the provider in person or over the phone upon making the referral to apprise them of the areas of concern and reason for referral); monthly thereafter.

Conduct home visits, including unannounced visits, to deter the behavior that resulted in the mental injury.

Minimum Frequency: monthly.

Services to address the needs

Arrange psychotherapy, counseling or other services for the caregivers in order to:

- Learn alternative forms of discipline
- Help caregivers understand and manage the child's behaviors that may have precipitated or provoked the abuse/neglect.
- Help caregivers understand reasonable expectations for the child, given the child's developmental level.
- Help the caregivers manage their anger and or frustration in a more productive, less harmful way.
- Help the caregivers identify the positive attributes of a child and build on those.
- Help the caregivers identify and manage any underlying mental illness, i.e., depression that may have increased the likelihood that harmful management of a child could occur, by appropriate referrals as necessary.

Arrange for evaluation, psychotherapy, or other services for the child to identify and manage problematic behaviors that may have provoked the abuse and to assist the child in coping with the behaviors inflicted upon him that caused the mental injury and to express his/her feelings regarding those behaviors in a positive way while building self-esteem.

Assist the caregiver(s) in locating day care, after school programs, recreational programs or other opportunities as a way to provide the caregivers respite, including extended family involvement.

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.
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Criteria for Case Closing

- **Child's intellectual, emotional or psychological functioning/development is restored to pre-SCR report level as evidenced by observation, collateral contacts including**

providers of mental health services (*e.g.*counselors, parenting/education support providers, psychiatrists, or psychologists) and interviews with verbal children. Improved functioning/ development must be observed for a period of 6 months.

- **The child is not afraid of parents/ caregivers as evidenced by observation, collateral contacts, and interviews with verbal children.**

- **Mental health service providers(*e.g.* counselors, parenting educators, support providers, psychologists, psychiatrists) agree that child's emotional and developmental needs are being met.**

- **Parents demonstrate understanding of their contribution to the intellectual, emotional or psychological development of their child and are able to demonstrate non-abusive, non-injurious forms of interaction with child as evidenced by observation, collateral contacts, and interviews with verbal children.**

- **Older child(ren) have access to at least one specified adult, who can provide support and to whom they can report recurrence of mental injury, and that adult is aware of this role and will assume responsibility of reporting recurrence of injury to SCR.**

- **Worker has verified that mental health service providers are aware that the Department's case is being closed, and that the provider will notify SCR of any future suspicion of mental injury.**

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Underlying Causes

Poor parenting practices resulting from lack of information, immaturity, inexperience or inappropriate learned behavior

Services

Arrange or provide psychotherapy, counseling or other services to the parent(s) to:

- ensure that he/she is capable of providing adequate protection and care for the child, by helping the parent learn basic child care techniques including such things as infant care, nutrition, basic medical care, household management or other matters relevant to the case

- help parent(s) understand and learn to manage the child's behaviors that may have precipitated or provoked the abuse/neglect

- help parent(s) understand reasonable expectations for the child given the child's developmental level

- help parent(s) to learn enriching activities to stimulate child's growth and development and foster a healthy parent-child relationship

Help the parent identify a support network involving the extended family, the church or other community supports to assist with the care and supervision of the child and mentoring of the parent

Help parents to identify their strengths and needs and actively advocate for and support the parents in using community resources to meet their needs (e.g., vocational training, education, assistance in finding employment, LAN)

Assist the parent(s) in locating day care, after-school programs, recreational programs or other opportunities for the parent(s) to have respite, including extended family involvement.

Efforts to Determine Whether Underlying Cause is Mitigated

Interview verbal children away from caregivers to determine whether there has been repeated abuse or neglect.

Minimum Frequency: at every visit with the child

Conduct home visits, including unannounced home visits, to determine ongoing abuse or neglect.

Minimum Frequency: weekly (throughout life of case) take out, half of them unannounced

Contact extended family members, school personnel or other collateral sources who may have relevant information to determine whether they have seen signs of ongoing abuse or neglect.

Minimum Frequency: monthly

Contact service providers to determine whether they have seen signs of ongoing abuse or neglect.

Minimum Frequency: monthly

Developmental Disabilities

Services

Arrange or provide homemaker, parent mentor or other services to:

- Ensure that the parent is capable of providing adequate protection and care for the child, by helping the parent learn basic child care techniques including such things as infant care, nutrition, basic medical care, household management or other matters relevant to the case

- Help parent(s) understand and learn to manage the child's behaviors that may have precipitated or provoked the abuse/neglect

- Help parent(s) understand reasonable expectations for the child given the child's developmental level

- Help parent(s) to learn enriching activities to stimulate child's growth and development and foster a healthy parent-child relationship

Help the parent identify a support network involving the extended family, the church or other community supports to assist with the care and supervision of the child and mentoring of the parent.

Explore co-parenting arrangements with extended family members or others who share a close relationship with the parent. For example, parent and child may live with another family member who has guardianship of the child.

Help parents to identify their strengths and needs and actively advocate for and support the parents in using community and governmental resources to meet their needs (e.g., vocational training, education, assistance in finding employment, LAN, DMHDD, ORS, DHS). Explore SSI benefits.

Efforts to Determine Whether Underlying Cause is Mitigated

Interview verbal children away from caregivers to determine whether there has been repeated abuse or neglect.

Minimum Frequency: at every visit with the child

Conduct home visits, including unannounced home visits, to determine ongoing abuse or neglect.

Minimum Frequency: weekly (throughout life of case) take out, half of them unannounced

Contact extended family members, school personnel or other collateral sources who may have relevant information to determine whether they have seen signs of ongoing abuse or neglect.

Minimum Frequency: monthly

Contact service providers to determine whether they have seen signs of ongoing abuse or neglect.

Minimum Frequency: monthly

Underlying Causes

Poor parenting practices resulting from lack of information, immaturity, inexperience or inappropriate learned behavior

Services Related to Poor Parenting

- Arrange mental health services (eg.counseling, support/education services, homemaker, parent mentoring or other appropriate services) to the caregivers to: ensure that he/she is capable of providing adequate protection and care for the child, by helping the parent learn basic child care techniques including such things as infant care, nutrition, basic medical care, household management or other matters relevant to the case

    - help parent(s) understand and learn to manage the child's behaviors that may have precipitated or provoked the abuse/neglect

    - help parent(s) understand reasonable expectations for the child given the child's developmental level

    - help parent(s) to learn enriching activities to stimulate child's growth and development and foster a healthy parent-child relationship

Help the parents identify child and family team members from the extended family, the church, friends, neighbors, service providers,or other community support systems.

Help the parents develop and use a support network through their child and family team.

Help parents to identify their strengths and needs and actively advocate for and support the parents in using community resources to meet their needs (e.g., vocational training, education, assistance in finding employment, LAN)

Assist the parent(s) in locating day care, after-school programs, recreational programs or other opportunities for the parent(s) to have respite, including extended family involvement.

Efforts to Determine Whether Underlying Cause is Mitigated

Interview verbal children away from caregivers to determine whether there has been repeated abuse or neglect.

Minimum Frequency: at every visit with the child

Conduct home visits, including unannounced home visits, to determine ongoing abuse or neglect.

Minimum Frequency: weekly (throughout life of case) take out, half of them unannounced

Contact extended family members, school personnel or other collateral sources who may have relevant information to determine whether they have seen signs of ongoing abuse or neglect.

Minimum Frequency: monthly

Contact service providers to determine whether they have seen signs of ongoing abuse or neglect.

Minimum Frequency: monthly

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.

Criteria for Closing

Older children have access to at least one specified adult to whom they can report child maltreatment and the specified adult is aware of this role and will assume responsibility to report to SCR.

Parents have demonstrated their ability to meet the children's needs either independently or with the help of an established support network on an on-going basis, for a period of 3-6 months. This is verified by private interviews with the child, worker's observations, and collateral contacts.

Developmental Disabilities

Services Related to Developmental Disabilities

Consult and review applicable Treatment Paths and supporting documentation.

Arrange or provide homemaker, parent mentor or other services to:

- Ensure that the parent is capable of providing adequate protection and care for the child, by helping the parent learn basic child care techniques including such things as infant care, nutrition, basic medical care, household management or other matters relevant to the case

- Help parent(s) understand and learn to manage the child's behaviors that may have precipitated or provoked the abuse/neglect

- Help parent(s) understand reasonable expectations for the child given the child's developmental level

- Help parent(s) to learn enriching activities to stimulate child's growth and development and foster a healthy parent-child relationship

Help the parents identify child and family team members from the extended family,the church, friends, neighbors, service providers or other community supportsystems.

Help the parents develop and learn to use a support network through the child and family team to assist with the care and supervision of the child(ren) and mentoring of the parents.

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Explore co-parenting arrangements with extended family members or others who share a close relationship with the parent. For example, parent and child may live with another family member who has guardianship of the child.

Help parents to identify their strengths and needs and actively advocate for and support the parents in using community and governmental resources to meet their needs (e.g., vocational training, education, assistance in finding employment, LAN, DMHDD, ORS, DHS). Explore SSI benefits.Assist the parents in locating day care, after school programs, recreational programs or other opportunities for the children to participate in socializing experiences and to provide respite for the parents.

Efforts to Determine Whether Underlying Cause is Mitigated

Interview verbal children away from caregivers to determine whether there has been repeated abuse or neglect.

Minimum Frequency: at every visit with the child

Conduct home visits, including unannounced home visits, to determine ongoing abuse or neglect.

Minimum Frequency: weekly (throughout life of case) take out, half of them unannounced

Contact extended family members, school personnel or other collateral sources who may have relevant information to determine whether they have seen signs of ongoing abuse or neglect.

Minimum Frequency: monthly

Contact service providers to determine whether they have seen signs of ongoing abuse or neglect.

Minimum Frequency: monthly

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.

Criteria for Closing

1. Parents have demonstrated their ablity to meet the children's needs either independently or with the help of an established support network on an on-going basis. The parents have demonstrated this ability consistently for a period of 6 months, verified by private interviews with the chid(ren), worker's observations, and collateral contacts.

2. Older children have access to at least one specified adult to whom they can report child maltreatment and the specified adult is aware of this role and will assume responsibility to report to SCR.

Developmental Disabilities

Services Related to Developmental Disabilities

Consult and review applicable Treatment Paths and supporting documentation.

Arrange or provide homemaker, parent mentor or other services to:

- Ensure that the parent is capable of providing adequate protection and care for the child, by helping the parent learn basic child care techniques including such things as infant care, nutrition, basic medical care, household management or other matters relevant to the case

- Help parent(s) understand and learn to manage the child's behaviors that may have precipitated or provoked the abuse/neglect

- Help parent(s) understand reasonable expectations for the child given the child's developmental level

- Help parent(s) to learn enriching activities to stimulate child's growth and development and foster a healthy parent-child relationship

Help the parents identify child and family team members from the extended family,the church, friends, neighbors, service providers or other community supportsystems.

Help the parents develop and learn to use a support network through the child and family team to assist with the care and supervision of the child(ren) and mentoring of the parents.

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Explore co-parenting arrangements with extended family members or others who share a close relationship with the parent. For example, parent and child may live with another family member who has guardianship of the child.

Help parents to identify their strengths and needs and actively advocate for and support the parents in using community and governmental resources to meet their needs (e.g., vocational training, education, assistance in finding employment, LAN, DMHDD, ORS, DHS). Explore SSI benefits.Assist the parents in locating day care, after school programs, recreational programs or other opportunities for the children to participate in socializing experiences and to provide respite for the parents.

Efforts to Determine Whether Underlying Cause is Mitigated

Interview verbal children away from caregivers to determine whether there has been repeated abuse or neglect.

Minimum Frequency: at every visit with the child

Conduct home visits, including unannounced home visits, to determine ongoing abuse or neglect.

Minimum Frequency: weekly (throughout life of case) take out, half of them unannounced

Contact extended family members, school personnel or other collateral sources who may have relevant information to determine whether they have seen signs of ongoing abuse or neglect.

Minimum Frequency: monthly

Contact service providers to determine whether they have seen signs of ongoing abuse or neglect.

Minimum Frequency: monthly

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.

Criteria for Closing

Parents have demonstrated their ablity to meet the children's needs either independently or with the help of an established support network on an on-going basis. The parents have demonstrated this ability consistently for a period of 6 months, verified by private interviews with the chid(ren), worker's observations, and collateral contacts.

Older children have access to at least one specified adult to whom they can report child maltreatment and the specified adult is aware of this role and will assume responsibility to report to SCR.

Domestic Violence

Services related to Domestic Violence:

Consult and review applicable Treatment Paths and supporting documentation.

Arrange for the provision of domestic violence assessment and intervention services, counseling or other services to the DV victims and perpetrators, where possible through a specialized domestic violence program approved by the Illinois Department of Human Services.

Domestic violence services may include:

- Emergency shelter for abused women and their children; in-home services and wrap services;
- Legal assistance, including domestic violence orders of protection and advocacy for abused women;
- Other support programs for victims of domestic violence such as counseling through a domestic violence service provider and education-support programs.
- Specialized domestic violence services, including counseling and support groups, for children
- Specialized assessment and treatment services for the perpetrator of domestic violence

Consider Norman certification and services.

Help the parent identify a support network involving the extended family, the church or other community supports to assist with the safety, care and supervision of the child as well as the safety and well-being of the adult victim.

Develop a domestic violence protection plan with the non-offending caregiver to ensure the child's safety in the event of a domestic violence incident.

Note: Couples, marital or family therapy that includes the batterer is not appropriate until professionals providing treatment services to the caregivers report that the domestic violence issues have been resolved.

Efforts to Determine Whether Underlying Cause is Mitigated

Interview verbal children away from caregivers to determine whether there has been repeated abuse or neglect.

Minimum Frequency: at every visit with the child

Interview adult victim away from perpetrator to determine whether there has been repeated abuse (psychological, economic, sexual and physical) or neglect of the child.

Minimum Frequency: at every visit with the adult victim.

Observe family members to determine if victim exhibits or tries to conceal physical evidence of violence (e.g., black eyes, wearing sunglasses).

Minimum Frequency: at every visit

Observe family interactions to determine whether the perpetrator of domestic violence seeks to undue control over members (e.g., refuses to allow partner or children to talk or be alone with worker).

Minimum Frequency: at every visit

Conduct home visits, including unannounced home visits, to determine ongoing abuse or neglect of the child.

Minimum Frequency: weekly, half of them unannounced

Contact extended family members, school personnel, police or other collateral sources who may have relevant information to determine whether they have seen signs of ongoing abuse or neglect to the child or ongoing abuse to the adult victim.

Minimum Frequency: monthly

Discuss with domestic violence providers what services will be provided by the DV program and to inform the DV providers about what services will be provided by DCFS, as well as information needed to determine if the child is being adequately protected.

Minimum Frequency: monthly

Contact service providers to determine whether they have seen signs of ongoing abuse or neglect of the child or going abuse of the adult victim.

Minimum Frequency: monthly

Obtain reports from the program treating the perpetrator of domestic violence to determine attendance, cooperation, and progress.

Minimum Frequency: monthly

- There are safety issues documented on the CERAP, or
- There is a paramour residing in the There is a safety plan, or
- home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.

Criteria For Closing

1. Domestic violence victim and older children have access to at least one specified adult outside of the home to whom they can report reoccurrence of domestic violence and specified adult is aware of this role and will assume responsibility to report to SCR if there is reasonable cause to suspect child abuse or neglect.

2. Parents/caretakers understand and accept their responsibility for the protection of their children as evidenced by their behaving in a consistently and appropriate protective manner for at least 6 months verified by private interviews with children, collateral contacts and worker's observation.

3. The domestic violence has been eliminated or mitigated as evidenced by the fact that no child has been harmed as the result of the domestic violence for at least 6 months.

4.

Alcohol & other Drug Abuse

Services

Consult and review applicable treatment paths and supporting documentation.

Complete an adult substance abuse screen (CFS 440-5) if one has not been previously completed or the facts of the case warrant a new screen being completed.

Refer parent to an agency listed in the Directory of OASA/DCFS Initiative Providers. If there is not an OASA/DCFS Iniatiative provider in the area, refer the adult to the nearest OASA funded provider for an assessment.
Call the AODA provider for the adult and set up the assessment appointment. Provide the referral information to the adult in writing.

Work assertively and closely with parent and treatment provider to ensure parent is given every opportunity to begin/cooperate with assessment and treatment. If possible, provide transportation to the intial intake appointment to ensure attendance.

Follow up with the AODA treamtment provider to assure that the appointment was kept and to schedule an initial case staffing to discuss joint service planning.

Set up monthly staffings with treatment counselor and client to continually assess progess, determine level of care transitions, and to ensure aftercare plans along with relapse plans are in place.

Provide/refer adults to complete random urinalysis as recommended by treatment provider (Discuss and consider results with supervisor and treatment provider)

Refer extended family members and significant others for alcohol and other drug education programs.

Work with the parent to engage extended family members in providing support to the parent in drug treatment and assisting in parenting responsibilities, if needed.

Assist the parent in locating day care, after-school programs and recreational programs, including the use of extended family, while the parent attends alcohol and other drug treatment, including AA and NA meetings.

When an infant is substance exposed, arrange for home visits by a public health nurse and maintain monthly contact with him/her. Ensure all children receive appropriate medical care.

Assist the family with transportation to medical appointments and other services.

Assist parents in getting their infant a 0-3 evaluation and, if necessary, enrollment in an early intervention program to prevent developmental delays (SEI infant).

Assist parent in getting health care and family planning, including HIV testing and treatment.

Refer family for housing, utilities, furnishings and food as needed. Consider Norman certification and services.

Refer parent to interactive parenting program once recovery has been sustained.

Efforts to Determine Whether Underlying Cause is Mitigated

Contact substance abuse treatment provider to obtain information about the parent's treatment plan, to share information about the client's treatment, to invite the provider to the family meeting and to request that the service provider advise the worker of the parent's non-compliance with treatment.

Minimum Frequency: at least monthly

Assure that there is a consistent medical provider (for allegation 65) and find out what the child's treatment plan is.

Contact medical provider to determine whether parent is following the prescribed treatment plan for the child.

Contact substance abuse treatment provider to determine parent's compliance and progress with alcohol and other drug treatment requirements.

Minimum Frequency: bi-weekly

Contact other service providers to determine if parent is cooperating and using service appropriately.

Minimum Frequency: monthly

Make home visits, including unannounced visits, to observe the home environment to check for any signs that the parent has resumed using alcohol or other drugs. (Observe behavior of parent, condition of the home, drug paraphernalia or alcoholic beverage containers, strangers in the home, children unkempt or not fed)

Minimum Frequency: weekly

Complete CANTS/LEADS on all adult caregivers in the home or providing childcare.

Minimum Frequency: Whenever additional adults move into the home and at case closure.

Interview verbal children away from caregivers to determine if parent has resumed use of alcohol and other drugs and is able to care for children

Minimum Frequency: weekly

Contact extended family, school personnel or other collaterals sources that may have relevant information to determine whether they have seen signs of alcohol or other drug abuse by parent and parent's ability to care for their children.

Minimum Frequency: monthly

Ensure that the child has a non-substance impaired adult available as a resource in the even that the parent suddenly relapses. For example, extended family members or clergy.

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.
- For SEI child, there is not a consistent medical provider and parent is following the prescribed treatment plan for the child
- There i not a non- substance impaired adult available as a resource in the event that the parent suddenly relapses

Criteria for Closing (In accordance with SAF policy 99.13)

1.The children show evidence of improved care, i.e in the areas of health care, supervision and responsiveness by the parent.

2.There is not risk to the child as indicated by the safety assessment.

3.There have been no additional indicated hotline reports for _____6_____months.

4.The parent has had negative urinalysis reports for the past _____3_____months.

5.LEADS check is free of current drug related charges.

6.The child(ren) have access to at least one specified adult outside of the home to whom they can call for assistance in the event of inappropriate activities related to substance misuse and the specified adult is aware of this role and will assume responsibility to report to SCR if there is reasonable cause to suspect child abuse or neglect.

7.Parents have been fully engaged in the recovery process for the past _____6____months or

a. Substance abuse issues have been addressed and no longer represent risk to the child(ren) or

b. In those cases where the parent does not successfully complete substance abuse treatment, but does provide and meet the physical and emotional needs for the child, and the worker is able to verify the safety and well being of the child(ren).

Mental Illness

Mental illness can stem from a variety of causal factors, including, a chemical imbalance, substance abuse, being a child victim of abuse or severe neglect, head trauma.

Services

Arrange for the provision of a psychotherapeutic assessment, psychotherapy or other services (such as group therapy, medication management, therapeutic day program or hospitalization) that would minimize and manage the harmful behavior exhibited by the parent.

Assist the parent in arranging for transportation to identified services.

Assist the parent in arranging for child care when needed.

Assist parents in identifying appropriate extended family members/friends, who would be willing to be supportive of parents' efforts to become better parents by providing respite, emotional support, etc.

Arrange for other family members to receive psycho-educational services.

Assist the parent(s) to identify and utilize community and governmental resources (community mental health center, DMHDD, DHS) to meet their mental health needs following the Department's intervention and provide support and encouragement for their strengths.

Advocate for the necessary financial resources to obtain needed medication, either through public aid, HMO or other insurance providers.

Efforts to Determine Whether an Underlying Cause is Mitigated

Contact mental health service providers to obtain information about the parent's treatment plan, and to determine what information will be shared. Obtain information from the clinician about what behaviors on the part of the parent may indicate that the parent's mental health is deteriorating and may be dangerous to the child and whether the parent is exhibiting any of these behaviors.

Minimum Frequency: monthly.

Contact mental health service providers to determine whether parent is complying with his/her treatment plan, his/her participation and progress.

Minimum Frequency: monthly

Interview verbal children away from caregivers to determine if there has been continued abuse or neglect, if parents are taking medication and if symptomology has increased/decreased.

Minimum Frequency: weekly.

Conduct home visits, including unannounced, to determine ongoing abuse or neglect, consistency in taking medication if prescribed and if parent's symptomology has increased/decreased..

Minimum Frequency: weekly (until preparing to close case) take out.

Contact extended family members, school personnel or other collateral sources who .may have relevant information regarding any going abuse or neglect or behaviors resulting from a mental illness.

Minimum Frequency: monthly.

FREQUENCY OF VISITS

Weekly face-to-face contact with family members, including parents/caretakers and children, must be maintained. However, as case situations dictate, supervisors may waive weekly client in-person contact. Minimum weekly contact must occur during the 45-day assessment period. There is no waiver of weekly contact during the initial assessment

period. Following the assessment period, contact must occur at a minimum of twice per month. This contact can only be waived as part of the termination plan.

Weekly contacts cannot be waived if:

- The case is in the assessment period (45-days), or
- There is a safety plan, or
- There are safety issues documented on the CERAP, or
- There is a paramour residing in the home, or
- Family is not actively involved in their service plan, or
- Children under the age of six and are not attending school, daycare, or another organized activity outside of the home.

1. Criteria for closing: Parent/caregiver is able to exhibit (through behavior) that symptomology has decreased to the point where she/he can provide all necessary care for child(ren) or that support system (*e.g.* extended family members/friends) is such that when parent/caregiver **is** symptomatic, all necessary care is provided for child(ren) for a period of no less than 6 months.

2. The child(ren) is/are not afraid of parents/caregivers as evidenced by observation, collateral contacts and interviews with verbal children.

3. Mental health service providers (e.g. counselors, educators/support providers, psychiatrists, psychologists) confirm that parent/caregiver is complying with treatment plan, including compliance with taking psychotropic medication, if indicated, and that parent/caregiver is not a danger to child(ren) and can provide adequate care .

4. A support system (extended family members/friends) has been identified to provide respite, if needed, and emotional support to parents/caregivers and

child(ren). These support providers understand their role and will report any future abuse, neglect, or risk to SCR.

5. Worker has verified that mental health service providers are aware that the Department's case is being closed and that the provider will notify SCR of any of any deterioration in the parent/caregiver's condition, which would place the child(ren) at risk of abuse or neglect.