FOUNDATION TRAINING PROGRAM

Illinois Department of Children and Family Services
Division of Clinical Practice and Development
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Illinois Child Welfare Fundamentals Study Guide

ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Illinois Child Welfare Fundamentals Study Guide

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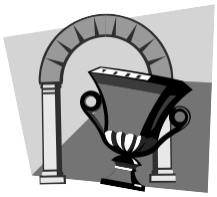

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Writers

JANET AHERN
CATHY AHERN
RON BAILEY
KAREN BEZ
JEANETTE HAMILTON
RUDY HARRIS
JOAN LANGAN
ROSETTA WEBB
WENDELL WINSLOW
CHERYL WILEY
LISA WILSON

Researchers

RON BAILEY
KAREN BEZ
COLLEEN FLAHERTY
KATHY GEROSKI
RUDY HARRIS
TERRY SOLOMON
WENDELL WINSLOW
CHERYL WILEY

Illinois Department of Children and Family Services

MISSION:

To promote prevention, child safety, permanency and well-being.
We bring the voices of Illinois children and families to the forefront,
building trusting relationships that empower those we serve.

VISION:

Communities strengthening families to ensure every child is safe,
healthy and productive at home and in school.

VALUES:

We value Trust.
We value Compassion.
We value Accountability.
We value Responsiveness, Relationships and Respect.
We value Empathy.
We value Safety.

Table of Contents

Introduction ……1
Purpose of This Guide
Who Needs a License… 1
Best Social Work Practice.....1

1 Illinois Core Practice Model 2

FTS Vision Statement 2
9 Core Child Welfare Practice..... 2
Family Centered, Trauma Informed, Strength-Based . . 2
Family Centered Practice ……..……2
Trauma Informed Practice 5
Definition of Trauma..... .5
Psychological First Aid …… 5
Types of Child Trauma..... .6
Adverse Childhood Experiences ……...8
Responses to Trauma Throughout Development ……..9
Tips for Talking to Children.....11
Three Types of Stress 12
Trauma and Brain Development 14
Protective Factors 15
Strength-Based Practice 17

2 Policy and History..... 20
Historical Evolution of Child Welfare ……21
Sources of Law Affecting Child Welfare …….. 22
Permanency Initiative ……28
Consent Decrees .……..……..…… 29
Illinois Statutory Definitions of Abuse, Neglect and Dependency …….. ….32
Eligibility ……34
Service Goals ……35
Agency Partners…… 36
Your Role in Child Welfare …… 38

3 Ethics & Professionalism 39
Delegated Authority ……..39
Code of Ethics.. …….. 41
Affirmative Action ……... ...43
Conflict of Interests…….……46
DCFS Structure and Responsibility ……47
Management and Supervision …..……50
Documentation ……...51

4 Human Behavior and Development 55
Normal Stages of Human Development …. 56
Family Life Cycle..... 63
Attachment and Bonding..... 64
Developmental Delay..... 69
Separation and Loss 69
Child Well=Being 72

5 Engaging Children and Families. .. 73
Engagement…….…….. 73
Family Systems Approach ……...76
Change Agents 77
Family Interviewing 79
Interviewing Techniques……...81
Critical Thinking..... 85
Child Protection Interview..... 86
Collaboration and Teamwork 92
Foster and Relative Caregivers..... 93
Older Caregivers 95
Visitation..... 97
Decision Making Process 100
Opening the Case/Case Assignment..... 101
Child and Family Team M eetings……..……..102

6 Culturally Informed Practice..... 104
Cultural Diversity 104
Definitions..... 105
Culture and Parenting 107
Cultural Competence/Culturally Informed Practice . 109
Disproportionality and Disparity..... 111

7 Assessment…….113
Four Stages of Assessment 113
Illinois Model of Integrated Assessment..... 115
Minimum Parenting Standards 116
Assessing for Safety and Risk. 117
Assessment Tools 119
Safety Assessment Protocol..... 121
Safety Planning 127
Child and Adolescent Needs and Strengths (CANS).130
Underlying Conditions 131
Culture and the Assessment Process……..…..140

8 Permanency Planning..... 141
Permanency Planning 141
Service Planning 144
Permanency Goals..... 146
Concurrent Planning..... 151
Service Plan Contents ……...153
Administrative Case Review……..154
Principles for Working with Client ……...155

9 Juvenile Court..... .157
Role in Juvenile Court..... 157
Court Personnel 158
Legal Court Process..... 159
Juvenile Court Hearings 160
Adult Guardianship 168
Child Protection Warrants..... 169
Parents Rights in Juvenile Court..... 170
Children's Rights in Juvenile Court..... 170
Poster Parent's Rights in Juvenile Court 171

Appendix

Appendix A - Child Welfare Definitions
Appendix B - Illinois Statutory Definitions of Abuse and Neglect
Appendix C - Safety Threats & Examples
Appendix D - SACWIS Risk Assessment
Appendix E - Licensure Exam Practice

Introduction

Child welfare professionals and their supervisors are required to have a basic knowledge of child welfare prior to direct child welfare practice in Illinois. The Foundation Training course is an overview of the Illinois Department of Children and Family Services policy, procedure and practice. The Foundation Training course is also a preparation for Child Welfare Licensure. Child welfare professionals are required to maintain a license in order to be employed by any of Illinois' child welfare agencies.

Purpose of This Guide

Information in the Child Welfare Foundation Training Study Guide provides an overview of the knowledge prerequisite for direct child welfare practice in Illinois. Policy information is based on the Department of Children and Family Services Rules and Procedures. The reader will gain the most benefit from the guide by going through the information from beginning to end.

Who Needs a Child Welfare License

The Children and Family Services Act was amended to require a license for those providing direct child welfare services in Illinois. By January 1, 2000, the Illinois Department of Children and Family Services and private child welfare agencies developed and implemented a Child Welfare Service Employee License.

As of January 1, 2001, all child protection investigators and supervisors, child welfare specialists and supervisors employed by the Department or its contractors must demonstrate a sufficient knowledge base and skills about child welfare practice to obtain and maintain the license.

Presently, the Department has determined that staff and their supervisors who directly work with children and families and provide child protection investigations or case management services, as well as those who work directly with intact families, will require a license.

Social Work Practice

The delivery of child welfare services in Illinois is based on best social work practice and requires that child safety, permanency, and well-being are part of every aspect of intervention and services delivered for children, their parents, relatives, and the Illinois community. Permanency, safety, and the well-being of children are the fundamental outcomes of all child welfare practice. The role of the child welfare professional is to achieve those outcomes in a timely and effective manner.

In child welfare, "practice" is the means by which individuals and families are helped to change their behaviors and circumstances. This is accomplished through interpersonal efforts to influence understanding of a problem and the actions necessary to resolve it while making available the necessary resources and providing the safety interventions required to prevent harm to children. The art of social work practice is the ability to successfully balance concerns for child safety with concerns for the emotional security and the importance of family to children for whom safety is sought.

The Department of Children and Family Services has carefully laid out the tasks and competencies of social work practice. This combination of knowledge, skills, and behaviors reflects the attitudes and values that support consistent, appropriate choices of action- leading to the child's safety, health, and well-being.

Social work practice builds on the following set of principles as its foundation:

- Engaging clients in a supportive relationship and treating them with positive regard.
- Building on clients' apparent strengths and motivations.
- Helping clients recognize their conditions, decisions, and patterns of behaviors and supporting them in the change process.
- Consistency, honesty, and trustworthiness in the delivery of child welfare services.
- Treating clients as individuals and families as unique units with respect for individuals, groups, and cultural diversity.
- Acceptance is demonstrated by treating parents as individuals and families with dignity and positive regard.
- Respecting families' rights to be involved in planning and decision-making processes.
- Maintaining a commitment to a high standard of personal and professional conduct.
- Clear expectations of the knowledge, skills, and values necessary for child welfare professionals to capably serve children and families.
- Training, supervision, and evaluation that enable and enhance the ability of staff to perform competently and in accordance with these principles and expectations.
- Timely decisions, based on the above set of principles that establish conditions encouraging and affording a sense of permanency in children's lives while ensuring their safety, health, and well-being.

The primary assumptions underlying social work practice are that:

- Most parents are capable of and motivated to protect and nurture their children.
- Caseworkers can be trained and are motivated to help families in which children are at risk for maltreatment.
- All change for the better takes place within the context of a helping, supportive relationship.
- The role of the caseworker is to offer the helping, supportive relationship that enables change to occur.

Illinois Core Practice Model

The Core Practice Model is anchored in a Family Centered, Trauma Informed, and Strength Based approach, often times referred to as simply "FTS."

FTS Vision Statement

Partnering with families in making decisions, setting goals, and achieving desired outcomes in a way that acknowledges the importance of the family, and builds upon usable strengths demonstrated by the child, parent(s), and family; all while continuously identifying, intervening, and mitigating the effects of adverse and traumatic experiences of children and families.

9 Core Child Welfare Practices

These practices apply for everyone in child welfare, regardless of specific role.

- Serve as an **agent of change**
- Form a helping **relationship** with the child and his/her family
- Conduct **initial and ongoing assessment**
- Provide information about the **impact of trauma** on the child and family
- **Advocate** for the child and family
- Provide **behavioral support**
- **Linkage** to appropriate services
- **Coordinate** all child and family services
- Demonstrate **cultural competence**

Family-Centered, Trauma-Informed, Strength-Based Practice

Family-Centered Practice focuses on helping children remain connected to their parents, extended family and others who are significant in their lives. Trauma-Informed Practice seeks to view children and families with a "trauma lens" and understand the impact of trauma on a child's development and behavior. Strength-Based Practice helps families identify and build on their strengths when planning services.

Family-Centered Practice

In previous units the definition of family was discussed; families determine who they include when they say "family." Family-centered practice is a way of working with families across systems. It focuses on the needs and welfare of children in the context of the family and community. It recognizes a family's strengths and the importance of the relationships among family members. It respects the rights, values and cultures of families. Family-centered practice is an attitude or philosophy about working with families.

Family Connectedness

Identifying, linking, supporting and enabling relationships, contacts, interactions and other means between and among family member in order to strengthen the family as a unit. Simply put, family connectedness is a sense of belonging to and being part of a family group.

All of us, as children and adults, have a very basic need to feel connected to a family. Research shows that the longer a child is in the system, the more likely she/he will lose family connections. Without family connections she/he is at greater risk for instability, depression, even unemployment and delinquency (source – Child Welfare Information Gateway).

Family Connectedness takes the family-centered conversation a step further and focuses on the importance of identifying and promoting family connections from the first contact child welfare has (including investigations) through the whole life of a case. It is also about recognizing how trauma or adverse childhood experiences impacts parents, children, and foster parents before, during and after case contact, as family connectedness provides context and support for understanding and dealing with trauma.

Culture and Identity

It is also vital to recognize the importance of culture while working to maintain family connections. From a family-centered perspective, child welfare professionals are encouraged to enlist the support of birth families (where possible) as cultural navigators, and to "serve as anchors to traditions, belief systems, and world views." Small studies of youth in foster care have shown that youth in kinship foster home placements have a stronger sense of ethnic identity than those in non-relative placements.

Visitation & Shared Parenting Strengthen Connections

For families with children in foster care, visits can minimize the impact of trauma and promote lasting connections. Shared parenting, community and familial support for older adolescents, and Child and Family Team Meetings are also important for building and maintaining connections.

Maintaining family connections and promoting family involvement can lead to positive outcomes for all family members and build upon protective factors and resiliencies.

Consistent visits between a child or children in care and their parents and/or extended family members provide us with additional opportunities to evaluate progress towards permanency. During visits, parents have the opportunity to apply newly acquired skills and receive feedback. Visits also provide professionals involved with the family opportunities to identify strengths and give feedback about attempts to utilize new parenting approaches. Furthermore, ongoing family interactions provide opportunities to help maintain specific cultural traditions or practices that are important to the child and family and may be supports for them.

Being family-centered means that we want children to remain or be returned to their parents, when appropriate, as soon as possible. When this is not possible, being family centered also means that we work diligently to ensure that familial connections are maintained as much as possible when appropriate.

Family-Centered Communication Skills

A key part of ongoing work with families is our ability to engage and communicate with them. At times, you may have to have difficult conversations with family members/families. Development and use of the following skills will facilitate better communication in your work with families:

- Shared understanding of the problems/ needs at hand;
- Collaboration among the professionals *and* with the family;
- Commitment to specific tasks by each party [including the family and the professionals];
- Consider how *(not if)* culture influences the interactions, observations and understanding of the meeting at-hand.

Child & Family Team Meeting

Child and Family Team Meetings (CFTM) should be the **center of our casework activities** and how all other staffings, or mandatory case processes should have information flowing from and back to the CFTM. We need everyone who participates in all the other circles depicted here to support the CFTM and recommend that decision made during these meetings be brought back to the CFTM.

Engagement - As we are engaging the family we obtain more information about the family's history and potential members for the Child and Family Team. A parent may be able to give further information about their family and potentially a missing parent and their family. As we receive more information about the family we will be adding to the CFS 458B.

Full Disclosure – Family members need to have all of the information disclosed to them so they can make their own decisions.

Open Participation – Parents select who they want to be a part of their Child and Family Team.

Collaboration – Involvement of the family in all aspects of case planning.

Planning for Permanency – Planning for permanency is the focus of all Child and Family Team Meetings.

Trauma-Informed Practice

This unit will focus on trauma-informed practice and how to integrate what is known about child trauma into direct service with clients.

Definition of Trauma

Trauma has both a medical and a psychiatric definition. Medically, "trauma" refers to a serious or critical bodily injury, wound, or shock. This definition is often associated with trauma medicine practiced in emergency rooms. Psychiatrically, "trauma" has assumed a different meaning and refers to a child's experience of an event that is emotionally painful, distressful, or shocking, which often results in lasting mental and physical effects. This is the definition of interest to those of us in child welfare.

Here are some specific definitions:

"The experience of an event by a child that is emotionally painful or distressful which often results in lasting mental and physical effects." (National Institute of Mental Health)

"Trauma is a psychologically distressing event that is outside the range of usual human experience, often involving a sense of intense fear, terror and helplessness. (Bruce D. Perry, M.D., Ph.D.)

"Psychic trauma occurs when an individual is exposed to an overwhelming event and is rendered helpless in the face of intolerable danger, anxiety, or instinctual arousal." (Eth and Pynoos, 1985)

Prevalence of Childhood Trauma

- Nationally, 4 out of 10 children report witnessing violence.
- One in four children will experience a traumatic event before they reach their 16th birthday.
- High number of teens have witnessed violence or experienced physical or sexual abuse.

Psychological First Aid (PFA)

The Illinois Department of Children & Family Services requires that all staff complete a course in Psychological First Aid. It is an evidence-informed approach for assisting people in the immediate aftermath of a loss, disaster, or exposure to trauma and terrorism. It is applied in child welfare to all of our interactions with children and families.

The **PFA** Approach will assist with:

- Reducing initial distress
- Fostering short term adaptive functioning
- Fostering long-term adaptive functioning

Objectives of PFA:

- Establish a human connection in a non-intrusive and compassionate manner.
- Enhance immediate and ongoing safety and provide physical and emotional comfort.
- Relieve emotional suffering by helping children and their caregivers to strengthen and use their own resources to rebuild shattered lives.
- Help children and their caregivers tell you specifically what their immediate needs and concerns are and gather additional information as appropriate.
- Offer practical assistance and information to help children and their caregivers with their immediate needs and concerns.
- Connect children and their caregivers with social support networks, including family members, friends, neighbors and community helping resources.
- Support adaptive coping, acknowledge coping efforts and strengths, and encourage adults, children and families to take an active role in their overall care.
- Provide information that may help children and their caregivers cope effectively with the psychological impact of trauma.
- Be clear about your availability, and (when appropriate) link the children and their caregivers to mental health services, public-sector services and organizations.

Types of Child Trauma

Sexual Abuse: Child sexual abuse includes a wide range of sexual behaviors that take place between a child and an older person. Sexually abusive behaviors often involve bodily contact, such as sexual kissing, touching, fondling of genitals, and intercourse. However, behaviors may be sexually abusive even if they do not involve contact, as in the case of genital exposure ("flashing"), verbal pressure for sex, and sexual exploitation for purposes of prostitution or pornography.

Physical Abuse: Physical abuse refers to actual or attempted infliction of bodily pain and/or injury, including the use of severe corporal punishment. Physical abuse is characterized by physical injury (for example, bruises and fractures) resulting from punching, beating, kicking, burning, or otherwise harming a child. In some cases, the injury may result from over discipline or physical punishment that is inappropriate to the child's age or condition. Physical abuse can occur in single or repeated episodes and can, in the extreme, result in death.

Psychological Maltreatment: Psychological or emotional abuse includes acts or omissions by parents or caregivers that caused, or could cause, serious behavioral, cognitive, emotional, or mental disorders. Examples include verbal abuse (e.g. insults, belittling, threats of violence), bullying and the use of coercive control, emotional neglect (e.g. shunning, withdrawal of love), and intentional social deprivation (e.g. isolation, confinement). Some forms of psychological maltreatment can be difficult to identify, and demonstrable harm to the child is often required for public agencies to intervene.

Neglect: Child neglect involves the failure to provide needed, age-appropriate care although financially able to do so, or offered financial or other means to do so. This includes physical neglect (e.g. deprivation of food, clothing, shelter), medical neglect (e.g. failure to provide the child with access to needed medical or mental health treatments or to consistently administer prescribed medications), and educational neglect (e.g. withholding child from school, failure to attend to special education needs). Also included under the definition of neglect are providing inadequate nutrition, clothing, or hygiene; exposure to unsafe environments; inadequate supervision, including the use of inadequate caretakers; and abandonment or expulsion from the home.

Community Violence: Community violence refers to both predatory violence (e.g. robbery) and violence arising from non-family interpersonal conflicts and may include brutal acts such as shootings, rapes, stabbings, and beatings. Children can be traumatized by exposure to community violence as direct victims or as witnesses (e.g. seeing someone killed, hearing gunfire).

School Violence: Types of school violence include fatal and nonfatal student victimization, nonfatal teacher victimization, students being threatened or injured with a weapon at school, fights at school, and students carrying weapons to school. Formal definitions of school violence range from very narrow to very broad, such as the Center for the Prevention of School Violence definition of school violence as "any behavior that violates a school's educational mission or climate of respect or jeopardizes the intent of the school to be free of aggression against persons or property, drugs, weapons, disruptions, and disorder."

Domestic Violence: Domestic violence—also referred to as intimate partner violence, domestic abuse, or battering—involves a pattern of assault or coercive behaviors that adults use against their intimate partners to gain power and control in the relationship. It includes actual or threatened physical or sexual violence, psychological and emotional abuse and economic coercion. Children's exposure to domestic violence can be as witnesses or may involve direct harm. Domestic violence can be directed toward a current or former spouse or relationship partner, including heterosexual or same-sex partners.

Traumatic Grief: Childhood traumatic grief occurs following the death of a loved one when the child objectively or subjectively perceives the experience as traumatic. The death can be due to events usually described as traumatic, (an act of violence, accident, disaster, or war) or it can be due to natural causes. The hallmark of childhood traumatic grief is that trauma symptoms interfere with the child's ability to navigate the typical bereavement process and at times, daily activities.

Natural or Man-made Disaster: A disaster is defined as any natural catastrophe (e.g. tornado, hurricane, earthquake), or regardless of cause, any fire, flood, or explosion that causes damage of sufficient severity and magnitude to warrant the intervention of local, state, or federal agencies and disaster relief organizations. Disasters can be the unintentional result of a manmade event (e.g. nuclear reactor explosion) but do not include damage that is intentionally caused, which would be classified as terrorism.

Terrorism: Terrorism is defined in a variety of formal, legal ways but the essential element is the intent to inflict psychological damage on an adversary. The U.S. Department of Defense defines terrorism as "the calculated use of violence or the threat of violence to inculcate fear, intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious, or ideological." Terrorism includes attacks by individuals acting in isolation (e.g. sniper attacks).

Medical Trauma: Medical trauma includes trauma associated with an injury or accident, chronic or life-threatening illness, or painful or invasive medical procedures. Examples include being told that one has a serious illness (e.g. cancer or AIDS) and the experience of difficult medical procedures such as changing burn dressings or undergoing chemotherapy.

Refugee Trauma: Refugee trauma includes exposure to war, political violence or torture. Refugee trauma can be the result of living in a region affected by bombing, shooting, or looting, as well as forced displacement to a new home due to political reasons. Some young refugees have served as soldiers, guerrillas or other combatants in their home countries, and their traumatic experiences may closely resemble those of combat veterans.

Adverse Childhood Experiences (ACES)[1] (often seen in child welfare)

Growing up (prior to age 18) in a household with:

- Recurrent physical abuse
- Recurrent emotional abuse
- Sexual abuse
- Emotional or physical neglect
- An alcohol or drug abuser
- An incarcerated household member
- Someone who is chronically depressed, suicidal, institutionalized or mentally ill
- Mother being treated violently
- One or no biological parents
- Removal from biological parents
- Unplanned placement moves
- Three or more placements in an eighteen month period

The Lifelong Effects of Trauma[2]

Trauma and Mental Health

- Trauma increases the odds for major depression nearly two-fold
- Trauma increases the odds for suicide
- Trauma is associated with poor response to antidepressant medication and poor overall treatment outcomes

Trauma and Substance Abuse

- Trauma significantly increases the risk for alcohol and drug abuse in adolescents
- Trauma is the best predictor of drug and alcohol abuse in women
- Trauma is associated with poor treatment outcomes/increased treatment drop out

Trauma and HIV/STD Risk

- Childhood trauma dramatically increases risks for HIV-risk behavior: IV drug use and promiscuity

Trauma and Physical Health

- Increased ACES correlate with smoking

[1] The Development of the IDCFS Behavioral Health System. 2005. A Paradigm Shift to Focus on Trauma.
[2] IDCFS: SI/Behavioral Health Team, Tim Gawron Statewide Administrator, Behavioral Health Services

- Increased ACES correlate with adult alcoholism
- Increased ACES underlie chronic depression (according to World Health Organization (WHO), depression is becoming the 2nd most costly illness)
- ACES correlate with increased sexual partners
- ACES correlate with history of Sexually Transmitted Diseases (STD)
- ACES correlate with sexual abuse of male children and their subsequent likelihood of impregnating a teenage girl, rape, unintended pregnancy or elective abortion

Trauma and Academics

- Trauma negatively impacts school readiness
- Trauma negatively impacts school performance
- Trauma impacts cognitive functioning which may result in behavioral difficulties

Responses to Trauma throughout Development

Infants (Birth- $2^1/_2$ yrs.)

- Eating disturbance
- Irritable, difficult to soothe
- Developmental regression
- Language delay
- Attachment disorder
- Failure to thrive
- Sleep disturbance

Attachment - Cannot trust or expect basic needs will be met; listless, unresponsive, irritable, labile, inability to calm, agitation, inconsolable, spacing out, looking away

Regulation of Emotions - Listless, unresponsive, irritable, difficult to console

Cognition and Dissociation - Delays in speech and motor development; does not respond to interaction with adults

Self-Concept – Awareness of self, development of a sense of worth and goal directed behavior.

Physical & Health - Failure to thrive, developmental delays, hypersensitivity to physical contact, suppressed immune system

Young Children ($2^1/_2$- 6 yrs.)

- Helplessness and Passivity
- Generalized Fear
- Confusion, difficulty planning
- Difficulty identifying what is bothering them
- Attributing magical qualities to traumatic reminders
- Fighting or threatening behavior
- Attention Problems
- Sadness/Depression
- Separation Anxiety
- Specific Fears

Attachment - Cannot trust or expect basic needs will be met; avoidant, anxious, disorganized, vacillation from clinginess to aggression, inconsolable, spacing out, looking away, poor peer relationships

Regulation of Emotions - Low frustration tolerance, restless, hyperactive, impulsive, moody

Regulation of Behavior - Aggressive, defiant, lying, inattention, hoarding things, significant problems with toilet training

Cognition and Dissociation - Inattention, difficulty problem solving, learning disabilities, school problems, continuous daydreaming, inability to feel pain, inappropriate emotional responses

Self-Concept - Social problems (controlling or overly permissive with peers), poor boundaries

Physical & Health - Suppressed immune system, headaches, stomachaches, dizziness, gastrointestinal problems, palpitations, intolerance of food, hypersensitivity to physical contact, difficulties with coordination and balance

School-age Children (6-11 yrs.)

- Physical complaints
- Bedwetting
- School failure/absenteeism
- Behavioral problems
- Attention problems
- Fighting or threatening Behavior
- Guilt feelings
- Acting like a parent to siblings
- Depression

Attachment - Oppositional, defiant, lying, stealing, hoarding food, poor peer relationships

Regulation of Behavior - Aggressive/withdrawn, defiant, lying, stealing

Cognition and Dissociation - Inattention, difficulty problem solving, learning disabilities, school problems, continuous daydreaming, inability to feel pain, inappropriate emotional responses

Self-Concept - Self-blame, sees self as "bad", self-harm, aggressive or difficult maintaining relationships with peers, sees the world as unfair.

Physical & Health - Suppressed immune system, headaches, stomachaches, dizziness, gastrointestinal problems, palpitations, intolerance of food, hypersensitivity to physical contact, difficulties with coordination and balance

Adolescents (12-18 yrs.)

- Antisocial behavior
- Runaway
- Depression/Suicidal
- Sleep Disorders
- Absenteeism
- Acting like a parent to siblings
- Eating Disorders
- Dating violence
- Substance abuse
- School failure
- Relationship problems

Attachment - Extreme difficulty establishing and maintaining relationships, social withdrawal, dangerous activities to gain attention

Regulation of Behavior - Drug use, delinquent behavior, sexual acting out, school failure

Cognition and Dissociation - Loses time, spaces out a great deal, skips school, inattention, poor problem solving, learning disabilities, school problems, continuous daydreaming, inability to feel pain, inappropriate emotional responses

Self-Concept - Difficulty seeing any future for self, sees the world as unpredictable and unfair, no sense of purpose, feels life has no meaning, rejects religion/spirituality, feels betrayed, relationship failures, lack of friends, self-harm, suicide

Physical & Health - Includes school-age difficulties noted above in addition to skin problems, fainting and losing consciousness, pseudo-seizures, painful or uncomfortable sensations associated with menstruation and health risk behaviors (e.g., HIV, pregnancy, smoking)

Tips for Talking With Infants, Toddlers, and Preschoolers

Children need to know that there will always be someone there to take care of them.

What you can say: "Scary things have happened to you, but you are safe now. You are with me and I will take care of you."

Children miss their parents, even if their parents have been abusive or neglectful.

What you can say: "I know you miss your mom and dad. They broke some rules when they [hit you, or left you alone/some simple phrase that describes the child's experience]. There are grown-ups who are helping them learn to follow the rules so you can be safe with them. Right now, you are with me, and I will take care of you."

Children need to know that it is not their fault they were taken away.

What you can say: "You didn't do anything wrong. Your mom was wrong to [hit you…]. You didn't deserve to be hit. She is trying her best to learn how to [not hit/take care of children] so you can be safe with her. Right now, you are with me, and I will take care of you."

Children need to know that their parents love them and want to take care of them.

What you can say: "Your mom and dad love you very much, but they have problems and sometimes they don't know what a little boy or girl needs to be safe and healthy. They are trying very hard to learn how to take care of you and grown-ups are helping them get better. Right now, you are with me, and I will take care of you."

Other things you can do:

- Remember that even babies who cannot speak understand much more than they can say. They are listening to you. Talk to them in simple words. Explain, as best you can, what is happening.
- It is comforting for children to have structure. Set limits, explain them, and enforce them.
- It is comforting for children to be close to adults. Little children who seem clingy are communicating a need for closeness. Let them stay near you as much as possible. Once they feel more secure, they will be able to explore more on their own.
- It is comforting for children to have rituals. Have special songs, prayers, or stories that you share.
- Always tell children the truth. If you don't know what is going to happen, be honest about that, but reassure them that there will always be someone to take care of them.
- Help children develop a sense of self by helping them build the stories of their lives. There are several ways to do this with little children:

- Build picture books that show pictures of the houses they've lived in and the people who cared for them. It would be good if the book could include a description of a small ritual or other comforting custom that occurred in each home so that the child can have a sense of really having been cared about and cared for in that home.
- If you can't build a book, tell children the story of the places they've lived and the people who have cared for them and loved them.
- Make sure that children have comforting objects (including special toys or blankets and their life story books) that can go with them from home to home.

Tips for Talking To School Age Children and Adolescents

The same rules that apply to older children and adolescents also apply to young children but the language, style of conversation, and the approaches shift according to the child's developmental (not necessarily chronological) age.

What Happened - Children need to hear a clear message about the neglect, abuse, and violence that led to placement in words that are honest, but not too frightening. The words need to be adapted to the developmental age of the child.

Placement is Never a Child's Fault - It is very common for children to blame themselves for what happened to them and what happened to their family. Validate the child's response to trauma as a normal reaction to what happened. It sometimes helps to have children think about how old, or how big, they were when the trauma took place that led to placement and that they were too young or too small to really make a difference. If the trauma occurred just recently, ask the child what they could have done instead. Begin to gently help the child understand that while they may want to believe that they could have prevented the trauma or saved their mother, father, siblings, etc., even the grown-ups in their family weren't able to do this.

Help for Parents - Children need to hear how their parents are being helped to do whatever is necessary to reunite and provide the safety, nurture, and guidance all children need. If parents are missing, children need to hear how service providers are working to search for them and help them once they are found.

Involvement in Service Planning - Older children can participate in information gathering and the service planning process. They need clear messages about progress, how parents/guardians are being helped, what parents/guardians are doing, the back-up/concurrent plan if parents/guardians can't or won't do what's necessary, time frames, and what children need to be doing day by day and in the next few weeks.

Time Frames - Older children need to hear a clear message of the time frame for working to make their families better including the timelines dictated by child welfare policy concerning the search for permanency.

Capacity for Change - Older children are busy trying to figure out who they are and how they fit in the world. They need to understand that their experience with trauma, especially chronic, early trauma that takes place within the context of their family, does not mean that they will grow up to be "just like" those who have hurt them or their family. For example: Just because a child was hit doesn't mean that he/she will hit their own children.

Three Types of Stress

Stressful events can be beneficial, tolerable, or harmful:

Positive stress: moderate, short-lived stress responses.

Tolerable stress: more intense stress responses that allow enough time to recover, or occur in a relatively safe environment with the presence of supportive adults.

Toxic stress: strong, frequent or prolonged activation of the body's stress management system, without access to supportive adults

Stress and the Body's Alarm System

The human body is designed to react to stress and danger in a way that preserves the individual. When the stress or danger is overwhelming or when it is prolonged, the body has trouble sustaining an adaptive response. Since this is true for adults, imagine what it is like for children. They are smaller, more vulnerable physically, emotionally and psychologically. They have had fewer opportunities to learn coping mechanisms that we have as adults. At an early age, the child won't be able to describe their thoughts and emotions. Due to the foundational nature of growth and development within the first three years of life, the detrimental effects of trauma at that age may well be the most profound of all.

Normal Stress & Danger	**vs**	**Overwhelming Stress & Trauma**
Dealing with Problems		**Feeling Overwhelmed**
---------- Body Signals----------		
Heart pounding		Heart feels like bursting
Rapid breathing		Gasping, feeling smothered
Muscles tense up		Muscles feel like exploding
Fight or flight		Overreacting or freezing
----------Feelings----------		
Excited or worried		Terrified or panicked
Frustrated, determined		Enraged or aggressive
Angry or scared		Hopeless or doomed
Some loss of control		Helpless or out of control
Worried about yourself		Worthless, like a failure
----------Thinking----------		
Some clear thinking		Confused, mentally shut down
Some clear memories		Memory like a broken puzzle
----------Actions----------		
Acting rapidly		Automatic freezing
Facing problems		Avoiding problems
Taking on challenges		Taking foolish risks
		Making a mess of your life

SPARCS. 04 Adapted from Ford et. Al.

Impact of Trauma on Brain Development

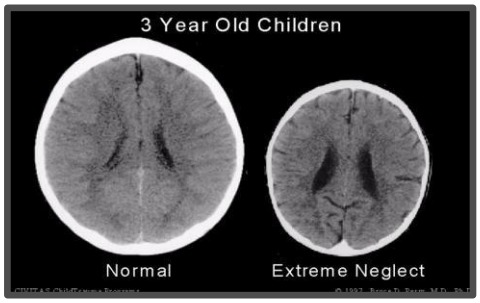


Photo on left is a normal view of a 3 year old child's brain. The one on the right is a 3 year old who suffered severe sensory deprivation. In this particular case, the neglect was so severe that the brain of the sensory-deprived child was actually smaller.

(Slide courtesy of Bruce Perry, M.D.)

Basic Principles of Brain Development [i]

1. The human brain begins its development about two weeks after conception, forming the neurons that are the basic material of the brain. By the time the fetus is 20 weeks, most neurons are already in place. At birth, all brain structures are present, but brain development is far from complete. During the first 2 years of life, the brain expands two-and-a-half times, and continues to develop through adolescence.
2. During the prenatal period, maternal alcohol, drug, and tobacco use, and other adverse experiences can have a negative effect on the developing brain. Maternal stress can also affect brain development.
3. The different parts of the brain have different functions. The brainstem and midbrain are responsible for the body's basic functions such as breathing, heartbeat, blood pressure, and the stress response. The limbic and cortex are responsible for more complex functions such as feeling and thinking.
4. The brain develops sequentially from less complex or basic functions to more complex functions. The brain stem, which supports basic functions, is fully formed at birth. The rest of the brain, which is responsible for more complex functions, remains more sensitive to development through learning and experience.
5. The autonomic nervous system is controlled by the brain stem. When someone experiences stress, a frightening event, or other adverse experiences, the autonomic nervous system sends stress hormones or chemical messages to the rest of the brain in order to "survive" the perceived threat.
6. The problem occurs when an individual remains in a state of chronic or extreme stress for long periods of time, the chemical "baths" that occur during this state disrupt normal brain development.
7. This is particularly critical for infants and very young children as most post-natal brain development occurs in the first few years of life.

1 Adapted from:

-National Research Council, Institute of Medicine, (2000), From Neurons to Neighborhoods. J. Shonkoff and D. Phillips, Eds. National Academy of Sciences.

-Perry, BD, Plooard, RA, Blakeley TL, Baker WL, Vigilante D. (1995). Childhood Trauma, The Neurobiological Adaptation and Use-dependent Development of the Brain: How States Become Traits. Infant Mental Health Journal, 16, 271-291

- Stein, P, and Kendall, J. (2004) Psychological Trauma and the Developing Brain, The Haworth Press, Inc.

Understanding the Effect of Placement on Children

Children in foster care often have changes in placement. Children can feel to blame for these changes and feel isolated. This may increase difficulty in making necessary attachments for healthy development. Effects of prior trauma are multiplied by frequent changes in foster care placements:

- Greater risk of delinquency and high school drop-out
- Increase depressive attitudes
- Decreased sense of belonging
- Decreased likelihood of permanent placement

Placement is another Adverse Childhood Experience (ACES)

- Separation is often unexpected and accompanied by terror (feeling kidnapped)
- Loss
- Child guilt – child may feel it is their fault that the family is

Reducing Trauma's Impact

Three steps to reduce impact of trauma:

- Identify trauma when it occurs and prevent it from reoccurring
- Provide early intervention to trauma victims
- Provide the child with a healthy and responsive caregiver as soon as possible

Even when we have "stopped" the trauma, without intervention, children may continue re-experiencing trauma. Episodes of re-experiencing trauma can manifest themselves with no conscious thought of the traumatic event itself. They may take the form of unexplained irritability, panic attacks, rage, or sudden sadness.

Isolated Trauma versus Complex Trauma

Isolated (acute) traumatic incidents tend to produce discrete conditioned behavioral and biological responses to reminders of the trauma (as in PTSD). Examples: witnessing and being unable to stop an adult from severely beating a child; witness to a criminal act

Complex (chronic) trauma interferes with neurobiological development and the capacity to integrate sensory, emotional and cognitive information into a cohesive whole. Complex trauma also involves interpersonal relationships and the failure of primary caretakers to protect or nurture. Examples: on-going domestic violence or abuse in the home and being helpless to stop; on-going neglect caused by substance abusing parents.[3]

Protective Factors

[3] Van der Kolk, B., 2005, Educational Access Project for DCFS in the Center for Child Welfare & Education at NIU – 2006

Protective factors are the existing strengths of a family. Every family exhibits some of the Protective Factors, in varying degrees. These Protective Factors assist families to overcome the stressors or difficulties that potentially can lead to abuse or neglect. These Factors can be built upon to keep families healthy and keep children safe.

Parental Resilience – (Be strong and flexible.) The critical ability when faced with problems or stressors. Resiliency is the process of adapting well in the face of adversity, trauma and tragedy.

Social Connections – (Parents need friends.) Social connections provide a family with a sense of belonging, emotional support and informal back up for life's challenges. Connections that keep families connected to the community; provide opportunities for growth, and connections to community resources.

Knowledge of Parenting and Child Development – (Being a great parent is part natural and part learned.) Parents should be able to recognize when their children are not developing at a rate similar to other children of a similar age. Parents who can identify developmental problems seek help for their children earlier. Knowledge of parenting techniques often benefits families when faced with additional family stressors.

Concrete Supports in Times of Need – (We all need help sometimes.) Supports include adequate food, clothing and shelter, providing families with necessities which are beneficial in times of other stressors in life. Lack of basic supports may cause tremendous stressors and threaten the entire family's physical health and emotional well-being.

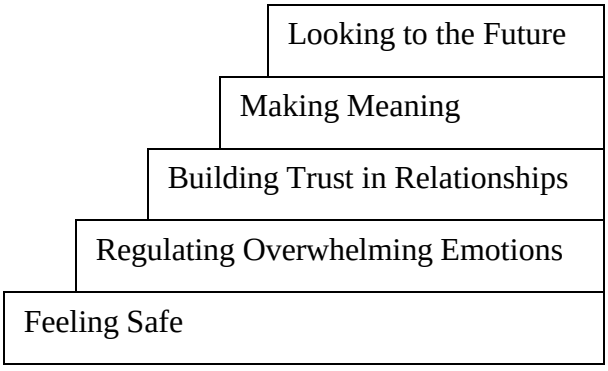
Social and Emotional Competence of Children – (Parents need to help their children communicate.) Children with well-developed social and emotional competencies are better equipped. The social and emotional skills such as the ability to exercise self-control, problem solving, empathy and anger-coping skills are carried over into adulthood.

Parent-Child Relationship – (Give your child the love and respect they need.) Parent-child relationships that are warm, nurturing and responsive are proven to help the child trust, learn, grown and explore the world.

Guiding Principles for Children Who Have Experienced Trauma

Feeling safe is not a passive goal but an active process. Helping a child feel safe means soothing, protecting, m onitoring, and intervening in a predicable manner. For children who have experienced trauma, "feeling safe" can be difficult to attain.

Caring adults can help a child feel safe by understanding the child's experience and taking concrete actions that match the child's development.



Take Care of Yourself

Trauma is essentially a normal response to an extreme event or series of events. It involves the creation of emotional memories about the distressful event or events that are stored in structures deep within the brain – so deep, in fact, that we may seemingly be unaware of them. When we are confronted with similar experiences, our emotional memories may surface in ways or at times we least expect them.

Sometimes our own "lens" is clouded by our own personal experience with trauma. We may not be able to accurately assess the presence of trauma or facilitate healing for those who are affected by it. If you suspect that you may have experienced adverse childhood experiences that may impede your work with a particular child or family, talk to your supervisor.

Vicarious Trauma is an occupational hazard for those working with traumatized persons and trauma material. It is the process of change that happens because you care about other people who have been hurt, and are responsible to help them (such as the role of child welfare worker). It occurs as a result of empathic engagement with traumatized clients. Worldviews are impacted resulting in changes in spirituality (beliefs regarding meaning, purpose, causality, connection, hope and faith), changes in identity (the way you practice or think about your identity as a service provider), and changes in beliefs related to safety, control, trust, esteem and intimacy. The signs and symptoms of vicarious trauma parallel those of direct trauma, but tend to be less intense.

Remembering that VT affects people differently, there are some ways in which it manifests.

1) Feelings of vulnerability
2) Difficulty Trusting
3) A changed view of the world

Strategies for decreasing vulnerability to vicarious trauma include: self-awareness (understanding your responses, feeling present and connected in the moment), maintaining a sense of balance (personal needs with demands of work, demanding work with less challenging work), and maintaining connection with other people, and with our spiritual selves. Intervention for those experiencing vicarious trauma include self-care (physical, emotional, psychological, spiritual, and workplace or professional) and engaging in transformative experiences that restores a sense of meaning, purpose, and joy to one's life.

Strength-Based Practice

Families usually come to the attention of the child welfare system because something bad has happened and needs to be corrected (allegation). There is a need, usually around safety, that brings the child and family to the attention of child welfare authorities. Some of the interventions that may be needed to correct the identified issues are based on a needs based medical model. In other word, deficits must be highlighted in order for the state/provider to be financially compensated for servicing the child/family. This makes it

challenging to focus on identifying family and individual strengths that could be utilized to address the identified deficits.

It is important to note that the medical based model is intended to assure the system that families are receiving appropriate services or interventions.

As discussed in other units, throughout our practice with families we emphasize building strengths. These strengths are identified during interviews and interactions with the family. Our understanding of a family's strengths guides us in selecting services with the family and evaluating their progress. We assist families in determining family, friends and community members who can support the family and be a part of their Child & Family Team.

Strength Based Practice is an attitude or philosophy of working with families.

- Recognizes the importance of using individual and family strengths in assessment and service planning
- Promotes family engagement
- Is individualized to meet the needs of the individuals within the family
- Is culturally responsive
- Is focused on family strengths (Parental Capacity / Protective Factors, Child Resilience)
- Builds relationships and supports for children and families

Principles of Strength-Based Practice

A profound belief in the client's potential is intrinsic to any strengths-based approach. Thinking about strengths begins with the understanding of what goals and dreams the person has; reflecting on the possibilities and hope in their lives. In this process, they can discover or develop new possibilities for themselves and change toward a better life.

We best serve clients by collaborating with them: Approach clients as a helper or collaborator (having specialized education, tools and experiences to offer but, open to the wisdom, knowledge, and experience that clients bring with them).

We work with clients rather than on their cases. In the Strengths Perspective, voices are heard and valued at all levels of intervention, such as in practice with individuals, families, and groups, communities and in policy and advocacy.)

These will be our principles from which we will work to operationalize or bring strengths-based practice alive for use in everyday practice.

Using Strength Based Language

How we report or document information about parents, children or caregivers can include our own biases.

Strengthening Families/Be Strong Families Illinois Protective Factors

Original Language

1. Enhance Parental Resilience
2. Develop Social Connections
3. Build Knowledge of Parenting and Child Development
4. Offer Concrete Support in Times of Need
5. Foster Social and Emotional Competence
6. Promote Healthy Parent-Child Relationships

Everyday Language

1. Be Strong & Flexible
2. Parents Need Friends
3. Being a Great Parent is Part Natural & Part Learned
4. We All Need Help Sometimes
5. Parents Need to Help Their Children Communicate
6. Give Your Children the Love & Respect They Need

These six factors (original and everyday language) were developed to assess the strengths of an individual family. These strengths are crucial for parents to keep their families strong. If these strengths are not present, then the focus needs to be on building those strengths.

Policy and History

Child welfare professionals need to understand the historic and policy foundations of child welfare and apply principles of social work practice within the statutory and administrative framework. This section summarizes laws and consent decrees that influence child welfare practice in Illinois. It covers the service goals and responsibilities of the Illinois Department of Child and Family Services.

Historical Evolution of Child Welfare

In many cultures, children in need of care were considered the responsibility of tribes, clans, or extended families. Historically in this country, "child welfare" referred to the well-being of children lacking adequate family support. Care of these needy children had traditionally depended on the compassion of private charities and religious organizations.

Early foster care was called "placing out." From about 1850 through the early twentieth century, the **"orphan train" movement** placed as many as 150,000 children from eastern cities, orphans or children from poor families, with Midwest farm families. Although some of these children became integral members of these families, many children were valued only in terms of the labor that they could provide. Child protection was not included in the early concept of child welfare.

The first legal intervention into child abuse occurred in 1874 in New York. Ironically, it was initiated by the American Society for the Prevention of Cruelty to Animals. When community social service agencies determined they did not have the authority to protect as abused child named Mary Ellen, the court was compelled to exercise protective supervision for her on the basis that she was a member of the animal kingdom. The following year the **Society for the Prevention of Cruelty to Children** was formally organized.

Settlements and charity organizations functioned as the principle sources of material relief until after the Depression in 1929. The **Freedmen's Bureaus** operated between 1865 and 1871. They assisted newly emancipated African-American families of the South after the American Civil War with educational and health services, direct cash relief, and employment opportunities.

In the late 1800's, two precursors of our current in-home social service system began. The first was the **settlement movement**. It was typified by Jane Addams, who established Hull House on the near west side of Chicago near the current University of Illinois. Hull House volunteers assisted poor immigrants in learning how to cope in the New World. The second was the establishment of the **Charity Organization Societies** in large cities. These societies coordinated various sources of charity and dispensed funds and other types of assistance.

In 1899, with the help of Jane Addams and Julia Lathrop of Hull House in Chicago, Illinois became the first state to adopt a Juvenile Court Act that contained basic child protection procedures. (For more information on the Juvenile Court Act, see Juvenile Court System unit.)

Overall shifts in society and the economy, followed by the Great Depression, gave impetus to federal legislation to help the most vulnerable members of society.

The first federal agency concerned with the welfare of children, the **Children's Bureau,** was established in 1920. In 1939 the high-water mark for social services came with an amendment to the **Social Security Act** that made federal funds available for services to children.

Effective January 1, 1964, the Illinois legislature created the Department of Children and Family Services, and the state assumed fundamental responsibility for safeguarding all Illinois children and families. This included comprehensive child welfare services to prevent child maltreatment and address the needs of parents and families of abused and neglected children.

The mission of the Department of Children and Family Services states that DCFS will:

- Protect children who are reported to be abused or neglected and to increase their families' capacity to safely care for them.
- Provide for the well-being of children in our care.
- Provide appropriate, permanent families as quickly as possible for those children who cannot safely return home.
- Support early intervention and child abuse prevention activities.
- Work in partnerships with communities to fulfill this mission.

The evolution of child welfare services is based on the goal of enabling children to remain with or return home to their families, when the children's health and safety can be ensured.

Protecting children and supporting families is called the **dual mandate**. Even when children are separated from their families, we do not view the children and their families as separate units and support the children's membership in their families of origin.

Sources of Law Affecting Illinois Public Child Welfare

Society frames when and how child welfare interventions take place through laws passed by governing bodies at federal and state levels. Child welfare practice in Illinois must comply with federal and state laws, regulations, procedures and consent decrees.

Constitutional Law

Although the impact or implications of constitutional law may seem remote, the federal and state Constitutions prescribe the organization, powers, and framework of government and establish the:

- authority of the legislature to create and regulate the delivery of public social services for the health and welfare of the public, and
- rights of citizens to due process, equal protection, and privacy that must be maintained and respected by any agency of the government.

Federal Law

Federal law is enacted by Congress. Bills that are passed by the House of Representatives and the Senate and signed by the President become federal legislation.

State Law

DCFS is an agency in the executive branch of Illinois state government. The Director is appointed by the Governor with the advice and consent of the state Senate. The roles and responsibilities of the Department are derived primarily from state laws enacted by the Illinois General Assembly, published in the Illinois Compiled Statutes.

Statutes are the legislative mandates that prescribe the manner in which government will use its powers.

Case law is based on court decisions and interpretations. Case law doesn't include statutory provisions. In any specific case, the court will interpret statutes, define terminology, and review compliance with statutorily prescribed procedures.

Federal Laws

Some of the federal laws that influence child welfare today are listed below.

SOCIAL SECURITY ACT TITLE IV-B

The Social Security Act, Title IV-B, establishes requirements to receive federal funding for family support services, time-limited family reunification services (up to 15 months), adoption promotion and support services. It also creates funds for general child welfare services.

SOCIAL SECURITY ACT TITLE IV-E

The Social Security Act was amended to include the Adoption Assistance and Child Welfare Act of 1980, which created Title IV-E funds. Title IV-E eligible children receive foster care reimbursement to achieve permanent living arrangements. Title IV-E also requires:

- Reasonable efforts must be made to prevent a child from entering foster care, and to reunify a child with the child's family.
- Written case plans with permanency goals, reasons a child is in foster care, services offered to resolve the cause for foster care.
- Periodic review of the progress toward permanency by independent third party--not same administrative unit.

INDIAN CHILD WELFARE ACT

The Indian Child Welfare Act (ICWA) was passed in 1978 as a result of congressional recognition of the importance of preserving the Native American heritage, culture, and communities. It was intended to address the best interests of Native American children and their families by preserving fundamental generational and tribal ties. It ensured the right of cultural identification to Native Americans residing on or off tribal reservations and granted jurisdiction to tribes over matters involving all Native American children.

- ICWA identified federal requirements regarding the removal and placement of Indian children in foster or adoptive homes and allows the child's tribe to intervene.
- The intent of ICWA is to "protect the best interests of Indian children and to promote the stability and security of Indian tribes and families." (25USCsec.2901)
- ICWA recognizes the sovereignty of Native American tribes and establishes preferences for the placement of Native American children who are eligible or have been determined to be members of the tribe. Each tribe determines membership and eligibility.

INTER-ETHNIC PLACEMENT ACT (IEPA)

The Inter-Ethnic Placement Act (IEPA) prohibits any consideration of children's race or ethnicity as a factor in deciding which permanent placement will be in their best interest. The Act intends to:

- Decrease time children wait to be adopted.
- Prevent discrimination on basis of race, color or national origin when selecting foster and adoptive placements.
- Recruit a diverse pool of foster and adoptive families of all races and ethnic groups.
- Provide stiff penalties, including financial penalties, for violation of the Act.

The Four Critical Elements of IEPA are:

- Delays in placing children who need adoptive or foster homes are not to be tolerated, nor are denials based on any prohibited or otherwise inappropriate consideration. Placement cannot be delayed if foster parent of similar background is not available.
- Discrimination is not to be tolerated, whether it is directed toward adults who wish to serve as foster parents, toward children who need safe and appropriate homes, or toward communities or populations, which may have been under-utilized as a resource for placing children.
- Active, diligent and lawful recruitment of potential foster and adoptive parents of all backgrounds is both a legal requirement and an important tool for meeting the demands of good practice.
- The operative standard in foster care and adoptive placements has been and continues to be "the best interests of the child."

Any consideration of race, color, or national origin in foster or adoptive placements must be narrowly tailored to advance the children's best interests. It must be made as an individual determination of each child's needs and in light of a specific prospective adoptive or foster care parent's capacity to care for that child.

Placement decisions require a case-by-case approach. The best approach to avoiding IEPA violations is to use care and sound clinical judgment in selecting the first placement for a child who requires substitute care and to avoid delay in selecting a suitable foster or adoptive home.

ADOPTION AND SAFE FAMILIES ACT (ASFA) 1997

The Adoption and Safe Families Act (ASFA) amends Title IV-E, Social Security Act. ASFA:

- Requires reasonable efforts to move children to permanency, while providing that "a child's health and safety shall be the paramount concern."
- Requires reasonable efforts to secure an adoptive placement when parental rights are terminated.
- Requires judicial permanency hearings for children no later than 12 months after the date children entered foster care, and; no less than every 12 months as long as the children are in foster care.

- Requires that states must file a petition to terminate parental rights when children have been in foster care for 15 of the previous 22 months. (This requirement has been challenged and months of placement cannot be the sole criterion).
- Establishes exceptions to the "reasonable efforts" which are:
  - Child is living with a relative;
  - Termination of parental rights not in the child's best interest;
  - The state failed to provide services consistent with case plan time frame.

Fostering Connections to Success and Increasing Adoptions Act of 2008

This Act extends assistance for foster care maintenance, adoption assistance, and kinship guardianship programs to eligible youth age 18 up to age 21. It provides instructions regarding changes resulting from the Patient Protection and Affordable Care Act and its effect on youth over age 18.

The case review system requires that the Title IV-E agency caseworker, or other child representatives, assist and support youth in developing a transition plan as he/she ages out of foster care. The transition plan must be developed during the 90-day period before the youth attains age 18, or before a later age for a youth in extended foster care.

The transition plan must be personalized at the direction of the child, be as detailed as he or she chooses, and include specific options regarding housing, health insurance, education, local opportunities for mentors and continuing support services, work force supports and employment services. Caseworkers are encouraged to include information in the plan relating to sexual health, services, and resources to ensure the youth is informed and prepared to make healthy decisions about their lives.

State of Illinois Laws & Initiatives

The following state laws influence child welfare services in Illinois.

CHILDREN AND FAMILY SERVICES ACT

Specifies the general duties and responsibilities of DCFS.

ABUSED AND NEGLECTED CHILD REPORTING ACT (ANCRA)

One of the most important pieces of legislation that guides the day-to-day work of child professionals in Illinois is The Abused and Neglected Child Reporting Act (ANCRA). ANCRA requires the Department to receive reports of abused and neglected children, to investigate these reports, and to provide services necessary to prevent further harm to children. The Act provides definitions of child abuse and neglect, lists the persons who are required to report allegations (mandated reporters), and describes how the Department is to accept and investigate reports and provide follow-up services.

Mandated Reporters - The Act lists some of the mandated reporters as:

- DCFS field personnel
- Social workers
- Social service administrators
- Teachers
- Any other child care workers
- Priests
- Doctors

Child welfare professionals are mandated reporters.

Child Abuse

"Abused" children are those whose parents, immediate family members, persons responsible for their welfare, individuals residing in their homes, or parents' paramours:

- Cause death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function by inflicting physical injury to the children by other than accidental means.
- Inflict excessive corporal punishment.
- Create a substantial risk of physical injury by other than accidental means that would be *likely* to cause death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function.
- Commit or allow to be committed a sex offense against the children as defined in the Criminal Code of 1961 (amended to include children under eighteen years of age).
- Commit or allow someone to commit acts of torture on children.

Child Neglect

"Neglected" children are:

- Not receiving the proper or necessary nourishment or medically indicated treatment necessary for the children's well-being as recognized under state law.
- Abandoned without a proper plan of care.
- Newborn infants whose blood or urine contains any amount of controlled substance.

The following are <u>not</u> reasons for children to be considered abused or neglected.

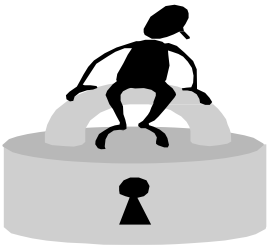
- Parents or responsible caregivers leave the children in the care of an adult relative for any period.
- Parents or responsible caregivers depend on spiritual means through prayer alone for the treatment or cure of disease or remedial care as provided in Section 4 of the Act.
- Children are not attending school in accordance with the requirements of Article 26 of The School Code, as amended.

Failure to Report

ANCRA specifies that **failure by mandated reporters to report suspected child abuse or neglect is a Class A misdemeanor**. Privileged communication involving child abuse or neglect does not constitute grounds for failure to report.

Note: Paramour is a significant other (e.g. boyfriend, girlfriend, lover, partner, friend, or putative father) who is involved in an intimate/romantic relationship with one of the custodial parents of the children who come to the official attention of DCFS through a child abuse or neglect investigation and/or open case; does not have a legally recognized and/or significant, continuous and stable relationship with all of the children; and may or may not live in the same household of the custodial parent of the involved children.

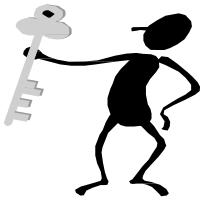
Confidentiality



Records concerning reports of child abuse or neglect are confidential and cannot be disclosed, except as specifically authorized by the Act or other applicable law. **Unauthorized release of any information contained in records is a Class A misdemeanor.**

Certain people, however, may have access to the records, the most significant of those being:

- DCFS staff who are investigating reports.
- Caseworkers or others who are providing services to the subjects.
- Certain law enforcement officers.
- The court and officers of the court, including the Guardian-Ad Litem.
- Legally authorized caretakers or guardians.
- Subjects themselves (with limitations).
- Physicians trying to determine if the children may be abused or neglected.
- Researchers with written authorization.
- Staff of the Department of Professional Regulation.
- Grand juries, coroners or medical examiners.



JUVENILE COURT ACT

Establishes the authority of Juvenile Court to intervene in the lives of children and families. All children in foster care fall under the jurisdiction of the Juvenile Court Act. This law governs the hearings discussed in the Juvenile Court Unit.

ADOPTION ACT

Specifies the grounds for parental unfitness and procedures governing adoption of children.

CHILD CARE ACT

Establishes the licensing regulations governing child welfare agencies, foster family homes, group homes, child care institutions, day care agencies, and individual day care providers.

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

Governs the provision of care for children in foster care from one state to another.

INTERSTATE COMPACT ON ADOPTION & MEDICAL ASSISTANCE

Governs the provision of medical care to children who are adopted in one state and move to another state.

EMANCIPATION OF MATURE MINORS ACT

Provides a means by which a mature minor who has demonstrated the ability and capacity to manage his own affairs and to live wholly or partially independent of his parents or guardian, may obtain the legal status of an emancipated person with power to enter into valid legal contracts.

FOSTER PARENT LAW

Outlines foster parent rights and responsibilities.

ABANDONED NEWBORN INFANT PROTECTION ACT

Often referred to as the "Safe Haven Law." This law allows an infant no more than 30 days old to be relinquished to a hospital, police station or emergency medical facility without question or consequence to the parent.

ILLINOIS DOMESTIC VIOLENCE ACT

Civil law that allows individuals to request orders of protection against individuals who are inflicting physical abuse or neglect, or exploiting family/household members or high-risk adults.

PROBATE ACT

Governs guardianship of minors and adults.

Permanency Initiative

In 1997, the Governor convened a broad-based group to determine what should be done to achieve safe, permanent homes for foster children in an expeditious manner. Three pieces of legislation were enacted: HB 165, HB 66, SB 1099. The provisions of these laws constitute the Permanency Initiative and include:

- Children's health and safety are always the paramount concern.
- Diligent searches must be made early after the initiation of services for missing parents or other family members who might be resources for the children.
- A court permanency hearing must occur for each child no later than 12 months after the date the child has entered foster care; and a permanency hearing must occur no less than every 6 months as long as a child is in foster care.
- The court must select a permanency goal for the child at the permanency hearing.
- The court must consider what action is in the children's best interest.

- Reasonable efforts are not required to reunify children with parents when aggravating circumstances exist or when the court selects a permanency goal other than one of three reunification-related permanency goals.
- Expedited termination of parental rights may be pursued when aggravating circumstances exist.
- Permission to engage in concurrent planning (simultaneously working to reunify children while also pursuing alternative permanent living arrangements if reunification efforts fail).
- Changing the criteria defining parental unfitness in the Adoption Act to make termination of parental rights more timely.

Consent Decrees

There are several state or federal court consent decrees that influence child welfare in Illinois. Consent decrees have the force of the law and child welfare professionals must comply with the requirements of each consent decree. The DCFS Rules and Procedures have been revised to incorporate applicable consent requirements.

ARISTOTLE P V. MCDONALD

Requires DCFS to make a diligent search to locate joint placement for siblings, as well as place siblings together, unless there are certain exceptions such as:

- Unable to locate joint placement despite diligent search.
- Best interest to remain apart.
- Special needs require different placements.
- Children at risk if placed with siblings.
- Existence of a court order.
- Joint placement would require removal from current placement and it is not in best interest to move children.

In the exceptions above, when siblings cannot be placed together, this decree 1) encourages frequent contact between siblings by phone and mail; and 2) specifies visitation twice a month.

BATES V. MCDONALD

Requires DCFS to:

- Provide weekly parent-child visits for children in substitute care with a "return home" goal.
- Arrange visits in parents' homes, unless harmful to children.
- Establish visitation plans within three days of non-emergency placement/ten days of emergency placement.
- Begin visits within the first two weeks after DCFS assumes temporary custody or guardianship.
- Increase visits in length, unless harmful to children.
- Provide statistical information related to visitation.
- Resolve transportation or other problems that make visits difficult to arrange.

BH V. MCDONALD

Requires DCFS to meet a standard of care that:

- Protects children in DCFS custody from foreseeable and preventable harm.
- Provides minimally adequate health care, including mental health care for serious mental health needs.
- Provides minimally adequate training, education, and services to enable children to secure their own safety and provide for their needs.

It contains specific provisions for:

- Protective services
- Screenings and assessments
- Case plans
- Administrative case reviews
- Case records
- Case staffing and management (caseload ratios)
- Health care
- Licensing, training and quality assurance

BURGOS V. SUTER

Requires DCFS to:

- Provide services in Spanish for Spanish-speaking clients.
- Maintain and/or hire a minimum number of bilingual employees.
- Provide a 24-hour central telephone number to assist Spanish-speaking clients.
- Provide certain documents with accompanying Spanish translation.
- Provide child welfare and counseling services to Spanish-speaking Hispanic clients by bilingual employees.
- Place Spanish-speaking children of Spanish-speaking Hispanic clients with Spanish-speaking foster parents.
- Obtain an affidavit from a bilingual employee stating that documents requiring signature from a Spanish-speaking Hispanic client have been translated and explained in Spanish.
- Ensure that bilingual social workers serving this class shall not have caseloads larger than others in the same office.

HILL V. ERICKSON

Requires DCFS to:

- Provide adequate placement and programming for DCFS youth in care who are pregnant and/or parenting.
- Appoint full time teen parent coordinators.
- Consult with quality assurance, ACR units, and training units.

IN RE LEE/WESLEY

Requires the DCFS Guardianship Administrator to notify the Guardianship and Advocacy Commission within 24 hours of admission of a Cook County youth in care to a mental health or drug dependency facility.

KATIE I. ET ALL V. TED KIMBROUGH, THE CHICAGO BOARD OF EDUCATION ET ALL

This decree requires DCFS to:

- Notify the Board of Education when a youth in care is admitted to a shelter.
- Provide the Board of Education with appropriate identification of DCFS youth in care in shelter care.
- Enable enrollment in an educational program.
- Verify immunization records of youth in care in shelter care.

NORMAN V. SUTER

Requires DCFS to:

- Not remove children or refuse to return children to their parents solely because of poverty or homelessness.
- Establish reasonable time guidelines to return children or initiate court actions to do so.
- Make reasonable efforts to keep children in parents' custody in domestic violence situations, unless danger is imminent, including exploring alternative housing and shelters for battered women.
- Provide housing, temporary shelter, case assistance, food, clothing, child care, emergency care takers, and advocacy with public and community agencies.
- Not remove children or prevent return of children to their parents because parents or guardians are living in shelters or housing considered too small for family size or that has building code violations, unless the children are in imminent danger.
- Make reasonable efforts to give services to remedy poverty-related conditions.
- Provide cash assistance for rent, security, or utility deposits and furniture.
- Document reasonable efforts.
- Provide assistance in obtaining housing.

DUPUY v MCEWEN

Requires that DCFS provides due process for people who are accused of abuse or neglect of children. People identified as child care workers are entitled to certain additional notices and processes during a child abuse or neglect investigation. A person determined to be a child care worker is required to receive notice of the Department's recommendation to indicate them for child abuse and/or neglect, a redacted Investigation Summary outlining the information obtained and the persons contacted during the investigation. They are also entitled to an Administrator's Teleconference, during which the child care worker or the child care worker's representative may present information or documentary evidence to explain why the case should not be indicated.

GOMEZ V. JOHNSON

Requires DCFS and the Illinois Department of Corrections (DOC) to work together regarding exchanging information and placement planning for DCFS youth in care who have been declared delinquent and are confined in juvenile correctional facilities in Illinois. DCFS and DOC staff are required to confer on a regular basis and exchange information regarding the DCFS youth in care.

Illinois Statutory Definitions of Abuse, Neglect and Dependency

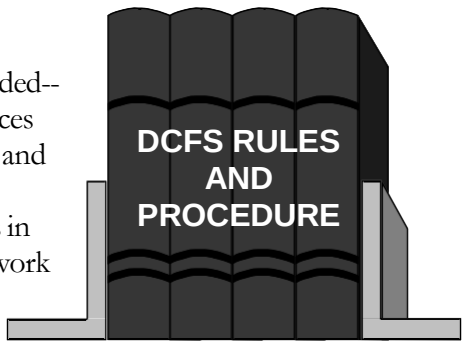
Illinois statutes clearly define abuse, neglect and dependency. These definitions make a clear distinction between abuse and neglect. The statutes left it up to the DCFS to develop the Rules and Procedures regarding the parameters of intervention in cases of abuse, neglect and dependency.

For example, DCFS uses Procedure 300 to apply the statutory definitions of abuse and neglect through an allegation system. The allegation system serves as a guide to the steps a Child Protection Specialist must follow when investigating an allegation of abuse or neglect. This procedure standardizes the process of planning and conducting investigations.

(Note: The Illinois Statutory Definitions of Abuse, Neglect and Dependency are in APPENDIX B.)

DCFS Rules and Procedure

DCFS Rules and Procedure indicate what services are provided--under what conditions (Rule) and how to deliver these services (Procedure). This material is available on the DCFS website and the DCFS D-Net. Child Welfare professionals who provide direct services should be familiar with Rules and Procedures in general and with specific sections in detail. Answers to casework and procedural questions can be found through referencing Rules and Procedures.



Rules are the written policies of DCFS. These policy statements define the general rights and entitlements of the public regarding DCFS authority, functions, and services. Rules are a form of **administrative law** that specify the manner in which DCFS implements statutory law. Proposed rules must be published in the Illinois Register, and comments considered and integrated before adopted as Rules. Rules, or their subsections, called Parts, are organized numerically.

Policy Guides are used to clarify, interpret, or detail a Rule, or to convey procedural instructions on an emergency or interim basis.

Procedure provides directions about how the Rules are to be implemented. Each Rule should be supported by a related Procedure. Procedure specifies activities that staff must engage in order to comply with the Rules. These are not law and may be changed with less formality than Rules. Procedures carry the same numbers as the related Rule and are organized to appear immediately following the related Rule.

Administrative Procedures deal with organizational management topics. They do not relate to specific Rules or Procedures. They are filed separately at the end of the Rules and Procedure. For example, Administrative Procedure #5, Organization of Case Records, sets guidelines for the organization of case files.

Interpretations are one- or two-page documents that answer specific questions about practice. These questions generally require interpretations or clarifications of Rules or Procedure. They may be filed with the cited section of Rule or Procedure.

Computerized version: Although hard copies of the DCFS Rules are distributed by DCFS to all contracted agencies, the DCFS Rules are available also on the DCFS Web page (www.state.il.us/dcfs).

How Children and Families Come to DCFS Attention

Children and families come to the attention of the Department by:

- Reports made to the statewide DCFS hotline (800-25-ABUSE) alleging that children are abused, neglected, or dependent.
- Referrals from agencies contracted by DCFS to provide services to children and families or other public or private agencies.
- Direct requests for child welfare services from families to:
    - Keep the families together.
    - Have children temporarily removed from their care until short-term crisis or problems are resolved (voluntary placement). Voluntary placement is limited to 60 days, but may be renewed one time.
    - Voluntarily surrender their children for adoption when adoptive placement resources for the children are expected to be available within 90 days. If adoptive resources are not readily available, DCFS will seek court-ordered legal responsibility for the children.

Eligibility for Child Welfare Services

Child welfare services, by law, must be provided to children and their families if the court finds the children to be:

- Abused and/or neglected
- Dependent
- Delinquent

  * under thirteen years

  * over thirteen years if currently in DCFS care

- MRAI (Minor Requiring Authoritative Intervention) for whom the Department already has court-ordered legal responsibility. *(Rule 304, P.T. 98.14, October 1, 1998)*

DCFS may also **elect to provide** child welfare services to other families requesting services, or to families identified by DCFS as needing and likely to benefit from services.

Taking Protective Custody of Abused or Neglected Children

Officers of **local law enforcement agencies**, **DCFS Child Protection workers**, or p**hysicians** treating the children may take temporary protective custody of the children without the caretakers' consent if they believe the children cannot be cared for at home without endangering the children's health or safety and there is no time to apply for a court order.

Child Welfare Services Defined

Child welfare services are defined in the act that created the Department of Children and Family services as the "…public social services which are directed toward the accomplishment of the following purposes:"

Protecting and promoting the health, safety, and welfare of children, including homeless, dependent, or neglected children;

Remedying, or assisting in the solution of problems which may result in the neglect, abuse, exploitation, or delinquency of children;

Preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the families where the prevention of child removal is desirable and possible when the child can be cared for at home without endangering the child's health and safety;

Restoring to their families children who have been removed, by the provision of services to the child and families when the child can be cared for at home without endangering the child's health and safety;

Placing children in suitable adoptive homes in cases where return to biological families is not possible or appropriate;

Assuring guardianship when return home or adoption are not alternatives;

Assuring adequate care of children away from their homes;

Providing supportive services and living maintenance, which contributes to the physical, emotional, and social well-being of pregnant and unmarried children for whom DCFS is legally responsible.

Service Goals

Child welfare services delivered by DCFS and contracted private agencies are directed toward four service goals.

Family Preservation

When family preservation is the goal, services are directed toward the children's development, safety, and well-being in their parents' homes and toward preventing placement away from families. These families may have been reported to DCFS due to alleged neglect or abuse, or referred by community services.

Services for these families may include:

- Counseling/advocacy
- Emergency caretaker
- Homemaker
- Family planning
- Self-help groups
- Parent education
- Intensive family preservation services
- Referral for legal services
- Protective and family maintenance day care and child development
- Referral for financial assistance and employment-related day care
- Referral for substance abuse treatment services.
- Referral for housing assistance or housing advocacy

Family Reunification

When family reunification is the goal, services are directed toward returning children to their parents' homes. The services help the children's parents achieve minimum parenting standards and ensure the children's safety and well-being upon being returned home.

The services may include:

- Counseling/advocacy
- Parent education
- Residential care
- Foster family home care
- Relative home care
- Homemaker
- Intensive family preservation services
- Referral for substance abuse treatment services
- Protective/family maintenance day care
- Family planning

Youth Development

These services are directed at helping youths live independently or assisting unmarried youths with planning for the birth or care of children.

Services may be provided to:

- Youths sixteen years of age or older for whom DCFS has legal responsibility to help them live independently from adult supervision and achieve economic self-sufficiency
- Youths who are high school graduates and have been awarded scholarships
- Unmarried, pregnant youths for whom DCFS is legally responsible

Services for youths for whom DCFS is legally responsible may include:

- Counseling/advocacy
- Family planning
- Homemaker
- Day care for children of unmarried youths
- Maintenance of payments for foster family home, relative home, or residential care payment, except that maternity home payment is limited to 90 days maximum

Adoption or Attainment of Permanent Living Arrangements

When adoption is the goal, or when the children cannot return home to their legal families, services are directed at securing new legal status in permanent living situations for the children.

Services may include:

- Counseling
- Subsidized guardianship
- Foster family home care
- Adoption
- Relative home care
- Intensive family services

Agency Partners

DCFS provides many, but not all, services to children and families directly. Often DCFS contracts with other agencies, organizations, and individuals statewide to provide needed services. Agencies contracted by DCFS are **private agencies** because the agencies' boards of directors decide their business and practices.

Illinois' child welfare system is often referred to as a **public/private partnership** between DCFS, a public agency, and the many private child welfare agencies contracted by DCFS to provide child welfare services.

Private Agencies provide a variety of child welfare services:

Agency contracts are usually written for one fiscal year (July 1 – June 30). Contracts specify services to be provided and the rate DCFS will pay for these services.

- **Family Maintenance** enables families to remain intact by preventing further harm to their children and stabilizing the home environment. Depending on the needs of the families, different combinations of services are provided, including counseling, advocacy, emergency caretakers, homemakers, child care, etc.
- **Substitute/Foster Care** provides temporary placements to ensure safety. Children are placed in foster family homes, group homes, or institutions.
- **Family Reunification** services facilitate the timely and safe return of children to their families. Children and their families receive these services during the period children are in substitute care and after they are returned home.
- **Adoption and Support** encourages adoption of children who cannot return home. Services include recruitment and preparation of prospective adoptive parents, preparation of children for placement, and pre and post-placement counseling.
- **Family-Centered Services** consist of support, preservation or a blend of both. Support services are preventive, directed toward a specific population, such as all young parents in a community. Preservation services help stabilize troubled families in times of risk, crisis, or other special needs.

Private Foster Care Agencies

Private agencies are contracted by DCFS to run foster care programs and receive foster care referrals from DCFS. Private agencies develop and enforce their own operating policies and procedures and their unique supports available to foster families and children, such as, camp, after-school care, and support groups.

These agencies:

- Work directly with the children and families.
- Meet foster children's individual needs.
- Report and document families' progress and children's health, safety, and well-being or needs to Juvenile Court.
- Recruit, train, and recommend licensure of agency foster parents to DCFS.
- Implement the Foster Parent Law within their agencies.
- Supervise and support agency foster parents.

DCFS Foster Care Program

DCFS also recruits, directly licenses, trains, supervises, and supports foster families for its own foster care program. Each DCFS region is responsible for recruiting, licensing, and training and must implement the Foster Parent Law within its region, just like private agencies. Like private agencies, DCFS decides what supports will be available to foster families under its direct supervision. Therefore, supports available to Illinois foster families may vary from agency to agency and from agency to DCFS.

Your Role in Child Welfare

If you are reading this guide as a new child welfare professional in Illinois, welcome to your new position. You are joining a committed group of professionals who serve children and families every day. There are dozens of roles in the child welfare profession, all of which work together to form the safety net for children and families. Some of these roles and their descriptions are listed below.

State Central Registry

Staff at the State Central Registry are often called "hotline worker". They take the calls at the 24 hour Child Abuse and Neglect Hotline, determine if calls meet the criteria for an abuse or neglect report, and route information to the proper path within the child welfare system. They provide the first assessment of a family that comes to the attention of DCFS.

Child Protection Specialist

Child Protection Specialists are often referred to as "investigators". They investigate reports of child abuse and neglect by conducting the initial in-person assessment with the family. They gather and analyze evidence to make determinations whether abuse or neglect occurred and make recommendations for services when appropriate.

Child Welfare Specialist – Intact Family Caseworker

Intact Family Caseworkers work primarily with families whose children remain at home with their parents or guardians. Their goal is to keep the children at home in a safe environment. They help families correct the issues that identified them as needing assistance.

Child Welfare Specialist – Placement Caseworker

Placement Caseworkers work primarily with families who have had children removed and placed in substitute care. Their goal is to help families correct the issues that led to the removal of their children and assist them in providing a safe environment for the children to return home. When returning children home is not possible, caseworkers assist in finding families who can provide permanent homes for children.

Child Welfare Specialist – Adoption Caseworker

When efforts to unite children with their parents are not successful, Adoption Caseworkers assist children in becoming a legal member of an adoptive family.

Family Home Licensing Representative

Licensing Representatives recruit foster families and assist them with obtaining foster parent licenses. Representatives provide screenings of applicants, ensuring the home and occupants meet safety standards established by law. They monitor foster homes to ensure that they are providing a safe and nurturing environment for children placed in their homes.

Ethics and Professionalism

Child welfare practice, policy, and programs are closely linked to values and attitudes. This section covers the values and personal and professional behaviors that enable child welfare professionals to complete assignments in an ethical, effective and efficient manner. It includes the professional requirements for case management supervision and documentation

Delegated Authority

Our society views the family as the basic unit for raising and socializing children and seeing to their needs as they grow. Our law and traditions strongly support the family. However the family's right to privacy and freedom from governmental intrusion is not absolute. When a family fails in its fundamental responsibility to protect children's and ensure their well-being, the Illinois legislature has delegated to DCFS, and child welfare professionals as agents of DCFS, the authority to intervene in that family's life.

Child welfare professionals function in a societal-sanctioned decision-making capacity for neglected and/or abused children and their families. When individuals accept the role of child welfare professional and the **delegated authority** inherent in that role, they publicly acknowledge their obligation to assume the professional responsibilities and ethical conduct accompanying that authority. Through delegated authority and the nature of the professional/client relationships, we assume an inherently unequal position of power with children and families.

Children, families, and society must be able to trust child welfare professionals to work with clients' interests in mind with no element of disrespect, punishment, or personal bias. Child welfare professionals are expected to not only to exercise their delegated authority appropriately, but to behave so that their clients and society perceive their use of authority as appropriate.

To build and maintain that trust, **full disclosure** must be practiced with families.
Families need all of the information about what is happening with their children and what they need to do to have them returned to their care. Caregivers need to know about the children in their care so they can provide for their needs.

Child Welfare Employee Licensure (CWEL)

Illinois is one of several states that mandate child welfare personnel obtain and maintain a **Child Welfare Employee License** (CWEL) as a condition of employment. Licensure is an important part of establishing professionalism and accountability, because it establishes a uniform standard of knowledge and expertise for the field. Obtaining a license to practice in any field says you have met the required standards of the profession, and can be entrusted to practice safely.

The CWEL is required to work in child welfare, regardless of any other licensure or credentialing you may have, such as an LSW, LCSW or LCPC license. To learn about specific requirements read relevant sections of the Illinois Administrative Rule 412: Child Welfare Employee Licensure.

Who needs a license?
In Illinois, per Licensing Requirement Rule 412.40, DCFS and private agency staff who work as caseworkers, investigators, licensing workers or supervisors of any of these positions are required to have CWEL.

Requirements for child welfare licensure include:

- Completion of the required application and authorization forms and submitted to the CWEL office.
- Completion of required training
- Clearing a criminal and child abuse background check
- Graduation from an accredited college or university, verified by your college transcripts being sent directly from your college or university to the CWEL office.
- Passing all required exams
- Not being delinquent in paying a child support order
- Not being in default of an educational loan

The CWEL Office can also help. To reach the office, call: (217) 785-5689, or e-mail: cwel.mailbox@illinois.gov

Maintaining Your License in Good Standing
Currently, you are not required to renew your license once you receive it. However, if you violate any part of Rule 412.50, Grounds for Suspension or Revocation, your license could be **suspended or revoked.**

The most common reason a worker's license get suspended or revoked is falsification of case documentation. Sometimes a worker gets so busy and overwhelmed that he or she has not found the time to make the required case contacts. The worker may think there is no harm in simply writing a case contact that says she or he saw the client when, in fact, that contact wasn't made. This is a HUGE mistake. Every year, workers lose their licenses for that exact thing. If you are unable to make a required contact, it is much better to simply explain that to your supervisor than to risk your career in child welfare. Knowingly providing false information in **case notes, contact notes or courtroom testimony** is a serious violation of the public trust which could result in revocation of your Child Welfare Employee License.

There are other acts that can cause a worker to lose his or her license, including inappropriate relationships with a client, or between a supervisor and subordinate. For a **complete list of the licensing violations**, be sure to see and carefully review Rule 412.50, Grounds for Suspension and Revocation.

Code of Ethics for Child Welfare Professionals

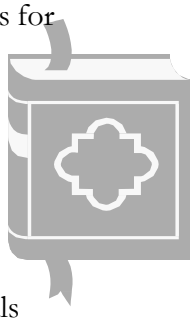
Preamble

"It is understood that ethical judgments are made by individuals who bring their personal values, culture, and experiences to the decision-making process. By making public the values and ethical standards shared by child welfare professionals, this code assists in making ethical decisions more consistent and objective and reinforces child welfare professionals' accountability to society and to those individuals with whom they have professional relationships." (IDCFS Code of Ethics: Preamble)

The Department's Code of Ethics sets forth ethical principles that should be applied by child welfare professionals whenever they must make ethical judgments. Values affect behavior and attitudes and influence individual choices of action. Consequently professionals' values influence their decision-making. The Code of Ethics establishes values and ethical standards of behavior for relationships between professionals, the individuals they serve, colleagues, supervisors, foster parents, the court and society.

The Code of Ethics:

- Identifies competing values and responsibilities for child welfare professionals.
- Guides the daily conduct of the child welfare professionals via standards for professional behavior.
- Assists child welfare professionals in making more consistent and objective ethical decisions.
- Reinforces child welfare professionals' accountability to society and to the individuals served.
- The Code of Ethics also indicates that:
  - If there is a conflict between two or more ethical principles and/or responsibilities in a particular case, child welfare professionals should consult with superiors and colleagues knowledgeable about ethics issues, or with a child welfare ethics committee, in choosing a proper course of action.
  - If the demands of agencies with which child welfare professionals are affiliated conflict with the Code of Ethics, child welfare professionals should clarify the nature of the conflicts in a way that permits fullest adherence to the Code.
  - If child welfare professionals observe violations of the Code by colleagues, they should bring the issues to the attention of the colleagues if informal resolution appears appropriate. If the issues cannot be informally resolved, child welfare professionals should refer them to appropriate superiors and/or to a child welfare ethics committee.



Note: Appendix B includes the entire Illinois Child Welfare Code of Ethics. It is also on the DCFS website and DCFS D-Net.

Fiduciary Relationships

The responsibilities of child welfare professionals are grounded in **"fiduciary relationships"** with clients. Fiduciary relationships are based on trust and trustworthiness. When we intervene in the lives of those less powerful, we practice fiduciary relationships based on:

Honesty	Diligence	Loyalty
Competence	Confidentiality	Promise-keeping
Individualized intervention	Client self-determination	Respect for persons

These values, behaviors and attitudes underscore the importance of accepting responsibility for one's actions and; their consequences, and holding professional behavior to a standard higher than self-interest.

Professional Conduct

Child welfare professionals should exhibit appropriate work habits, dress, language, and decorum in their work. They carry out their fiduciary responsibility to clients and the public by not engaging in activities that will malign their professional role or relationships and by demonstrating:

Integrity

- Recognizing the vulnerability of their clients and the serious responsibilities associated with intervening in the parent/child relationship.
- Exhibiting behavior that reflects the emphasis of the social work profession on interests and trustworthiness and the values of respect for persons, client self-determination, individualized intervention, competence, loyalty, diligence, honesty, promise-keeping, and confidentiality.

Trustworthiness

- Conducting themselves in a responsible, professional manner in all work situations whether with clients, co-workers, or the public.
- Maintaining public trust by refraining from conduct that could adversely affect the public's confidence in the integrity of the child welfare system and services.

Competence

- Providing services only within the boundaries of their competence based on their education, training, supervised experience, and professional experience.
- Honestly representing their qualifications, educational backgrounds, and professional credentials.
- Pursuing professional development by taking advantage of continuing education and other opportunities for attaining or maintaining a high level of competence.

Cultural Competence

- Valuing cultural diversity, respecting differences
- Recognizing the significance of cultural differences for engaging in the helping process
- Understanding that bias and prejudice can negatively affect services to children and families

Setting clear, appropriate professional boundaries

- Clarifying with all parties (child, birth parents, foster parents, child's other relatives or siblings, etc.) the nature of the professional responsibilities to each of them, and the ways in which appropriate boundaries will be maintained.
- Refraining from socializing with their clients, clients' family members or close associates, and foster parents with whom employees have a working relationship, except when it is part of the normal performance of their professional duties.
- Engaging in no romantic or sexual contact with the clients, clients' families, or close associates, as it could affect their work with the clients.

Affirmative Action

The goals of Affirmative Action are to create and maintain a workplace environment which discourages discrimination in any form and responding to and ending acts of workplace discrimination, that result from unequal (disparate) treatment of one employee compared to another employee similarly situated.

Affirmative Action relates to all matters of employment: recruitment, hiring, promotion, renewal of employment, selection for training, discipline, tenure or terms of employment, privileges or conditions of employment and discharge. It includes discrimination by prohibited reason of race, color, or religion; national origin or ancestry; gender; age; sexual orientation; disability; physical or mental handicap unrelated to ability; mental status; by reason of any handicap; citizenship status; or marital status.

Federal Anti-Discrimination Laws

- **Civil Rights Act of 1964 Title VII**
  - Prohibits discrimination on basis of race, color, religion, national origin, gender;
  - Is illegal to retaliate against a person because the person complained about discrimination; or filed a charge of discrimination; or participated in an employment discrimination investigation or lawsuit;
  - Requires employer to reasonably accommodate applicants and employees religious practices; unless doing so would impose an undue hardship on the operation of the employer business. Burden is on employer to show hardship on business operation.
- **Civil Rights Act of 1964 Title VI**
  - Prohibits discrimination on basis of race; color; or national origins in programs and activities receiving federal financial assistance (e.g., Federal Title IV-E FFP)
- **Title I of the American with Disabilities Act (ADA)**
  - Prohibits discrimination by employers with 15 or more employees against qualified individual with disabilities;
  - Is illegal to retaliate against a person because the person opposed employment practices that discriminate based on a disability; or for filing a charge of discrimination; or participated in an employment discrimination investigation; or proceeding; or litigation brought under the Act;
- **The Rehabilitation Act of 1973**
  - Prohibits discrimination on the basis of disability and programs receiving federal financial assistance;

- Standards used to determine employment discrimination under the Act are the same as used under the ADA.

❖ **Age Discrimination Act of 1967,** 42 U.S.C. 6101 et seq., as amended
- Protects individuals who are 40 years of age or older from employment discrimination on the basis of age; Protects both job applicants and employees.
- Is illegal to discriminate against a person because of the age of the person with respect to any term, condition, or privilege of employment, including hiring, firing, promotion, layoff, compensation, benefits, job assignments and training.
- Prohibits retaliation against an individual who has complained about discrimination based on age or opposed employment practices which discriminates on the basis of age; or filed a charge of age discrimination or participated in a proceeding or litigation under ADEA.

❖ **U.S. Department of Labor Executive Order 11246. Parts II, III and IV**
- Prohibits federal contractors and sub-contractors and federally assisted contractors and sub-contractors which have contracts that exceed ten thousand dollars from discriminating in employment decisions based on race, color, religion, sex or national origin;
- Requires contractors to take affirmative action to ensure equal opportunity is provided in all aspects of their employment;
- Office of Federal Contract Compliance in U.S. Department of Labor administers compliance.

❖ **Indian Child Welfare Act of 1978** (directly related to child welfare-see Unit 1)

State of Illinois Anti-Discrimination Laws

❖ **Illinois Human Rights Act, Section 2-102 Civil Rights Violations-Employment**
- It is a civil rights violation for any employer to refuse to hire, to segregate, or to act on the basis of unlawful discrimination or citizenship status with respect to recruitment, hiring, promotion, renewal of employment, selection for training or apprenticeship, discharge, discipline, tenure or terms, privileges or conditions or employment.

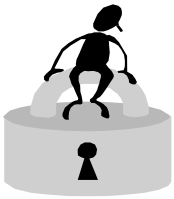
❖ **DCFS Rule 429.3 Equal Employment Opportunity Through the Department of Children and Family Services**
- The Department will not discriminate in employment on the grounds of race, color, religion, sex, marital status, national origin or ancestry, age, physical or mental handicap unrelated to ability, or an unfavorable discharge from military service other than dishonorable discharge.

❖ **DCFS Rule 308.30 a) and b) Non-discrimination Requirements of Department Service Providers.**
- The Department shall contract only with service providers who, in their services and opportunities for employment, exercise non-discriminatory policies and practices.
- All purchase of service providers must provide contractual exhibits assuring that they do not discriminate in their employment and service delivery practices.
- Every provider shall comply with Title VI and VII of the Civil Rights Act of 1964; Section 503 and 504 of the Rehabilitation Act; the U.S. Constitution; the 1970 Illinois State Constitution; all other state and federal law, regulations or orders which prohibit discrimination in employment on grounds of race, color, religion, sex, age, national origin or ancestry, marital status, physical and mental handicap unrelated to ability, an unfavorable discharge from military services other than a dishonorable discharge, the inability to speak or comprehend the English language or by reason on any handicap.

Professional Conduct and Sexual Harassment

Sexual harassment is defined as any unwelcome advances or requests for sexual favors or any conduct of a sexual nature when:

- Submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's employment.
- Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or
- Such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating hostile or offensive working environment.



Confidentiality

Child welfare professionals should respect the confidentiality rights of children and families, use confidential information only for professional purposes, and inform the children and families of relevant confidentiality requirements. All child welfare professionals must understand and adhere to the DCFS confidentiality policy. Child welfare professionals employed by private agencies also need to consider the confidentiality requirements and limitations of their agency.

The DCFS confidentiality policy indicates the prohibitions and limitations on the release of personal information about families and children whether clients or others contacted by child welfare staff. Employment in a child welfare agency does not entitle individuals to information about investigations or cases except the child welfare professionals, supervisors, or clerical staff directly responsible for the case. Seeking information not related to employment responsibilities is a violation of confidentiality and misuse of authority.

Confidentiality protects the identity of reporters and others who provide information in child abuse or neglect investigations. Except under specific circumstances, confidentiality protections also cover subjects of protective service and child welfare clients. Specific exceptions to the release of child abuse information are generally designed to facilitate investigation and treatment. Information that is shared with DCFS or private agencies under promise of confidentiality should not be released, except as allowed by DCFS rules or state statutes.

Guardians, parents, and/or minors may need to give specific consent for the release of personal information. There are special limitations on release of information for those who may be HIV-infected, and for mental health information. Parents who have surrendered their parental rights or had parental rights legally terminated may not have access to their children's personal information. Parents may indicate in writing if they would allow the children access to their names and information about them sometime in the future. Only the Director of the Department may release information to legislators.

Conflict of Interest

Conflicts of interest are as prevalent in child welfare as they are in government and big business. It is important to know what it means to have a conflict of interest, why such conflicts are ethical problems, and how they can be addressed. A conflict of interest has two identifying elements:

A person is entrusted to exercise objective judgment in the service of another party

AND

that person has an interest that would lead a reasonable person to believe that the interest would interfere with the objectivity of his/her professional judgment, making it less reliable than it would otherwise be.

Interests usually include private interests or multiple relationships. The danger with a conflict of interest is that interference with a professional's objective judgment can undermine trust and compromise services to clients and/or jeopardize the credibility of your agency. Conflicts of interest can be actual, potential, or apparent.

Actual Conflicts - A child welfare professional entrusted to exercise objective judgment in the service of an agency and its clients has an interest that could interfere with the objectivity of that judgment.

Potential Conflicts - A conflict of interest is potential if there is no existing conflict, but there is some likelihood that the situation will change such that there would be an interest which could reasonably affect future decision-making.

Apparent Conflicts - An apparent conflict of interest means that even though there may not be a potential or actual conflict a person, unaware of the facts of the situation, might reasonably infer that a conflict exists.

There are several ways to address conflicts of interest.

Disclosing the Interest: While disclosing the interest may resolve the conflict in some situations that is usually not the case in child welfare. Once an interest is disclosed, clients are not in the position to choose to dissolve or maintain their relationship with the child welfare professional.

Recusal: The most common strategy for diffusing conflicts of interest is recusal. Withdrawing from the decision-making process is usually effective in situations where the conflict is not an on-going circumstance and other staff members are available to undertake the additional responsibility.

Divestment or Change of Position: If the conflict is ongoing, it is unlikely that disclosing the interest or recusal will be sufficient. To resolve this conflict, a person may need to divest themselves of the outside interest or leave one's position. (Note: For more information see DCFS Policy & Procedures Rule 437.)

DCFS Structure and Responsibility

It is the responsibility of child welfare professionals to understand the organizational structure of DCFS and, if applicable, of the private agencies for which the professionals work. Most families who require DCFS intervention require the professional to navigate them through the complex state child welfare system. Child welfare professionals should have or know how to access information for the children and families related to DCFS' role and responsibilities. Major divisions and responsibilities:

Administrative Case Review

Assists workers, supervisors, and families in:

- Recognizing practical case objectives.
- Reviewing implementation of service plans.
- Documenting family progress and efforts to provide needed services.
- Planning permanency for children.

Child Protection

- Provides a 24-hour Abuse/Neglect Hotline (800-25-ABUSE).
- Investigates allegations of child abuse and neglect.
- Determines if credible evidence of harm to children exists.
- Ensures immediate safety of children through a safety plan or taking protective custody when necessary.

Intact Family Services

- Ensures the safety of children who remain in the care of their parents/guardians.
- Helps families to resolve the issues that brought the children to the attention of DCFS.

Makes referrals to obtain community services for families.

Clinical Services

- Provides access to specialized expertise, consultation and guidance for caseworkers to support their clinical judgments.

Provide resources related to Domestic Violence, Alcohol and Other Drugs (AODA), Developmental Disabilities and Lesbian, Gay, Bi-Sexual, Transgendered and Questioning Youth.

Foster Care and Permanency Services

- Emphasizes the importance of foster caregivers in caring for children.
- Guides DCFS efforts on permanency, including returning children home more quickly; or, if return home is not appropriate, the need to move children as quickly as possible to an alternate permanency option.
- Consolidates DCFS policy direction and planning for DCFS activities that involve foster care and permanency planning.
- Coordinates DCFS involvement in and response to various foster and parent adoptive advisory groups throughout Illinois.

Adoption, Guardianship & Post Adoption Services

- Prepares caregivers for the process of adoption and completing adoptions
- Assists caregivers for permanency through private guardianship or the KinGap guardianship program
- Offers services and support to caregivers after permanent placements

Foster Home Licensing

- Recruits foster caregivers
- Provides training for foster and relative caregivers
- Licenses and monitor foster caregiver homes

Day Care, Agency & Institution Licensing

- Licenses and monitor day care homes
- Licenses and monitor agencies and institutions

Training and Professional Development

- Provides orientation, basic training, and on-the-job mentorship to employees new to the Department, and provides core training for lateral and promotional positions.
- Develops and delivers recruitment and retention programs, including professional degree programs, scholarships, paid field placement, advance development and certification programs, and leadership and management development programs.
- Provides Department and private agency staff with information dispersal on law, policy, and procedures, as well as in-service training programs; develops and delivers training on CERAP, licensure, and other required programs.
- Assists field administrators and supervisors with region- and division-specific training planning and delivery through performance assessment, analysis, and application of training needed to address and enhance performance.
- Ensures training development and region-based field education through a network of education partnerships with Illinois universities' schools of social work programs; works with the Child and Family Research center to incorporate research findings into training programs.

Operations and Community Services

- Provides statewide administration overseeing services to children and families.
- Manages referrals for services purchased from private child welfare providers and community agencies.
- Provides critical follow-up services to children for whom DCFS is legally responsible, as well as to families whose children are or have been at risk of coming under DCFS care.
- Licenses foster families supervised directly by DCFS.
- Local Area Network (LAN) development

Purchase-of-Service (POS) Monitoring

- Office of Litigation Management.
- Conducts agency performance reviews.
- Performs special field audits.
- Assists private agencies with quality improvement activities.
- Issues licenses to foster families supervised by private agencies.
- Licenses day care services.
- Licenses private child welfare agencies.

Support Services

- Supports management functions of DCFS, which include:
- Budget development
- Financial management
- Contract processing and payments
- Legislative Affairs

Office of the Guardian

- Serves as legal guardian of children and youth in DCFS custody.
- Responsible for provision of consents for medical treatment and other services.
- Authorizes other individuals to act as "Authorized Agents" to sign defined levels of consent.

Office of Quality Assurance

- Conducts comprehensive reviews of DCFS direct service operations, products and evaluates outcome information.
- Responsible for Department's accreditation compliance in association with the Office of Clinical Services.

Office of the Inspector General

- Assures accountability for services to children and families.
- Investigates allegations of misconduct, misfeasance, malfeasance, and violations of rules, procedures, or laws by employees, foster parents, or Department contractors.
- Recommends changes, including systemic changes, based on investigation results.
- Monitors compliance with recommendations.
- Investigates deaths of children in Illinois if there is an appearance of abuse or neglect when there was an open case or DCFS involvement within the previous six months.

Management and Supervision

All child welfare staff are members of a professional team and need to continue with their own professional growth and development. Policy requires that those in direct service positions with clients receive regularly scheduled supervision. Depending on their role, staff may receive four types of supervision.

Educational Supervision— directed toward helping staff learn what they need to know to carry out their job responsibilities. Examples may include:

- Training staff on Rule and Procedure
- Teaching staff how to do paperwork
- Assessing staff's knowledge and skill level
- Providing an orientation to new staff
- Planning for ongoing professional development with staff

Supportive Supervision— directed toward creating a positive psychological and physical climate for staff. Examples may include:

- Advocating for staff
- Resolving conflict
- Listening to staff concerns and issues
- Fostering self-awareness
- Team building

Administrative Supervision— focuses on job performance and how it is related to the agency's mission. Examples may include:

- Employee Handbooks (DCFS workers: find this resource on-line)
- Establishing performance objectives and measures, Monitoring work performance
- Employee performance evaluations, employee discipline
- Tracking client contacts
- Meeting mandates

Clinical Supervision— directed toward clinical interventions Examples may include:

- Discussion of safety and risk factors.
- Reviewing family progress toward the permanency goal.
- Discussing possible service needs.
- Reviewing the service plan.
- Making critical decisions.
- Provide clinical guidance related to casework.
- How to address underlying conditions
- Identify parallel processes (e.g. transference and counter transference.)
- Identify the impact of personal values, beliefs, assumptions and biases.
- Case management problems, etc.
- Recognize knowledge and skills as well as limitations and areas for growth.
- Plan for professional development

The Appreciative Inquiry Model of Supervision

The Appreciative Inquiry Model of Supervision focuses on recognizing and building on strengths. These three questions are the focus of supervision: **what is going well**, **why it is going well** and **how to replicate in other areas**. This model is a "two way street" as staff can also recognize and build on strengths in the supervisory relationship.

Ongoing Training

As part of Educational Supervision, supervisors help workers achieve their highest potential in their current role and for future roles. Supervisors help staff identify areas of strength, interests and areas for growth. A number of venues, including training, help staff achieve their goals.

The **Virtual Training Center (VTC)** is the source for training information. Course information is provided in the VTC and on-line courses can be taken from this site. A transcript of all completed trainings is maintained for each staff person. Every staff person should also have a **Professional Development Plan** specifically developed for their ongoing growth which may include plans for further training, supervision and shadowing experienced staff.

Documentation

Documentation that is accurate, complete, up-to-date, meaningful, readable, well-written, well-organized, and timely is vital to the appropriate delivery of child welfare services. Effective, efficient documentation facilitates permanency planning and teamwork among families, courts, and service providers. Documentation must be free of bias. It is not based on a worker's personal opinion, but on observations and professional recommendations.

Documentation can be one of the most challenging areas for child welfare professionals. They see their job as one where work with people is essential, frequently neglecting documentation as less important. In fact, far from being irrelevant to good social work practice, documentation is one of the cornerstones of permanency planning.

Case Recording

The first step toward keeping appropriate documentation is to complete the case recording as soon as possible after the completion of the activity. Recollection of conversations and observations will be more vivid, comprehensive, and accurate.

Effective documentation involves systematically recording in-person contacts, contacts by phone, attempted contacts, as well as appointment cancellations, either during or immediately following the contact, in the format that will go in the case record. To ensure that documentation happens, set aside time for it in you in weekly schedules.

Consider the following when writing case documentation:

Relevance to the agency's involvement and achievement of permanency planning goals. Not everything learned while working with a client can be written down, but important issues should be documented. The best way to focus writing is to make sure that case recordings are related to the agency's involvement and/or progress toward achieving case goals. Applying this standard to all reports, assessments, and ongoing recordings will help to organize and focus writing.

Behaviorally specific descriptions. Behaviorally specific writing sets down the facts, rather than feelings or assumptions. Courts and other professionals need a descriptive behavioral picture of what has been observed or heard. Any assertions should be backed up by observed behavior.

Factual, not based on assumptions. Police reports, evaluations by other professionals, observations, and conversations contain facts that are recorded in the case file.

Objective, not subjective. Being objective means treating or dealing with facts without distortion by personal feelings or prejudices. There is no way to be totally objective, but make an effort to avoid any distortion or manipulation of facts to prove assertions

Simple and clear. Long, rambling sentences full of complex terminology can make documentation difficult to understand.

Jargon free. Only professional terms that are behaviorally specific, descriptive, and relates to case facts should be included in case recordings.

Identify sources of information. Professionals should document the name and address or location of the contact, including the date, time, and nature of the contact, and the professional's signature.

Clients can review their files. Family members have a right to review their case record. Professionals are expected to share crucial information with the families. In reviewing their file, families should not find information that comes as a surprise to them.

ONGOING CASE CONTACT RECORDING (CASENOTES)

Recordkeeping of ongoing case contacts, designating whether the contact was in person or by phone, is a vital, high-priority activity that requires time, accuracy, and clarity. This information is valuable because it provides information about:

- Family changes or progress toward the goals of agency involvement.
- Important aspects of contacts on behalf of families.
- Specific activities accomplished by the agencies and the professionals on behalf of families.
- Work with other staff and providers.
- Important facts, discussions, case events, and observations that affect important case decisions.
- Other agency documents (assessment, case review, closing summary, etc.)

OTHER AGENCY DOCUMENTS

In writing more extensive documents, like the Integrated Assessment Report and Service Plan, there should be a clear understanding of the specific purpose of each document and any decisions that will be made because of what is reflected in the document. The purpose of these other agency documents includes:

- Providing summaries of longer periods of case activity and changes or progress toward case goals during those periods.
- Consolidating information from a variety of sources into one structured, organized, and purposeful document.
- Providing structured, organized information that can serve as a basis to form major case decisions.
- Serving as an ongoing source of documentation and justification for case decisions.

CORRESPONDENCE

Correspondence should be concise, easily understood, and written in the language preferred by the recipient. The writer should not try to accomplish too much in a single item of correspondence. Copies should be retained for the case record. Examples of purposes of correspondence are:

- Documenting the mutual expectations between the agency and other parties, including information that may have been initially shared verbally.
- Arranging for the initial contacts with family, collaterals, service providers and other parties involved in the case.
- Reminding families of appointments.
- Advocating, lodging complaints, or formally expressing concerns.

  Requesting services.

Standards and Elements of a Good Case Note (Council on Accreditation)

1. **Case name and client's name -** The case name will typically be under the mother's last name. The client's name can be different from the case name if the child has a different last name than their mother, or if there is another caregiver in the home with a different last name.
2. **Caseworker's name**

3. **Date of contact**
4. **Time and type of contact -** Case notes should identify the type of contact made with the family. Examples include: In Person, Phone, Court, School, Attempted Contact in Person or Attempted Contact by Phone.
5. **Where the contact took place -** Examples include: Family Home, Court, Police Station, Foster Home, Counseling Center, School, Visiting Center or Group Home.
6. **Who was interviewed and who else was present -** Case notes should identify who is being contacted and whether by phone or in person. Examples include: Mr. Fred Jones (father to John Jones), Officer Wright (investigating police officer).
7. **Purpose of the contact -** Case notes should always identify the purpose of the contact. The majority of case contacts should directly relate to the families involvement with DCFS. Examples include: obtaining social history information, discussing visitation schedule.
8. **Describe the process and family response to the process -** Case notes should reflect a summary of the worker's attempts at engaging the family in addressing the purpose of the contact, documenting the family's cooperation, their progress and their response to suggestions/interventions.
9. **Provide Assessment -** Case notes should identify the worker's assessment of service effectiveness and family's progress toward correcting the conditions that led to the attention of DCFS. Notes should include facts obtained and observations. Quotes from the interviewee should be used whenever possible.
10. **Identify the plan -** Case notes should identify any follow up activities that will be conducted, other persons that need to be contacted, the date of the next contact, and any plan for intervention as a result of this contact.
11. **All case notes must:** - Avoid using acronyms (MGM) or pronouns (He). If handwritten, be written using black ink and have mistakes lined out and initialed by the writer. Do not use white out. Be signed by the worker, including degree, DCFS title, and date note was written.

Statewide Automated Child Welfare Information System (SACWIS)

All professional child welfare staff in Illinois record case information in the Statewide Automated Child Welfare Information System (SACWIS). SACWIS allows staff to obtain information quickly and provides guidance regarding practice expectations. Cases are opened in SACWIS and records for the family are maintained there. All assessments and the service plan are recorded there. All recording of contacts with children and families are documented in SACWIS.

Human Behavior and Development

To assess the needs of families and children, child welfare professionals must understand basic patterns of human development and human behavior, the family life cycle, how children develop attachments, and why these attachments are important for children's healthy development.

Human growth is a continuous process that begins with conception and proceeds stage by stage, following an orderly pattern. All children grow and develop according to the same general pattern. The rate of growth may vary considerably from one child to another, but the pattern is the same. All babies learn to lift their heads before they learn to sit alone. They sit up before they walk.

Human growth is continuous and can be irregular. One part may grow faster than another, one part may rest for a while until the other parts catch up and move ahead. Most children experience irregular growth during both behavior and physical development.

If human beings are provided with the right conditions, they will progress through predictable stages of development. However sometimes children face conditions that negatively affect or delay growth and development and, therefore, may later influence the adult personality.

Five Domains of Human Development and Behavior

Physical Development	Size and ability to perform tasks, such as lifting one's head, walking, crawling, riding a bike, writing, running, etc.
Cognitive Development	Making sense of the world, such as learning to speak, understanding speech, reading, writing, doing arithmetic, and advancing in academic areas.
Emotional Development	Recognizing, understanding, and controlling feelings, such as, love, anger, sadness, and happiness.
Social Development	Relating to other people, empathizing with their feelings, and understanding their reactions.
Sexual Development	Becoming sexually mature and able to procreate. Puberty is the stage in human development when the body changes from a child's body to an adult's.

Normal Stages of Human Development and Behavior

Child welfare professionals have the responsibility to assess what services or interventions are needed for any area of children's development when there is question or concern about any area of children's normal development. Several theorists have described normal human behavior and development. One is Erik Erikson, who formulated eight stages to describe a person's social and emotional development.. Each stage is a "psychosocial crisis" that arises and demands resolution before the next stage can be satisfactorily worked out.

Erikson's Eight Stages of Development

Learning Basic Trust Versus Basic Mistrust (Hope)

Chronologically, this is the period of infancy through the first or second years of life. The child who receives appropriate nurturing and care develops trust, security, and basic optimism. The child who does not becomes insecure and mistrustful.

Learning Autonomy Versus Shame (Will)

The second psychosocial crisis occurs during early childhood, probably between about eighteen months or two years and three-and-a-half to four years of age. The "well-parented" child emerges from this stage sure of himself, elated with his newfound control, and proud rather than ashamed. Autonomy is not, however, entirely synonymous with assured self-possession, initiative, and independence. At least for children in the early part of this psychosocial crisis, it may include stormy self-will, tantrums, stubbornness, and negativism. For example, one sees two-year-olds resolutely folding their arms to prevent their mothers from holding their hands as they cross the street. "NO" is a word often used by children during this psychosocial stage.

Learning Initiative Versus Guilt (Purpose)

This stage occurs during the later preschool years when healthily developing children learn to:

- Imagine and broaden their skills through active play of all sorts, including fantasy.
- Cooperate with others.
- Lead as well as follow.

If children are immobilized by guilt, they:

- Are fearful.
- Hang on the fringes of groups.
- Continue to depend unduly on adults.
- Are restricted both in the development of play skills and in imagination.

Industry Versus Inferiority (Competence)

This stage occurs during the "school age," up to and possibly including some of junior high school. Here children learn to master the more formal skills of life:

- Relating with peers according to rules.
- Progressing from free play to play that may be elaborately structured by rules and may demand formal teamwork, such as baseball.
- Mastering reading, social studies and arithmetic.

The need for self-discipline increases yearly. The child who, because of his successive and successful resolutions of earlier psychosocial crises, is trusting, autonomous, and full of initiative will learn easily enough to be industrious. The mistrusting child will doubt the future. Shame and guilt-filled children will experience defeat and inferiority.

Learning Identity Versus Identity Diffusion (Fidelity)

During the fifth psychosocial crisis (adolescence, from about thirteen or fourteen to about twenty) children begin to learn how to answer satisfactorily and happily the question "Who am I?" However, even the best-adjusted adolescents may experience some role identity diffusion—rebellion, self-doubt, experimentation with minor delinquency.

Erikson believed that, during successful early adolescence, mature time perspective is developed; young persons acquire self-certainty as opposed to self-consciousness and self-doubt. They come to experiment with different—usually constructive—roles, rather than adopting a "negative identity" (such as delinquency). They actually anticipate achievement, and they achieve, rather than being "paralyzed" by feelings of inferiority or by inadequate time perspectives.

In later adolescence, clear sexual identity is established. Adolescents seek leadership (others to inspire them). Adolescents who successfully negotiate this stage gradually develop a set of socially congruent and desirable ideals.

Learning Intimacy Versus Isolation (Love)

The successful young adult, for the first time, can experience true intimacy.

Learning Generativity Versus Self-Absorption (Care)

In adulthood, this psychosocial crisis demands generativity, both in the sense of marriage and parenthood, and in the sense of working productively and creatively.

Integrity Versus Despair (Wisdom)

If the other seven psychosocial crises have been successfully resolved, mature adults develop the peak of adjustment and integrity. They trust, they are independent and dare the new. They work hard, have found well-defined roles in life, and have developed self-concepts with which they are happy. They can be intimate without strain, guilt, regret, or lack of realism; and they are proud of what they create--their children, work, or hobbies. If one or more of the earlier psychosocial crises have not been resolved, they may view themselves and their lives with disgust and despair.

Piaget's Theory of Cognitive Development

Another theorist is Jean Piaget, a developmental biologist who devoted his life to closely observing and recording the intellectual abilities of infants, children and adolescents. The stages of cognitive development formulated by Piaget appear to be related to major developments in brain growth. The human brain is not fully developed until late adolescence or, in the case of males, sometimes early adulthood. Therefore, children do not think like adults.

Developmental Stage & Approximate Age	Characteristic Behavior
Sensory Motor Period	
Reflexive Stage (0-2 months)	Simple reflex activity, such as grasping, sucking.
Primary Circular Reactions (2-4 months)	Reflexive behaviors occur in stereotyped repetition, such as, opening and closing fingers repetitively.
Secondary Circular Reactions (4-8 months)	Repetition of change actions to reproduce interesting consequences, such as, kicking one's feet to move a mobile suspended over the crib.
Coordination of Secondary Reactions (8-12 months)	Responses become coordinated into sequences that are more complex. Actions take on an "intentional" character, such as, the infant reaches behind a screen to obtain a hidden object.
Tertiary Circular Reactions (12-18 months)	Discovery of new ways to produce the same consequence or obtain the same goal, such as, the infant may pull a pillow toward him in an attempt to get a toy resting on it.
Invention of New Means Through Mental Combination (18-24 months)	Symbolizing the problem-solving sequence before actually responding. Begins to find hidden objects under two or three covers. Sorts by color and shape. Make-believe play
Preoperational Period	
Preoperation Phase (2-4 years)	Increased use of verbal representation, but speech is egocentric. The beginnings of symbolic, rather than simple, motor play. Can think about something without the object being present by use of language.

Intuitive Phase (4-7 years)	Speech becomes more social, less egocentric. Intuitive grasp of logical concepts in some areas, but still a tendency to focus attention on one aspect of an object while ignoring others. Concepts formed are crude and irreversible. Easy to believe in magical increase, decrease, disappearance. Reality not firm. Perceptions dominate judgment. In moral-ethical realm, not able to show principles underlying best behavior. Rules of a game not developed, only uses simple do's and don'ts imposed by authority.
Period of Concrete Operations 7-11 years	Evidence for organized, logical thought. Ability to perform multiple classification tasks, order objects in a logical sequence, and comprehend the principle of conservation. Thinking becomes less transductive and less egocentric. Capable of concrete problem-solving. Some reversibility now possible (quantities moved can be restored, such as in arithmetic: 3+4=7 and 7-4=3, etc.) Class logic-finding bases to sort unlike objects into logical groups, where previously it was on superficially-perceived attribute, such as color. Categorical labels, such as "number" or "animal" now available.
Period of Formal Operation 11-15 years	Thought becomes more abstract, incorporating the principles of formal logic. The ability to generate abstract propositions, multiple hypotheses and their possible outcomes is evident. Thinking becomes less tied to concrete reality. Formal logical systems can be acquired. Can handle proportions, algebraic manipulation, other purely abstract processes. If a+b=x, then x=a-b. If ma/ca=IQ-1.00, then Ma-CA. Prepositional logic, as-if and if-then steps. Can use aids, such as axioms to transcend human limits on comprehension.

Early Childhood (Ages 0-3)

The early years of a child's life, particularly the first three years, are the life-long foundation for social competence, coping skills, learning behavior, mental health, and physical health. Research shows that the rate of human learning is most rapid during the first 24 months of life and the brain is especially efficient at learning during this time. For example, the brain of a three year old is twice as active as an adult brain.

Experience during the first three year is essential to healthy brain development, as the infant's day-to-day experiences help decide how his or her brain cells connect and process information. Early care and experiences makes a difference in children's ability to learn; if

an infant does not have certain kinds of experiences some areas of the brain will not make the necessary connections.

Normal Stages of Human Development

(Birth to Five Years)

The chart below represents some of the milestones children experience from birth to age five. The areas covered are physical, social, and emotional. The milestones are based on average development. Children attain these milestones at different rates. Developmental milestones reached within a six month period of time are considered reached "within normal limits."

Physical & Language	Emotional	Social
Birth – 1 month *Feedings*: 5-8 per day *Sleep*: 20 hour per day *Sensory capac*ities: makes basic distinctions in vision, hearing, smelling, tasting, touch, temperature, and perception of pain	Generalized tension.	Helpless. Asocial. Fed by mother.
2-3 months *Sensory capacities:* color perception, visual exploration, oral exploration. *Sounds:* cries, coos, grunts *Motor ability:* control of eye muscles, lifts head when on stomach.	Delight. Distress. Smiles at a face	Visually fixates and smiles at a face. May be soothed by rocking. Imitates some movement and facial expressions.
4-6 months *Sensory capacities:* localizes sounds *Sounds:* babbling, makes most vowels and about half of the consonants *Feedings:* 3-5 per day *Motor abilities:* control of head and arm movements, purposive grasping, rolls over.	Enjoys being cuddled. Responds to other people's emotional expressions.	Recognizes mother. Distinguishes between familiar persons and strangers. No longer smiles indiscriminately. Expects feeding, dressing, and bathing.
7-9 months *Motor abilities:* control of trunk and hands, sits without support, crawls about.	Specific emotional attachment to parents. Protests separation from mother. May be fearful in some situations.	Enjoys peek-a-boo. Repeats sounds or gestures for attention.

Physical & Language	Emotional	Social
10-12 months *Motor abilities:* control of legs and feet, stands, creeps, apposition of thumb and forefinger. *Language:* says one or two words, imitates sounds, responds to simple commands. *Feedings:* 3 meals, 2 snacks. *Sleep:* 12 hrs., 2 naps.	Anger. Affection. Fear of strangers. Curiosity, exploration.	Responsive to own name. Waves good-bye. Plays pat-a-cake. Understands "No." Gives and takes objects. 
1 – 1-1/2 years *Motor abilities:* creeps up stairs, walks (10-20 min.), makes lines on paper with crayon.	Dependent behavior. Very upset when separated from mother. Fear of bath.	Obeys limited commands. Repeats a few words. Interested in his mirror image. Feeds himself/herself.
1-1/2 –2 years *Motor abilities:* runs, kicks a ball, builds six-cube tower (2 yrs.), capable of bowel and bladder control. *Language:* vocabulary of more than 200 words *Sleep:* 12 hrs. at night, 1-2 hr. nap.	Temper tantrums (1-3 yrs.) Resentment of new baby.	Does opposite of what he is told (18 mos.) Increasingly aware of himself/herself as separate from others.
2-3 years *Motor abilities:* jumps off a step, rides a tricycle, uses crayons, builds a 9-10-cube tower. *Language:* starts to use short sentences, controls and explores world with language, stuttering may appear briefly.	Fear of separation. Negativistic (2-1/2 yrs.) Violent emotions, anger. Differentiates facial expressions of anger, sorrow, and joy. Sense of humor (plays tricks). 	Talks, uses "I", "me", and "you". Copies parents' actions. Dependent, clinging, possessive about toys. Enjoys playing alongside another child. Negativism (2-1/2 yrs.). Resists parental demands. Gives orders. Rigid insistence on sameness of routine. Inability to make decisions.
3-4 years *Motor abilities:* Stands on one leg, jumps up and down, draws a circle and a cross (4 yrs.). Self-sufficient in many routines of home life.	Affectionate toward parents. Pleasure in genital manipulation. Romantic attachment to parent of opposite sex (3-5 yrs.) Jealousy of same-sex parent. Imaginary fears of dark, injury, etc. (3-5 yrs.)	Likes to share; uses "we"; cooperative play with other children. Imitates parents. Beginning of identification with same-sex parent; practices sex-role activities. Intense curiosity and interest in other children's bodies. Imaginary friend.

Physical & Language	Emotional	Social
4-5 years *Motor abilities:* mature motor control, skips, broad jumps, dresses himself, copies a square and triangle. *Language:* talks clearly, uses adult speech sounds, has mastered basic grammar, relates a story, knows over 2,000 words (5 yrs.)	Responsibility and guilt. Feels pride in accomplishment. Able to distinguish fantasy from reality. Sometimes demanding.	Prefers to play with other children. Becomes competitive. Prefers sex-appropriate activities.

Early Childhood Intervention

Early Childhood Intervention is the process and services by which a child with disabilities, developmental delays, or substantial risk of delays receives appropriate intervention to help him or her reach full potential. Through Early Childhood Intervention, families are encouraged to actively include intervention strategies in family or childcare routines.

Though early childhood intervention is certainly good for children, birth to age three, it also offers parents and other caregivers support, understanding and guidance in caring for the child who is challenged with a developmental delay or disability. Parents and other caregivers can become overwhelmed with the needs of a child with developmental delays or disabilities, and the demands of other children in the family.

Often, parents/caregivers are frustrated with their own inability to help the child who is challenged with a developmental delay. Providers of early intervention services inform and educate parents and other caregivers on what they can do on a daily basis to assist the child. Providers help set expectations for the child's development that are consistent with the specific developmental delay or disability.

Sexual Development

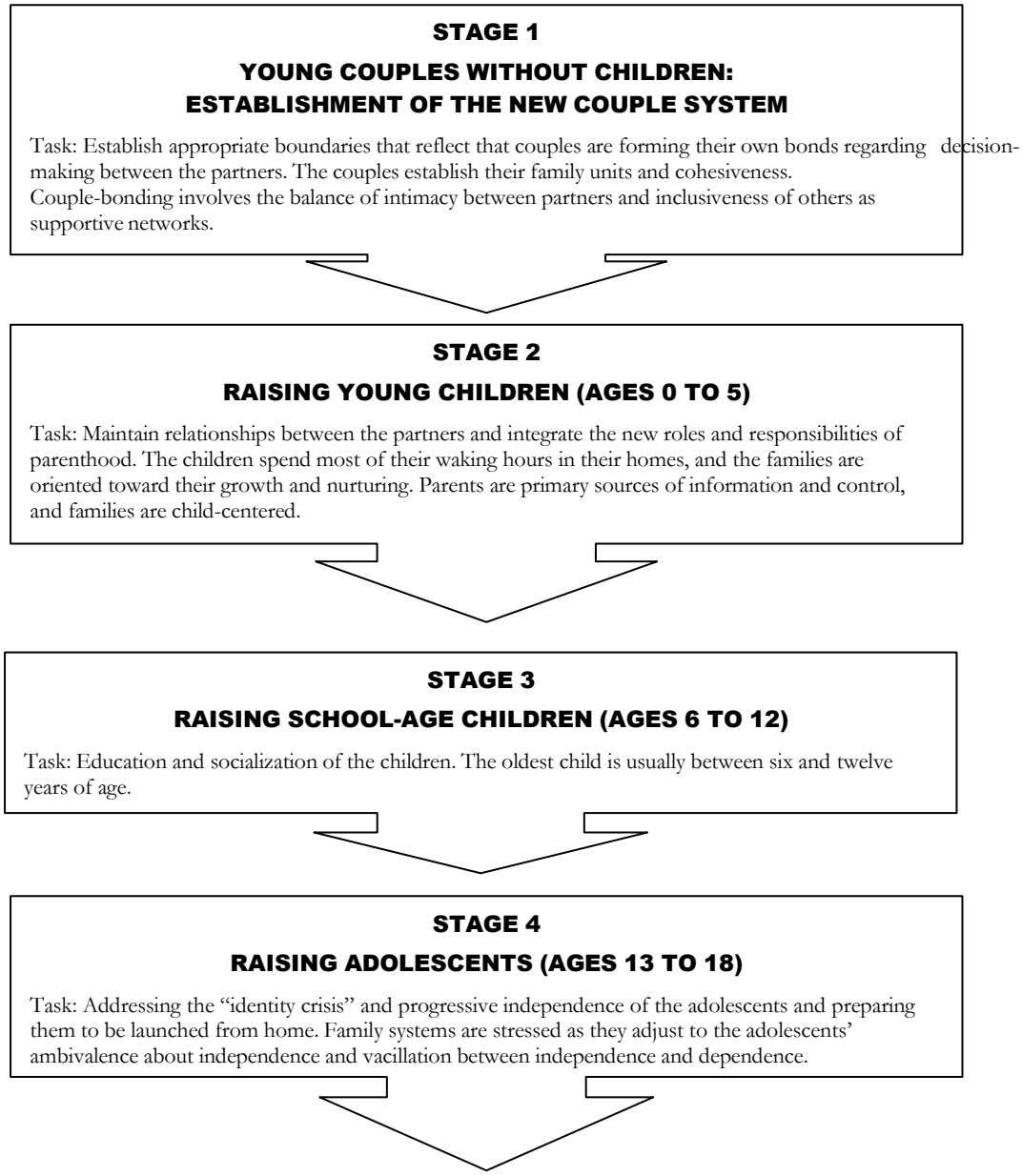
The generally recognized average age for physical, sexual maturity is twelve for females and fourteen for males. This is typically immediately following the period of most rapid growth (the growth spurt). Consequently, the age of puberty may be established by determining the period during which the person grew rapidly. The period of rapid growth may begin as young as seven-and-a-quarter for females compared with nine-and-a-half for males. Some females may not reach sexual maturity until age sixteen; some males may not until age eighteen.
Pubescence refers to all the changes that lead to sexual maturity. Among the first signs in both sexes is the appearance of pigmented pubic hair. At about the same time as pubic hair begins to appear, males' testes and females' breasts enlarge.

Females continue pubescence with rapid growth, their first menstrual periods (menarche), growth of underarm hair, and a slight lowering of the voice. The males' pubescence involves dramatic changes in their voice; rapid growth, particularly in height and length of limbs; the physical capacity to ejaculate semen; and growth of facial, underarm and other body hair.

Family Life Cycle

The family life cycle describes the stages families go through over time. Every family has predictable patterns in addressing the tasks of beginning a family. There is disagreement on the number of stages in family life cycles, but as with any development, the stages are successive and depend on resolution of the preceding stage for successful development. Child welfare professionals consider family life cycles in assessing the needs of families and planning for services.

The stages presented reflect middle-class, two-parent families. Socioeconomic status and culture will alter the stages, as well as divorce, single-parenting, remarriage, and step-parenting.



STAGE 5

LAUNCHING (AGES 19 OR OLDER)

Tasks: Successfully launching adolescents and the realignment of the partners' relationship. The adolescents leave home. The couples' roles and rules change as they begin to function without the daily needs and interaction of dependent adolescents.

STAGE 6

EMPTY NESTERS (ALL CHILDREN GONE)

Task: Establishing relationships with adult children and grandchildren. The primary focus is towards the couples' needs.

STAGE 7

RETIREMENT (OVER 65)

Task: In this stage, the couples have usually completed raising children. The partners have completed major career contributions and are involved with couple maintenance and relationships with extended families and friends.

Attachment and Bonding

Attachment is one of the essential concepts of human behavior. It is the basis for all human development and is essential for the survival of human infants. Understanding attachment is a critical concept for child welfare professionals. Many children in the child welfare system require intervention because of attachment issues.

Bonding

Bonding is the initial tie that develops between newborn babies and their mothers. Bonding phenomena is not totally understood. Research indicates that bonding is based on an innate, physiological drive of mothers and their babies to recognize each other and to be emotionally linked to each other. It is believed that bonding develops during pregnancy for mothers and, probably, for babies. Bonding continues through the close contact of feeding and holding immediately after birth. The term bonding should be used to describe this intense, extremely special relationship between mothers and newborns.

Attachment

Attachment occurs as a result of children expressing their needs and mothers or primary caregivers satisfying the children's needs each time they are expressed. Infants are completely dependent on adult caregivers to meet all of their needs. As each need is expressed and met, infants develop a sense of trust and attachment to the persons meeting their needs. This cycle begins at birth and continues throughout individuals' lives. There is no limit to the number of attachments people will develop throughout their life cycles.

Early close relationships established between mothers or primary caregivers and children are known as the **symbiotic stage.** In this stage, babies see their mothers or primary caregivers as part of themselves. Mothers or primary caregivers act as "need satisfying objects" to the children. The children begin to see self and mother as separate entities by about seven months, beginning the succeeding stage, called **separation-individuation.** Because human babies are adaptable and sociable, they have the capacity to develop strong emotional ties to other people. This ability is defined as attachment.

Most children form attachments to their parents or caregivers even if their parents or caregivers do not adequately meet their needs. Therefore, when children are taken out of abusive and neglectful homes they are often depressed or grieve the loss of their families.

Assessing Attachment and Bonding – Birth to One Year

Does the child:	Does the parent:
Appear alert? Respond to people?	Respond to the infant's vocalizations?
Show interest in the human face?	Change tone of voice when talking to or about the baby?
Track with his eyes? Vocalize frequently?	Engage in face-to-face contact with the infant?
Exhibit expected motor development?	Exhibit interest in and encourage age appropriate development?
Enjoy close physical contact?	Respond to the child's cues?
Signal discomfort? Appear to be easily comforted?	Demonstrate the ability to comfort the infant?
Exhibit normal or excessive fussiness?	Enjoy close physical contact with the baby?
Appear outgoing or is he passive and withdrawn?	Initiate positive interactions with the infant?
Have good muscle tone?	Identify positive qualities in the child?

Assessing Attachment and Bonding – One to Five Years

Does the child:	Does the parent:
Explore his surroundings?	Use disciplinary measures appropriate to the child's age?
Respond positively to parents and parent limit setting?	Respond to the child's overtures? Initiate affection?
Keep himself occupied? Seem relaxed and happy?	Provide effective comforting?
Show signs of reciprocity, empathy, pride and joy?	Initiate positive interactions with the child?
Look at people when communicating?	Accept expressions of autonomy?
Show emotions in a recognizable manner?	See the child as positively "taking after" a family member?
React to pain and pleasure?	Seem aware of child's cues?
Engage in age appropriate activities?	Enjoy reciprocal interaction with the child?
Use speech appropriately?	Respond to child's affection?
Show signs of embarrassment, shame or guilt?	Set age appropriate limits?
Demonstrate normal fears?	Respond supportively when the child shows fear?

Assessing Attachment and Bonding – Grade School Years

Does the child:	Does the parent:
Behave as though he likes himself?	Show interest in child's school performance?
Show pride in accomplishments?	Accept expression of negative feelings?
Share with others?	Respond to child's overtures? Initiate affectionate overtures?
Accept adult imposed limits?	Provide opportunities for child to be with peers?
Verbalize likes and dislikes? Try new tasks?	Handle problems between siblings with fairness?
Acknowledge his mistakes?	Use disciplinary measures appropriate for child's age?
Express a wide range of emotions?	Assign the child age appropriate responsibilities?
Establish eye contact? Smile easily?	Seem to enjoy the child?
Exhibit confidence in his own abilities?	Know the child's likes and dislikes?
Appear to be developing a conscience?	Give clear messages about behaviors that are approved?
Look comfortable when speaking with adults?	Give clear messages about behaviors that are disapproved of?
React positively to parent being physically close?	
Have positive interactions with siblings or peers?	

Assessing Attachment and Bonding – Adolescence

Is the Adolescent:	**Does the parent:**
Aware of personal strengths? Weaknesses?	Set appropriate limits?
Comfortable with his sexuality?	Encourage self-control?
Engaging in positive peer interactions?	Trust the adolescent?
Performing satisfactorily in school?	Show interest in and acceptance friends of adolescent's
Exhibiting signs of conscience development?	Display an interest in teen's school performance?
Free from severe problems with the law?	Exhibit interest in teen's activities?
Aware of his parents' values?	Have reasonable expectations regarding chores?
Keeping himself occupied in appropriate ways?	Stand by the adolescent if he gets in trouble?
Accepting of adult imposed limits?	Show affection?
Involved in interests outside the home?	Think this child with "turn out" okay?
Developing goals for the future?	
Emotionally close to parents?	

Fahlberg, V. (1991). *A Child's Journey through Placement.* Indianapolis: Perspectives, p. 41-44.

Attachment Disorder

When children's normal processes of attachment have been disrupted, attachment disorders might develop. Attachment disorders usually result from extreme cases of maltreatment and multiple rejections. This can happen when children's familial environments are not safe and have led to the children's physical, emotional, or psychological injury. Attachment-disordered children are often severely withdrawn and depressed, or they may be very destructive and aggressive. Children might vacillate between both extremes. Children who are withdrawn and depressed, destructive and aggressive, or both require therapeutic intervention.

Many children who are in the child welfare system have never formed secure attachments to caregivers. These children may behave in ways that compensate for this lack of attachment.

- **Manipulation**
- **Chronic anxiety**
- **Authority problems**
- **Aggressiveness**
- **Hostility**
- **Poor peer relationships**
- **Poor self-esteem**
- **Self-isolation**

Parents and caregivers can promote attachment and reduce behavior problems of poorly attached children through:

- **Positive interactions**
- **Strong nurturing and engagement**
- **Allowing children to grieve and mourn**
- **Providing structure in the home**
- **Appropriately touching the children**
- **Appropriately holding, caressing, and having eye contact with the**

Common symptoms in children with attachment problems:

Psychological or Behavioral Problems:

- **Conscience Development**
- **Impulse Control**
- **Self-esteem**
- **Impersonal interactions**
- **Emotional problems**

Cognitive Problems:

- **Trouble with cause and effect**
- **Problems with logical thinking**
- **Confused thought process**
- **Difficulty thinking ahead**
- **Impaired sense of time**
- **Difficulty with abstract thinking**

Developmental Problems:

- **Difficulty with auditory processing**
- **Difficulty expressing self verbally**
- **Gross motor problems**
- **Delays in fine motor adaptive skills**
- **Delays in personal-social development**
- **Inconsistent level of skills in all of the above areas**

Developmental Delay:

Significance of Environment and Genetics

Genetic predispositions are inherit physical and character traits from their birth parents. The environment affects an individual's development and can either promote or limit individuals in reaching their full potential. Certain genetic or environmental conditions can cause developmental delays and attachment problems may result. When children experience developmental delays or attachment problems, they may not meet the normal developmental milestones or may have significant problems in these areas.

Factors That May Impede or Delay Child Growth and Development

Genetic or congenital conditions	Physical abuse
Neglect	Lack of prenatal care
Emotional maltreatment	Sexual abuse
Accident and trauma	

Children with developmental delays/disabilities usually have severe problems in one or more areas.

Personal presentation	Self-care
Walking	Getting along with others
Speech	Manners
Age-appropriate use of home/neighborhood	Comportment
Self-direction	

Separation and Loss

Separation, loss, and grieving are part of the human experience. Separation is the change that occurs with the breakup in a relationship. Loss is the effect on people when something important is withdrawn. Grief is the process that helps people work through the pain of separation and loss.

Seven Factors That Influence How Loss Is Experienced

- Type of loss and whether it was expected or unexpected.
- Age of the person at the time of the loss.
- Degree of attachment to the persons from whom the child is being separated.
- Ability to understand why there was a separation.
- Amount of emotional strength the children had before the loss.
- Circumstances causing the loss.
- Number of previous separations.

Children who enter the child welfare system experience a variety of losses when entering substitute care. The initial separation of children from the home of their biological or foster parents is, at least, anxiety producing and, at most, severely traumatic. They experience obvious losses, such as family relationships, school and/or peer relationships, and their home settings. The effects of loss are profound and long-term.

Separation, loss, and grieving are part of family foster care and adoption. It is the most common experience children, birth families, foster families, and adoptive families will share in becoming involved in the child welfare system. Child welfare professionals' ability to identify the kinds of losses that participants in the system experience is necessary to aid in the preparation of effective service plans.

When children are separated from their families, they experience an unexpected loss. Children in substitute care usually have experienced many losses in very brief periods. They probably have not had opportunities to process these losses. The development of effective service plans can be a crucial step in assisting children to deal with loss.

Grief Process

People, regardless of age; share common reactions and behaviors when they experience loss. After loss, they usually enter the grieving process. This process consists of the following stages:

Shock, denial, and protest

During this stage, people try to stop losses from occurring or try to deny that losses have occurred. When children in substitute care are in this stage, they may cry often, long, and loudly.

Bargaining

Individuals in this stage feel that they can make deals so the situation will go away. They feel that some atonement, some action they can take, can forestall the threat of what is happening. There are usually feelings of guilt with this stage.

Children in substitute care often bargain by believing they are in substitute care because they are "no good." They attempt to identify their own behavior that has led them into substitute care or resulted in mistreatment by their families. Then they bargain that they will be good or refrain from what they have identify as "bad" behavior.

Some children believe that their parents are the reasons that they are in substitute care. In the bargaining stage, they are willing to forgive their parents for their maltreatment if their parents will take them back.

Other children do not view themselves or their parents as the cause of their problems; rather they see the caseworkers or others as being at fault. They reason that, if their caseworkers, foster parents, etc., could be replaced, they could go back home.

Acting out

In this stage, anger is turned outward, and individuals engage in angry and hostile behaviors. They realize that losses have in fact occurred and cannot be undone. Children may use profanity, fight, disobey, or outwardly express their anger.

Depression

This stage is also a form of anger, but the focus of the anger is turned inward. Anger turned inward is usually called depression. Children may exhibit the following behaviors during the depression stage:

- Excessive fear
- Lack of interest or ability to engage in normal expected activities of children at that stage of development
- Clinging behaviors
- Lack of expected affect from happy or sad experiences
- Anxious behavior and nightmares
- Withdrawals from relating to peers and adults
- Suicidal gestures, which in younger children may include placing themselves at risk: running onto the street, jumping from high places
- Substance abuse and sexual promiscuity
- Poor school performance
- Poor hygiene and physical appearance

Understanding and Coping

The understanding and coping stage is the beginning of "letting go" of the powerful feelings of grief. Individuals can understand in a more realistic way, according to their age, abilities, and their emotional development, what happened to them and why it happened.

When people reach an understanding of their losses, they are able to express, depending on their age and abilities, why they feel ashamed, guilty, mad, sad, or glad. Coping allows more energy to be applied to the tasks of life, and there is a sense of hope for the future.

Children in substitute care may begin to express both positive and negative feelings about their parents when they reach the understanding and coping stage. The impact of loss causes delays in the normal progress of children's development, and children may require therapeutic intervention to help them catch up. These children often need to overcome their multiple losses, or they will remain stuck in the grieving process. Depending on the cognitive and emotional abilities of the children to understand and cope at their particular stage of development, children often have to revisit the grieving process at each new developmental stage. New losses can bring up some of the angry and sad feelings from old losses.

Interventions to Help Children to Manage Loss

- Provide support.
- Provide consist nurturing.
- Provide gentle encouragement.
- Continue contact with significant family members and siblings.
- Determine what continuous support the children will need to deal with the effects of the loss throughout childhood and youth.
- Allow sufficient time.
- Provide consist structure.
- Acknowledge successes and efforts.
- Work with and use other formal and informal support members to help meet the children's needs.
- Discuss information about the past, present, and future in a non-judgmental, age-appropriate manner for the children's stage of development and situation.

Child Well-Being

The term "child well-being" is used repeatedly in child welfare. The reference to well-being refers to more than child development. It considers the most significant domains in a child's life.

Consider these **nine domains** when determining child well-being.

- **Safety** – Is the child safe? What are the child's behaviors and behavior patterns in the home, school and other settings?
- **Physical Needs** – Does the child have adequate space, clothing, furniture, toys, food and other necessities?
- **Family Attachment** – Is the child attached to the family and vice versa? What are family relationships like? Is the child supported and nurtured?
- **Socialization** – How does the child interact with others? Does the child have access to social and recreational activities?
- **Cultural and Spiritual** – Does the child have opportunities to participate in cultural and spiritual activities that will facilitate the child's positive identify with his/her culture and meet his/her spiritual needs and interests?
- **Emotional/Psychological** - Has the child experienced significant trauma? Does the child need assessment and intervention?
- **Health** – A child's health affects their emotional health, development and all other areas of life. Does the child need a physical exam, ongoing health care for a condition or preventive care?
- **Educational/Vocational** – What are the child's educational needs? Are they attending school or pre-school? Do they have a special interest in learning a particular skill?
- **Legal** – Is there a history of involvement with the delinquency system or department of corrections? Is the child a minor requiring authoritative intervention (MRIA)? Are the children in this country legally?

Engaging Children and Families

Child welfare professionals employ a complex set of skills in engaging and interacting with children and families to support the achievement of preferred outcomes in a timely way. Effective interviewing skills are required to determine child safety, plan for permanency and assess well-being. Critical thinking skills assist in information gathering, collaborative assessment and planning for interventions.

Engagement

Engagement is a means of helping you meet a client "where they are". It is the first step in working with families. It is important to understand that clients have their own set of needs, experiences and values (both cultural and personal) that shape their actions. Unless and until the family members believe their worker understands their needs little progress will be made.

Definition of Engagement

Engagement is a manner of interacting with another individual for the purpose of encouraging participation. Engagement is the process of establishing one-to-one, interpersonal connections with individuals and families.

What is Family?

To fully engage families we must expand our definition of what makes a family. Our definition of family generally comes from our own experience with our families of origin as well as through our professional experiences with families. To broaden our scope of what defines a family, we must be aware that families come in all shapes and sizes. Family is defined broadly to include birth, blended, kinship, and foster and adoptive families.

"We are better able to plan and implement effective services if we understand the context within which people live; the involvement of others in their problems; and the resources available from immediate family, friends, and extended kin." [1]

Family Centered Practice

Family-centered practice includes a range of strategies, including advocating for improved conditions for families, supporting them, stabilizing those in crisis, reunifying those who are separated, building new families, and connecting families to the resources that will sustain them in the future.

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[1] *Working with Families of the Poor; Minuchin, Colapinto, Minuchin, 2007, 2nd Edition. The Guilford Press, Pg. 5*

Some key points in family-centered practice:

- A way of working with families across systems
- Focuses on needs and welfare of children in the context of the family and community
- Recognizes strengths and the importance of relationships
- Enhances family autonomy
- Respects the rights, values and cultures of families

Strength-Based Practices

Recognizing and supporting family strengths provides child welfare professionals with the key to family growth, as well as the tools for change. Family culture, tradition, religion, and race all represent facets of family members and indicate what families can become. Though we emphasize strengths, family problems are real and should never be diminished or excused. Identifying and encouraging family strengths nourishes the entire family system.

Child welfare professionals should encourage families to look to their own resources—relatives, neighbors, church members, and others in the families' social networks—as supports in affecting the change process.

Core Conditions of Helping Relationships

Child welfare involves establishing "helping relationships" with families geared toward alleviating the causes of child maltreatment and making choices about the future of children and their families. The positive regard for people that supports the development of helping relationships depends on these core conditions.

Empathy: tuning into a person's emotions and communicating understanding without losing objectivity. In this process, one person attempts to experience another person's world and then communicates understanding of, and compassion for, the other person's experience.

Facilitative **genuineness:** absence of mixed messages in communication .

Respect: the ability to maintain a non-judgmental attitude that conveys caring, concern, and acceptance of the other person as a unique human being.

Competence: the knowledge and skills in human development and child safety. Families need confidence that the systems, child welfare and Juvenile Court, are fully understood and can be explained to them.

Full Disclosure

The client needs to continuously review their choices and the potential consequences of those choices. By fully disclosing all information, we keep the family engaged in the relationship. Failure to disclose information can lead to a breakdown in trust.

Engaging Fathers

Since 2003, findings from Federal Child and Family Service Reviews and other sources have pointed to the need for improvement in casework contact with and engagement of fathers. The assumptions we make about the participation of a father with his child and family will affect our success in engaging and involving fathers in services.

Examples of assumptions about fathers:

- Mothers, not fathers, are the primary caregiver and it is more natural to work with her …
- Fathers/males can be intimidating …
- Fathers don't care about their children the same way moms do…
- We don't have to engage incarcerated fathers.

What research found:

- The overwhelming **majority of fathers had informal supports** on which they could rely to help themselves and their child and family (Chapin Hall, 2009)
- These **supports** were frequently immediate or extended family (their own, a spouse or partners); the nature of the support included housing, child care, financial assistance and emotional support (Chapin Hall, 2009)
- In over half the cases, **father had a stable and adequate residence** for himself; just over one-third of the fathers were cohabitating with adults other than mother or paramour (Chapin Hall, 2009)
- While a vast majority of the involved fathers admitted to or had documented evidence of past criminal conduct, **less than one-fifth of the fathers involved were incarcerated** at the time of placement (Chapin Hall, 2009)
- **Half of the fathers interviewed completed high school**, and some went on to attend a trade school or college; some had a post-secondary degree. Of the fathers who had dropped out of high school prematurely, half returned to complete their General Educational Development (GED) Certification.
- While 1/3 of the fathers described a history of repeated job loss, unstable or sporadic employment (often due to past incarceration), **more than half the fathers assessed were employed** at the time of the IA (Chapin Hall, 2009).
- While finances were clearly strained, **most men relied on family support for money and housing**, rather than public benefit programs;

Historically, the child welfare system has directed more of its resources to working with and providing services to mother than to father (Chapin Hall, 2009; Franck, 2001; Hornsby, 2002) Social work literature often praises the resilience of single mothers, forgetting the implication for father involvement (Sieber, 2008).

The attitudes and behavior of mother, caseworkers and service providers may play a role in sustaining a differential focus on mother (Chapin Hall, 2009). Additionally,

high level of adoption for children with unknown and uninvolved fathers may indicate many fathers are only contacted for Termination of Parental Rights (TPR) (NQIC on Non-Resident Fathers and the Child Welfare System, 2009)

In order to encourage and increase the participation of the father, we must identify and plan dialogue with him around the specific activities:

- Setting an expectation that the father will be involved
- Frequent contact
- Engaging the fathers in case planning discussions
- Eliminating any barriers to visitation and/or service participation
- Encouragement/support to the father in the parenting role
- Assessing and discussing knowledge of child behavior and development
- Building rapport with the father
- Having an ongoing discussion of rights and responsibilities
- Identifying and evaluating paternal relatives as resources throughout the
- life of the case
- Discussing options to build and/or sustain attachment with his child

Family Systems Approach

A family systems approach in social services intervention starts with the premise that individuals have "connectiveness" to others in their lives, particularly their family members. The systems theory postulates that all human behaviors, including neglectful or abusive parenting practices, are understood only within the context of interactions and relationships with others.

This theory developed out of the earlier general systems theory. General systems theory explained the relationships among all things on a universal level. The application of systems theory to working with families emerged from the study of communication patterns among people of all origins. This research revealed similar relationship patterns; that is, the behavior and condition of individuals were directly related to their interactions with others. Systems theory, and family systems theory in particular, is based on the simple notion that individual parts of a whole operate dependently. Consequently, assessment, service planning, and intervention related to children's abuse or neglect and their well-being needs to be viewed in the framework of the family members' interactions.

When individuals interact regularly, they establish repetitive patterns of interactions to the point of becoming interdependent. Family members join together to establish a routine. They all cooperate in repeating this routine. Family members know how other family members will react and will adjust their behaviors accordingly. In this way, families establish their own individual balance or stability.

When a family system is organized around the maltreatment of children, even family members not involved in the actual maltreatment, follow particular patterns of behavior that maintain stability, albeit an unhealthy stability. To stop the maltreatment, families have to change these patterns of behavior. The challenge for child welfare professionals is to help families find new patterns of behavior and stability in which family members can meet all their needs sufficiently, so that child maltreatment is no longer a part of their lives.

Characteristics of Family Systems

Families have systems characteristics. A family has:

- **STRUCTURE and HIERARCHY** – Different roles are defined for different members, and power is not distributed evenly.
- **POWERFUL RULES OF CONDUCT** - Some rules are not spoken or acknowledged.
- **SET OF POLITICS** – Particular members are closer to some members than to others; two members might support each other against a third; one member may temporarily defer to another out of self-interest. The politics may change, depending on the situation.
- **BOUNDARIES** – The means by which individuals, subsystems, and generations protect their differentiation and maintain a sense of identity. (Woods and Hollis, 1981).
- **HABITUAL PATTERNS** – The tendency of families to act and react to one another, to situations, and to problems in ways or patterns that do not change.
- **HISTORY** – Anyone who becomes involved in a family steps into its history: significant people, circumstances and events.
- **INFLUENCES FROM THE OUTSIDE** – These influences include the extended family, the neighborhood, work and school communities and the environment at large – media, politics, economics and other factors.
- **TENDENCY TO RESIST CHANGE** - A family, like an individual, has a sense of self, and it will resist a challenge to its self-definition.

Change Agents

Child welfare professionals work as change agents. They begin intervention by establishing a relationship with the family so that families may change their behavior and learn healthier patterns of relating to each other and more appropriate discipline techniques.

Why do People Change?

EXTERNALLY MOTIVATED CHANGE	INTERNALLY MOTIVATED CHANGE
Change motivated by submitting to an authority. **Works only as long as external influences exist.**	Change motivated by authority that lies within ourselves. It is **longer-lasting and leads to a person becoming self-reliant**.

Variables Influencing Human Change

PRESENT DISCOMFORT	Discomfort related to something the family wants but does not have
INTERNALIZATION OF RESPONSIBILITY	Person/family must see themselves at least partially responsible for the discomfort they are feeling
EMOTIONAL SECURITY	Relationships that offer emotional security make it possible to risk making a change
A PREFERRED ALTERNATE FUTURE	For a person to leave one place, they must be able to see something better is within their grasp
EFFICACY	The belief in yourself that you can do something – which you have the power or ability to produce desired results

Child Welfare Professionals as Change Agents

- Conduct assessments
- Act as brokers for services
- Advocate for services
- Implement service plans
- Provide leadership and support to all member of child welfare teams
- Help families identify their own problems
- Help families recognize their strengths
- Help families find solutions to problems
- Identify short term services

Changes Occur Through Helping Relationships

The need for protective service interventions precipitates a crisis for families and requires immediate, intensive, and continuing response from those providing the helping interventions. Child welfare professionals must maintain a balance between recognizing patterns of abuse and neglect and recognizing family strengths.

Focusing only on interactions, behaviors, attitudes, and values within families that contributed to the abuse or neglect can obscure recognition of family strengths. Families are more likely to be receptive to child welfare professionals in the role of helper if they believe they are not being blamed for "problems," but rather, assisted in meeting needs.

Families can change their behaviors given the right conditions and supporting relationships. The helping relationship between the child welfare professional and the family becomes the principle tool in dealing with crisis, resistance, and the acceptance that can lead to change.

Working With Families as a Whole

Families are the focus of attention in changing behaviors or conditions to care safely for children. Children, even when living apart from their families, maintain their membership in the families and need for the emotional security that connection to the families provides. (See Human Development and Behavior section, "Attachment" and "Separation and Loss.")

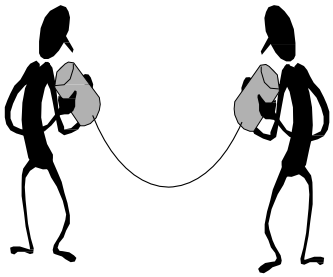
Placement as a Safety Intervention

Whenever possible, safety planning should be about keeping families together. When the safety of children cannot be ensured and families cannot remain together, placement of the children is usually required. The purpose of placement is to provide the children with a safe environment. Placement also provides the time needed to further assess needs and assist families in correcting the conditions or changing the behaviors essential to the children's safety.

Children's Needs and Sense of Time

Children's needs relate to age, stage of development, and children's sense of time. These factors are critical in the decision-making process for achieving safety, permanency, and well-being. The life-shaping decisions made and imposed on children and families must consider the best interest of the children and the families' willingness and ability to meet the children's needs, with the children's health and safety always the paramount considerations. (See also, "Principles of Permanency Planning", Service Planning.)

Family Interviewing



Interviewing is the purposeful communication between individuals. In the delivery of child welfare services, this communication is to ensure the children's safety and well-being, and to plan for permanency. When families and children feel that the child welfare professional is really listening to them they become participants in the planning and delivery of services.

The Child Protection Specialist makes the first contact with the family. They conduct an investigation to address the allegation and to see if there are any threats to the safety of

the children. There is usually a particular incident or circumstance that needs to be addressed. **An important tool for a child welfare professional uses to protect the child is the ability to interview children.** This interview must facilitate their ability to tell you what is or is not happening. This interview could determine whether the child requires protection.

During interviews with children or parents, the child welfare professional should convey a sense of positive regard for the children and parents by demonstrating the core conditions of empathy, genuineness, competence, and respect.

Four Stages of Interviewing

It is critical that child welfare professionals engage family members in interviews while determining the safety, permanency, and emotional well-being of the children.

Interviewing can be divided into four stages: **social, problem definition, focus, and closure**. (Jay Haley)

Social

During this stage, the child welfare professional should engage family members in conversation about everyday matters in everyday language. This can be brief, but each family member should be included, beginning with the adults. Family members can talk about non-threatening topics. This allows the child welfare professional to relate to family members on a more human, person-to-person level.

Problem Definition/Needs Identification

At this stage, the child welfare professional is seeking the family's perspective of their situation. Family members describe what they feel is happening in their family. Problem definitions are usually best framed by asking family members two questions: What do you want for your family? What concerns you or worries you about your family?

Focus

This "interaction stage" encourages family members to talk to *each other*. The child welfare professional works to focus the family's concerns while integrating concerns

regarding the children's well-being. This empowers the family and engages family members in problem- solving about child safety, permanence and well-being.

Closure

During the final stage of the interview, the child welfare professional, with the family, reviews the information gathered during the interviewing process to gain a sense of closure. The child welfare professional should identify any agreements or commitments, and should discuss what will happen next.

Interviewing Techniques

The helping relationship requires child welfare professionals to move along a continuum— from listening and responding, to directing and influencing changes in behaviors or conditions. Interviewing skills continues to be important as child welfare professionals deliver services.

Accommodating

The child welfare professional uses the skill of accommodating when he or she communicates to the family members that they are being heard. This technique also assists child welfare professionals by ensuring that they have a clear understanding of the families' perceptions of the problems. Accommodating skills include techniques, such as attending behaviors (physical and psychological), reflections, summarization, and concreteness.

Attending Behavior

- **Physical attending** behaviors create an environment conducive to effective communication, including how the interviewer uses their body to enhance communication. Interviewing environments should be comfortable, and distractions should be minimized. Professionals are expected to use appropriate body language: gestures, eye contact, voice quality, facial expression, and body posture.
- **Psychological attending** describes the professional's perception of what a person's verbal and non-verbal behavior might communicate about the person feelings.

The meaning of a message is communicated by three components: **Verbal** refers to the actual spoken word; **Paraverbal** relates to how the words are spoken (e.g., tone, pitch, and pace); and **Nonverbal** or visual elements e.g., head nods, posture, eye contact, etc.). Only a small percentage of the meaning of the message is communicated by spoken words. The message is conveyed by how it is spoken and the body's actions when the words are spoken.

Listening and good verbal following are also important in psychological attending. Good verbal following is demonstrated when interviewers make responses and comments that relate to and follow from what is stated by the families or children. If child welfare professionals frequently interrupt and initiate seemingly unrelated topic changes, family members will not feel listened to or heard. (Kadushin)

Reflections

Reflections are concise restatements of a person's immediate past statement, based on careful physical or psychological attending to both verbal messages and non-verbal cues. There are three types of reflections: feeling, content, and combined.

Reflection of feelings consists of attending to, then restating, emotions or emotional aspects of the person's message. The professional attempts to describe to the person's emotional state and then acknowledges the feeling.

Reflection of content refers to the process of attending, then restating, beliefs, opinions, events, and facts of the person's message. The professional should paraphrase rather than "parrot back" the content of the message.

Combined reflection combines the two types of reflections, restating both the content and the feelings. The professional conveys a sense of what the person is feeling and the events, facts, beliefs, or opinions the person has described.

Summarization is a condensed restatement of the person's multiple statements of feeling or content. Summarizations should be concise and should come at natural pauses. A good summary communicates acceptance of the family members' perspective and experience, and encourages family members to correct the professional's perception or interpretation if necessary. Summarization may be used to clarify understanding of messages, focus discussions, make conversational transitions, highlight contradictions, and structure interviews.

Concreteness assists families to communicate more descriptively and specifically. Vagueness is often used unconsciously by family members to avoid addressing sensitive areas. For example, it is less painful for a wife to say, "I'm really feeling down," than to say, "My husband hurt me last night." It is difficult to assist families in problem-solving when their messages or statements are vague. Child welfare professionals have the responsibility to assist family members in making concrete statements. Concreteness can be encouraged by:

- Examining perceptions and explore the basis for the family member's conclusions.
- Clarifying vague or unfamiliar terms.
- Assisting family members to personalize their statements and state specifically how they feel.
- Drawing out details about experiences, interactions and behaviors.
- Focusing on the here and now.

Tracking

Tracking techniques allow child welfare professionals to influence the direction of interviews. Tracking skills include questions, positive reframing, and spring boarding. Solution-focused tracking techniques influence the direction of the interview and convey empathy, genuineness, and respect. Good child welfare interviewing requires a balance of both accommodating and tracking skills.

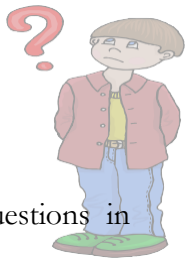
Questions

Questions solicit issues, positions, or views during interviews. When the interviewer asks questions rather than making statements, the concerns, perceptions, experiences, and goals of the family remain the focus. In most professional interviews, there are purposeful intents or goals. Child welfare professionals have delegated authority that affords the privilege to ask very personal questions. The privilege of delegated authority also requires responsibility to be sensitive to the family's needs as the professional involves them in the process of identifying and resolving their problems.

There are three types of questions:

- **Open-ended** questions encourage family members to use their own words and elaborate on a topic.
- **Closed-ended** questions usually limit family members to yes or no answers or questions that can be answered with one or two words.
- **Indirect** questions often incorporate statements that imply questions, e.g., "I wonder if…" or "It would be helpful if…"

Open-ended questions may be used to begin interviews and invite family members to explore feelings and ideas. **Closed-ended** questions may be used to obtain information and verify accuracy of information. **Indirect questions** may be used to bring up sensitive topics. Open-ended or closed-ended questions can be used to focus on a topic.



To be most effective, professionals should use all three kinds of questions in conjunction with other interviewing skills and technique.

Positive Reframing

Positive reframing operates under the assumption that there are positive intentions behind most negative acts or behaviors. Positive reframing does not condone negative behavior, but the technique provides a way to explore underlying positive intent. For example, an adolescent's defiant, aggressive behavior can be a way to gain control of his life, a form of self-protection to draw limits around himself or to protect those he cares about.

Positive reframing can help child welfare professionals build productive and cooperative working relationships with families because the technique engages the family's positive intents, characteristics, or traits regarding the care of their children and interactions with each other. For example, a birth parent with a child in foster care may state to the child welfare professional regarding his/her child, "When it comes to my child, no one asks me about MY opinion!" A positive reframe back to the parent could be, "It's important to you that you be involved in decisions concerning your child's care." There are three guiding principles for using positive reframing. The reframe should be: an affirmation statement, short, and believed by the professional (genuine).

Springboarding

Springboarding works in tandem with positive reframing. The professional asks questions that follow positive reframing and invites family members to work collaboratively. By reframing situations or behaviors, the professional acknowledges the positive intention behind negative acts or behaviors. With springboarding, the professional "springs" forward toward more productive, optimistic subjects. For example, a conversation between a wife and a child welfare professional:

Wife: "He doesn't spend any time with me or the kids. It's work, work, work, and that's all he does."

Child welfare professional ***reframe***: "It is important to you that your husband is part of the family."

Springboard: "Was there a time when you, he, and the children spent more time together?"

Circular Questions

Circular questions involve asking one person in the family about another person. They elicit a tremendous amount of information very quickly. Family members can gain new information and a different perspective about themselves and other family members. Example of a circular question:

"Jason, how do you think your mom feels when your dad yells at you?"

Solution-Focused Questions

Solution-focused questions help the client picture a preferred alternate future. These questions come from the solution-focused therapy model that emphasizes that every person, no matter how they look, sound, smell or behave, have positive potential. There are five types of solution-focused questions:

Past Success Questions: Finding out about times when the family was functioning well enough not to need the interventions of a child welfare agency.

"Do you recall a time when you asked your son to do something and he did it, and there were no arguments or fights?"

Exception Questions: Finding out about the times when the problem could have occurred but did not.

"Were there times when you felt frustrated and angry with your son, but did not hit him or yell at him?"

Miracle Questions: Asking the family member to describe how things would look if the problem no longer existed (as if a miracle had occurred).

"If everyone in the family went to sleep this evening and while you were asleep a miracle occurred, how would you know in the morning that it occurred, what would be different?"

Scaling Questions: Rating the severity of the problem, from different family members' perspectives.

"On a scale of one to ten, with ten meaning you believe this problem can and will be solved, and one meaning you don't think it can be solved at all, where would you put yourself today?"

Coping Strategies: Helping the client discover his/her own resources and strengths that might not be apparent at the moment. Highlights the "efficacy" of the family and family members.

"Given the high level of frustration and tension in the family, can you tell me how your family members have stayed so closely connected to one another?"

Critical Thinking Process

Skills in Critical Thinking will help in all areas of child welfare from information gathering to clear decision making.

Definition of Critical Thinking: The process of evaluating propositions or hypotheses and making judgments about them on the basis of well supported evidence.

The purpose of thinking critically about practice-related claims is to maximum services that are effective in achieving valued outcomes and to minimize ineffective and harmful services. Good intentions are not enough to protect clients. Critical thinking involves the careful appraisal of beliefs and actions to arrive at well-reasoned ones. It involves reasonable and reflective thinking focused on deciding what to believe or do.

Six Steps of Critical Thinking

1. **What information is available?**
2. **What am I being asked to believe or accept, what is (are) the hypothesis(s?**
3. **What evidence is available to support these assertions, is it reliable and valid?**
4. **Are there alternative ways of interpreting the evidence?**
5. **What additional evidence would help to evaluate the alternatives?**
6. **What conclusions are most reasonable based on the evidence and the number of alternative explanations?**

"Viewed broadly, the process is part of problem solving. It requires clarity of expression, critical appraisal of evidence and reasons, and consideration of alternative points of view. Critical thinking questions what others do not. They challenge accepted beliefs and ways of acting. They ask questions such as: Have there been any critical tests of this claim? What are the results? Could there be another explanation?" [2]

[2] "*Critical Thinking in Clinical Practice: Improving the Quality of Judgment and Decisions" – Eileen Gambrill.*

Child Protection Interview

Child protective investigators and law enforcement agencies have the legal responsibility for conducting initial interviews with the child victims. If possible, child interviews should occur outside the presence of alleged perpetrators or the children's caretakers. Other persons whom the child trusts may be present if this will make the child more comfortable.

Safety-Based System

DCFS has a "safety-based" approach to child welfare practice, within the structure of its existing reporting system for child abuse and neglect. Under a "child safety" approach or model, the question of "What have you seen the parent or caregiver do to the child" is refocused from the parent/caregiver to the child and restated as: "What have you seen or what do you know that would cause you to believe the child might be in imminent danger of significant harm?"

Instead of first asking whether the allegation against the parent is true – which that, of course, eventually needs to be determined as part of the assessment -- we focus our concern on whether the child is safe. The distinction between an allegations-based system and a child safety-based system is not a matter of "one against the other," but rather a matter of initial focus and response. The goal is for all child welfare workers to regard the child's safety as the predominant priority in their involvement with the child, family and caregivers in all aspects of casework practice.

Interview Preparation

Whenever it is feasible and practical, child welfare professionals have the responsibility to make families and children comfortable by providing comfortable and confidential settings. This is the objective whether interviews are conducted in homes, offices, or other locations.

In reviewing case files and reflecting on previous family contacts, child welfare professionals should evaluate their personal prejudices, attitudes, and emotions. The professional doing this self-appraisal should consider a number of issues. Some issues have been covered in previous units such as cultural competency, appropriate use of delegated authority, professional boundaries, competence, etc. Child welfare professionals should determine tentative interview goals, the time available, and strategies to accomplish the goals.

Recognizing Signs and Symptoms of Child Abuse and Neglect

State law defines **abused children** as minors under age eighteen who are being harmed by any person responsible for their welfare, including a parent, family member, any person who resides in the home, a boyfriend or girlfriend of the parent, a babysitter or day care provider. Harm to the children may be physical or emotional injury (or serious risk of injury), excessive punishment, sexual abuse, or torture.

State law defines **neglected children** as children whose parents or persons responsible for their welfare do not provide necessary support as required by law, medical, or other care for the well-being of the child, or necessities such as adequate

clothing, food, and, shelter. Children who have been left with relatives as their plan of care are not considered neglected.

Investigative staff designated by the Department is responsible for investigating reports of suspected child abuse or neglect and is the only Department staff permitted to take children into temporary protective custody. (See detailed legal descriptions of abuse and neglect and the four subtypes of maltreatment in Appendix B).

Indicators of Abuse and Neglect

Continually assessing safety and risk and ensuring the protection of children are the primary responsibilities of child welfare professionals. The skill to recognize physical and behavioral indicators of child abuse and neglect is essential.

Type of Maltreatment	Physical Indicators	Behavioral Indicators
Physical Abuse	-Unexplained bruises, welts, burns, fractures	-Wary of adult contacts -Apprehensive when other children cry -Aggressive or withdrawn -Frightened of parents -Afraid to go home
Emotional Maltreatment		-Cut off from normal social relationships -Engaged in anti-social and destructive behavior
Sexual Abuse	-Difficulty in walking or sitting -Torn, stained or bloody underclothing -Pain or itching in genital area, vaginal or anal areas -Venereal disease, especially in preteens -Pregnancy	-Unwillingness to change for gym or participate in physical education class -Withdrawal -Infantile behavior -Bizarre, sophisticated, or unusual sexual behavior or knowledge
Neglect	-Unexplained lacerations or abrasions to mouth, lips, gums, eyes, external genitalia -Consistent hunger, poor hygiene, inappropriate dress -Consistent lack of supervision, especially in dangerous activities or for long periods -Unattended physical problems or medical needs -Abandonment	-Extended stays at school (early arrival and late departure) -Constant fatigue, listlessness or falling asleep in class -Delinquency, states there is no caretaker -Alcohol or drug abuse

Summary of Investigation Procedures

Initial Investigation

When a report of child abuse or neglect is received, the DCFS child protection staff make an initial investigation to determine whether a report of suspected child abuse or neglect is a good faith indication of abuse or neglect and, therefore, requires a formal investigation. "Good faith" in this context means that the report was made with the honest intention to identify actual child abuse or neglect. Child Protection staff are mandated to begin an investigation within 24 hours after the Department receives a report alleging child abuse or neglect.

The following circumstances require that the **State Central Registry (SCR)** notify the local police and that investigative staff respond immediately, i.e., initiate the investigation without delay at any hour of the day or night:

- The alleged child victim is believed to be in immediate danger of physical harm
- It is likely that the family of the alleged child victim(s) will flee with the children
- They are presently being violently assaulted
- They are in need of immediate medical care
- Children five years of age or less are presently left alone
- Children over five years of age who are incapable of protecting themselves are presently left alone, e.g. severely disabled children
- Data check and Soundex (see Definitions) of family members.
- In-person or telephone contacts with the reporter(s) and any persons listed as other sources, if the reporter's identity is known.
- In-person or telephone contacts with law enforcement (if the reports were first investigated by the police).
- In-person contact with alleged child victims.
- In-person examination of the environment for inadequate shelter and environmental neglect reports.
- In-person contact with mothers of infants hospitalized due to the presence of controlled substances in their system or in the environment in which the mothers will live with the infant.

All children in the home environment should be seen if the allegations are of abuse and if the applications of pertinent risk factors so indicate. If initial investigations determine that reports contain good faith indications that child abuse or neglect exists, the investigative staff should notify the parents/caretakers and alleged perpetrators that there will be a formal investigation.

Unfounded Reports: Unfounded reports are reports of child abuse or neglect for which it is determined after investigation that no credible evidence of the alleged abuse or neglect exists.

Indicated Reports: Indicated reports are reports with the determination of either child abuse or neglect.

Background Clearance – CANTS & LEADS

During the initial assessment, one of the first things a Child Protection Specialist will do is request background checks on all adult household members, paramours whether they reside in or out of the home, and any adult acting in a caretaking capacity.

Child Abuse and Neglect Tracking System (CANTS) – Prior history of reports of abuse or neglect in Illinois

Law Enforcement Agency Data System (LEADS) – Illinois criminal history record information for adults or juveniles who were tried as adults. (If a criminal record outside of Illinois is suspected, contact the Office of the Inspector General (OIG), Bureau of Investigations.)

Formal Investigative Process

Formal investigations follow the initial investigation as soon as child protection staff make a determination that there is reasonable cause to believe that child abuse or neglect exists. Formal investigations determine whether reports of suspected child abuse or neglect are indicated or unfounded.

Such activities include:

- Evaluation of the environment of the children named in the report and any other children in the same environment.
- Determinations of risk to such children if they continue to remain in existing environments, as well as determinations of the nature, extent, and cause of any conditions enumerated in the reports, and the names, ages, and conditions of other children in the environment.
- Evaluation as to whether there would be immediate and urgent necessity to remove the children from the environment if appropriate family preservation services were not provided.

After seeing to the safety of the children, the Department will notify the subjects of the reports in writing of the existence of the reports and their rights in regard to amendments or expungements. *[325 ILCS 5/3]*

Communication Requirement

During all stages of the investigation when dealing with limited/non-English speaking persons or persons with hearing /visual impairments, the Department should facilitate effective communication between investigators and subjects of the report by:

- Assigning child protection staff who have the ability to communicate in the language (foreign or sign) of the subjects.
- Procuring the services of interpreters who agree to respect the confidential nature of investigations prior to any investigative activity when limited/non-English speaking or hearing impaired persons will be interviewed.
- Assuring that no family members, friends, or children are used as interpreters.

Observation of the Child

Whenever child protection staff undertake to observe, photograph, or videotape children's external marks or injuries, there should always be parents/guardians or other professional persons present, preferably of the same sex as the children, regardless of the children's age. Any photographs or videotapes must use DCFS issued cameras only.

If the child is age six or above, the child protection staff should not observe any part of the children's bodies that would normally be covered by bikini bathing suits, unless the staff person is of the same sex as the child. Children who are verbal should be told the purpose of the observations in words that they can understand. If the children are hearing-impaired or do not speak English, the child protection specialist should use the child's mode of communication, e.g., sign language or foreign language interpreters, etc.

Child Protection Specialists should make good faith efforts to obtain parental or guardian consents before observing children for marks/injuries when clothing must be adjusted or removed. If the children's parents refuse to cooperate with or allow the investigators to observe the children for external marks/injuries, the investigators should inform the parents that, pursuant to Illinois statute, they have the responsibility to observe the children. The investigators should then offer the parents/guardians the option of taking the children to their physician or to a hospital emergency room for a physical examination, at which time the investigators can secure written reports from the examining physicians. The parents can also be offered the option of professionals, e.g., school nurses or teachers, policemen, etc., to observe the children.

If the parents/guardians refuse to cooperate, and the investigators determine that the children are at imminent risk of harm if left in the custody of the parents/guardians, the investigative workers should take the children into temporary protective custody and proceed to have the children examined by a physician. If the children are not at imminent risk of harm, and the parents refuse to cooperate, the investigators may not take temporary protective custody and may not observe the children's bodies.

Internal Injuries

Investigators should never attempt to examine alleged child victims for internal injuries or attempt to move children with internal injuries. If the investigators are able to contact the children's parents/guardians, the investigators should ask the parents/guardians to take the children for examination immediately.

Sexual Abuse

If child victims are alleged to have been sexually abused or to have a sexually transmitted disease, and the investigators and supervisors determine that physical examination is necessary, the investigators should attempt to secure cooperation from the children's

parents/guardians to arrange for examination and treatment. The investigative workers should also inform the parents/guardians that the children must be taken for examination as soon as possible, and no later than the next eight hours, and that the investigative workers will secure verbal and/or written reports of the examination from the physician.

If the parents/guardians refuse to take the children for physical examinations and treatment, and the workers determine the children are in imminent risk of harm, the investigators should take the children into temporary protective custody and take them to a hospital emergency room for examination.

Observation of the Environment

Investigators may observe specific areas of homes reasonably related to the allegations. Reports by mandated reporters should provide reasonable cause to expand the investigation to specific areas of the home.

Investigation of an Incident or Injury

All child welfare professionals should be familiar with objective investigative practices. Caseworkers must be able to evaluate an incident or injury to determine how to proceed (e.g., call the hotline, increase monitoring, etc.) and child protection investigators must know how to conduct thorough, well-reasoned investigations that result in an accurate outcome. Objective investigative practices include:

FACT FINDING

- Interviews with caregivers, witnesses and others who have relevant information about the family, including who, what, where, when, why, and how of the incident;
- Construction with caregivers of a 24 to 72 hour time line of events leading up to the incident;
- Verification of information obtained in interviews (through other interviews or reviewing available documents);
- Visual observation of the child, including developmental abilities;
- Medical examination of the child when an injury has occurred.

SCENE INVESTIGATION

- Observation and documentation (description, measurements, photos) of the scene where the incident occurred and any objects alleged to have been involved;
- Mock demonstration (reenactment) by caregiver(s) of the incident using appropriate props (such as a lifelike doll) in the environment where the incident occurred.

COLLABORATIVE ANALYSIS

Putting together all the information collected; analyzing it with supervisors and others involved in investigation, such as medical personnel and law enforcement; and making decisions.

When Protective Custody is Needed - When the Child Protection Specialist determines that a child cannot be safely maintained in his/her home, placement should be guided by what is in the best interest of the child. When a child is removed from the care of a custodial parent, placements must be explored in a certain order.

This order of placement helps the child preserve family and community ties.

- Placement with the non-custodial parent
- Placement with siblings in care
- Placement with other relatives
- Placement with foster caregiver (by school district)

Collaboration and Teamwork

Collaboration and teamwork are essential in providing formal intervention as well as informal support to families. Child welfare professionals and supervisors provide leadership to the child welfare team. The team's approach is based on sound social work practice and the best interest of the children in achieving preferred outcomes.

At a minimum, team membership includes the parents, children, child welfare professionals, and supervisors. If children are in placement, foster and relative caregivers, or substitute care facilities, (e.g., group homes, residential treatment, etc.), are included as team members. Other agency staff and community service providers, such as therapists, and medical, school, and juvenile court personnel, may also be included as team members. Teamwork is a process that includes:

Determining and communicating desired goals and objectives

Collaboration and teamwork begin with the child welfare professional's role in jointly developing service plans with families that translate family problems into positive need statements related to the children's permanency goals.

Making and implementing decisions and plans to meet desired goals and objectives

Collaboration and teamwork continue as child welfare professionals locate resources and initiate and complete referrals that meet families' needs. Child welfare professionals should ensure that solid linkages are established and maintained between individuals and resources to ensure seamless, consistent treatment and services.

Identifying and respecting complementary roles and individual expertise

Members of the family team represent a variety of resources and expertise. Family members are considered experts on their own family problems. Child welfare professionals should exercise appropriate use of personal authority and recognize other service providers within the community and agency, including therapists, resource workers, educational liaisons, adoption specialists, quality assurance specialists, and supervisors.

Resolving conflicts that impede achieving the goals and objectives determined

Child welfare professionals must understand how interactions among the various providers and systems can affect case outcomes. The emotionally charged issues inherent in child welfare can lead to conflicts among team members. Child welfare professionals must be resourceful and creative in maintaining positive relationships demonstrating organizational skills and balancing assertiveness, persuasiveness, and persistence with patience, flexibility, and respect in providing leadership to teams.

Assessing progress and achievements in meeting goals and objectives

Family meetings, administrative case reviews, and supervisory conferences provide the formal means of assessment when the family team gets together to review progress. Child welfare professionals not only respect the roles and opinions of other team members, but also seek and accept their feedback to incorporate into service planning and delivery.

Establishing new plans and setting new goals and objectives as needed

Child welfare professionals use ongoing assessment of a family's progress in correcting the behaviors and conditions that led to the children's maltreatment and the children's need for permanency. The safety and health of the children remains the paramount consideration in determining needed revisions to the family's service plan or the children's permanency goals.

Role of Foster and Relative Caregivers

Initially the role of foster or relative caregivers is to provide temporary care to ensure the safety, health, and well-being of children when out-of-home placements are required. During placement, parents work toward reunification by correcting behaviors and conditions related to the children's maltreatment. Foster and relative caregivers play a critical role in achieving permanency for children by their commitment to the children's care and well-being while in their homes. At the same time, they need to be invested in the children's successful reunification by working actively with birth parents, as well as with the children. This combination of roles can be extremely difficult and requires the full understanding and support of the child welfare professional.

Responsibilities of Foster and Relative Caregivers

- Meet children's medical, educational, physical, emotional, and other developmental needs.
- Address children's developmental delays.
- Support children's family relationships.
- Promote permanency planning with a special focus on reunification.
- Work as members of the family team.
- Protect and nurture children.

Specific rights and responsibilities of foster caregivers are enumerated in the licensing standards for foster homes and Public Act 89.19, known as the Foster Parent Law. The Foster Parent Law serves as a "job description" by defining the foster caregivers' role in child welfare and the responsibilities and agency expectations associated with that role.

Casework with Foster and Relative Caregivers

- Providing all available information about the children's strengths and needs in relation to health, education, psychological-emotional, and physical development to ensure the caregiver's ability to appropriately care for the children.
- Providing full disclosure of the children's current legal status and permanency goals and updates on the progress or lack of progress in achieving permanency for the children.
- Discussing the children's needs, behaviors, adjustment to placement, and separation and loss issues.
- Making timely and appropriate referrals for services to meet the children's needs and support the children's placements.
- Involving caregivers in plan for the child.
- Involving caregivers in reunification activities, parent/children visits, sibling visits, coaching/mentoring parents, and including them in the child's daily life.

Special Needs of Children in Placement

It is essential to address issues related to daily routines, schedules, appropriate discipline, the children's developmental ages, and physical functioning. Caregivers may have to make accommodations based on the children's needs and level of functioning. Parents also need to understand the routines and rules established for the children's care so that potential conflict with caregivers can be reduced.

Special Considerations for Relative Caregivers

Bonds, attachments, networks, common heritage, shared culture, and past experiences are major factors that set kinship care apart from traditional foster care. These factors can be beneficial, but may also include an emotional component that can cause stress. Child welfare professionals take an active role in sensitively raising and resolving issues that tend to go to the very heart of family matters. They need to understand the relationships within the triad of children, parents, and relative caregivers from both a family systems perspective and that of managing changes to promote safety, well-being and permanency for the children.

Change in Roles and Relationships

When aunt, uncle, grandmother or other relative assumes the parental role, the children's expectations change. Children may experience the loss over of their previous role with the relative caregiver. The change in role shifts authority for relative caregivers and parents. Relative caregivers have familiar, existing legal or blood relationships to the children's parents and have known the children in the context of those relationships.

Needs of Kinship Caregivers

Children or sibling groups may be literally dropped in the laps of relatives without any preparation or financial, emotional, physical, or environmental support. Living space, the number of beds, linens, and food in the homes may be initially inadequate. Concrete assistance may be necessary.

Supports and services needed by relative caregivers often resemble family preservation services, rather than traditional foster care services. Many relative caregivers are older and may face physical limitations and health problems. Child-rearing techniques and methods may need to be reviewed and updated. Agencies' policies on discipline may require adaptations in the relatives' discipline style. Child welfare professionals may need to train relative caregivers on agency policy, child development, and discipline as well as providing information about licensing options.

Working with Older Caregivers

The practice of grandparents and other relatives raising children is nothing new, relative caregiving has been occurring since the beginning of time. The incidence of relative (kinship) caregiving has increased over the past couple of decades and is continuing to rise. In fact nationally 1 in 12 children are cared for by grandparents or other relatives.

In DCFS, the numbers are much higher. One in four care providers are older caregivers. As of the close of 2009 there were over 5,700 caregivers over the age of 60 who were caring for over 10,300 children involved in the child welfare system.

DCFS uses the federal designation of age 60 when describing an "older caregiver." The age of 60 is also consistent with federal program funding eligibility requirements.

Life-Span Approach

In most people's lives, such things as alertness, vigor, and physical and mental well-being change as aging occurs. Plans made at one point in a family's life may no longer be workable years down the line. This will be true more frequently with older caregivers.

A "life-span approach" recognizes that some older caregivers will experience physical or cognitive changes as they age that may affect their ability to provide a healthy and safe environment, not only for themselves, but also for the children in their care. If these normal events are not anticipated and planned for in advance, the results can be devastating to families.

Establish lasting permanency for children

We know from actual field practice and evidence, that some older caregiver families have experienced difficulties preserving safe and stable placements**.** The assessment process allows workers and the family to identify real or potential challenges and begin planning on how to meet these challenges.

There have been issues in older caregiver cases that should have acted as triggers but did not. The tools and evaluations made by professionals in the Aging Network can assist the worker in making sound decisions based on real evidence.

These tools offer the worker concrete data about functional capacity, cognition, finances, housing and caregiving responsibilities to others in the home (spouse, parent) that will assist the worker in making decisions about the placement.

- Is the caregiver ready, willing and able to assume responsibility for the child?

- If the caregiver was able to care for the child when he/she first came into their care, what about 5 years later?
- Does the caregiver depend on extraordinary assistance to care for self or child?
- Do the caregiver's own health needs present a serious obstacle to the care or well-being of the child?
- Is the caregiver able to make appropriate judgments in the child's behalf?

Long Term Care Plan

A long term care plan is a "global" review of the plan for the child that includes a backup plan. Long term care refers to the plan for the family throughout the child's life, especially once DCFS is no longer in the pictures and permanency has been achieved. The caregiver, extended family, older children and other supports to the family should be included in developing the plan.

Back-up Planning

The back-up plan is the plan the caregiver (and extended family) have developed for ongoing care for the child if the time comes when the older caregiver can no longer care for the child. The back-up plan should be specific, in writing, and legal if possible (standby or short term adoption or guardianship).

Everyone significantly involved with the family should know and agree with the plan. The caseworker should make sure that the back-up plan is detailed enough to cover predictable contingencies. The plan should address the needs of the child that will or will not be covered in the subsidy agreement. The plan should provide full disclosure about the needs of the child and the responsibilities of the back-up care provider.

The person identified as the back-up should also be informed about limiting factors in the older caregiver's situation so that the back-up can make a fully informed decision about their agreement and their on-going role in the life of the child. The need for a back-up may not occur for years; but in creating a plan, the family, child and caregiver will have a start with building goals and preparing for contingencies.

60-Plus Process

The 60-Plus Process applies to all pre-adoptive and pre-subsidized guardianship cases. In Cook County there are Adoption Coordinators who meet with the pre-adoptive parents or guardians and their back-up caregivers. In other counties this process is a paper review. The 60+ Process, which went into effect in February of 2006, recognizes the importance of designating a back-up caregiver and ensuring that the back-up is fully informed about the child.

Extended Family Support Program (EFSP)

EFSP is a deflection program designed to keep children out of the child welfare system and to stabilize relative caregiver families by gaining private guardianship of the children and other state benefits. The relative must be willing and able to continue in the caregiving role.

Only DCP investigators can make a direct referral to EFSP. Referral of these uninvolved children and their relative caregivers to EFSP enables the children and families to access much needed short term supports, such as beds, clothing, diapers, etc. EFSP will also assist in gaining other family caregiver services and financial supports.

All other families must contact the DCFS Hotline directly to request a referral to EFSP. The referrals can be made when closing an Intact Family Services case, when closing an investigation case or at any point in work with the family where there are children for whom there is no open DCFS case and who need additional supports. It is strongly encouraged that the workers assist the families in making the call to the hotline to request EFSP.

Visitation

Family reunification may occur at any time in the life of a case, but research shows that, if reunification has not occurred within six months of temporary custody, the likelihood of it significantly decreases. **Research also indicates that the single-most significant factor in achieving family reunification is the occurrence of parent/children visits.** In addition, sibling relationships typically are the longest-lasting of all birth family relationships and can provide long-term connections to a child's personal history and self-identity, whether or not reunification takes place.

Through visits, children can be reassured that:

- They still are loved and lovable and have not been forgotten.
- Their parents are all right.
- Their parents give permission for them to stay with foster or relative caregivers until reunification.
- Their parents and the child welfare team are working together for reunification.

Visits assure parents that:

- They still are loved and lovable and have not been forgotten.
- Their children are being cared for adequately.
- Their commitment to their children is valued.
- Their children have not forgotten them, that they are still a meaningful part of their children's world.
- They will be kept informed of their children's growth and development.
- They can be assisted in more skillfully parenting their children.

Visits are important. They are:

- A right for the child to become or remain connected to family, community, and culture.
- A right for parents to remain connected to the children.
- A responsibility for parents, child welfare professionals, and agencies to maintain or improve the parent/child relationship and for parents to actively express their desires and intents to have their children returned to them.
- An opportunity for all members of the child welfare team to meet children's need for connection to their past history and for resolving issues related to children's need for permanency.
- Viewed by the court as an indicator of parent's commitment to the child.

If permanency goals are reunification and there are no issues related to visits and safety, parents have the right to:

- Visits within ten days after the children have been removed from the home.
- Visiting plans that encourage visits with the children.
- Help in developing visitation plans if specified in their service plans.
- See their children every week.
- Visits in their home.
- Extend length of visit over time.
- Appeal the caseworker's decision on visiting plans.

Visits are essentially for the benefit of the children. They are therapeutic as feelings stimulated in children by visits support their ability to grieve. In fact, children's reactions to visits indicate where they are in the grieving process. Visits can help children substitute reality for "magical thinking" about the reasons for their separation from parents and the likelihood of reunification. Visits can also help children separate from parents and move on to establish relationships with new, permanent families.

Caseworkers can support visitation:

- Develop and enhance their relationship with parents by actively affirming the parents' rights and desires to be adequate parents.
- Provide direct, therapeutic input in parent/child relationships.
- Obtain data upon which to base decisions regarding the selection and implementation of permanency goals.

Foster and relative caregivers can support visits:

- Keep in touch with changes in the family's situation as they pertain to permanency goals for the children.
- Better understand the children's relationships with their parents.
- Better support the children's attempts to understand their situation.
- Develop more effective working relationships with parents.
- Find opportunities for coaching or mentoring parents.

When visits do not work out, the effects can be harmful to children and the child welfare team is faced with the challenges of helping children manage the damaging effects. Effective planning, preparation, and implementation of visits result in visits that will have the optimum chance of meeting their purpose.

Planning, Preparation, and Implementation of Visits

Observation of parent/child interaction and assisting parents in enhancing the parent/child relationship is the purpose of visitation. Conducting other case-related business, such as making future appointments or discussing progress or lack of progress, should not take place during the children's time with parents.

Planning
- Locations
- Time and length
- Frequency
- Whether they will be supervised or unsupervised

Preparation
- All those involved understand the purpose for the visits.
- All those involved understand the arrangements for the visits.
- Children need to be prepared for parents' reactions to visits. If parents often fail to attend, become emotional, or there are safety concerns, possible reactions should be discussed with the children.
- Children need to be prepared for their feelings and reactions to visits.
- Feelings can range from guilt, grief, anger, or euphoria and can be unpredictable.
- Foster and relative caregivers need to be prepared that some emotional reaction to visits is normal for children.

Implementation
- Make referrals for additional services if parenting skills cannot support effective visits.
- Find the most comfortable locations possible.
- Provide ample time before terminating visits so parents and children have time to say goodbye.
- After saying goodbye, remove the children as quickly and calmly as possible.
- Notice the children's cues following visits. Some children want to be left alone; others want to be with someone. Many children need to sleep.
- Tell the child that all children have feelings following visits and give the child permission to express those feelings.
- Refrain from extensive questioning of children about the visits.
- Do not force children to eat or drink.
- Do not push children to be affectionate or force affection from children.
- State to both parents and children as specifically as possible when the next visit will be.

Decision Making Process

The decision-making process begins with child welfare professionals and their supervisors. They possess first-hand knowledge about the families and case-related issues. The child welfare professionals and supervisors, with input from families and children, are in the best position to make informed, clinical, case-related decisions. In high-profile or high-risk cases, supervisors should consult with managers or other administrators, who may involve other internal or external consultants as needed. Child welfare professionals and supervisors are responsible for making case-related decisions that comply with applicable law, rule and procedure, and policy.

Critical Decisions

Decisions affecting children and families are important. Some decisions identified by DCFS policy and procedure require approval of the child welfare professional's supervisor. These are the most critical decisions affecting children and families:

- Deciding whether services can prevent placement away from their parents or primary parent figures or whether to remove a child from the home of the parents or primary parent figures.
- Deciding whether to recommend the return of a child to the home of the parents or primary parents figures from placements away from their parents or primary parent figures.
- Deciding to decrease the frequency or duration of parent and/or sibling visits with the children and whether visits should be supervised.
- Deciding to change a child's placement.
- Deciding to seek termination of parental rights and seek alternate permanent homes.
- Deciding if children are prepared for partial or total independence.
- Deciding whether children should be placed apart from siblings who are also placed in substitute care.
- Deciding whether to release the name, address, and telephone number of the foster /relative caregiver to the parent and/or siblings placed apart (Procedure 315.70)

Service Appeal Definitions

Children, families, relative or foster caregivers may appeal decisions related to services, planning, changes in placements, and payment decisions made by the DCFS or private agencies by requesting service appeals. The service appeal process for the Department consists of **mediation**, which is optional, and a **fair hearing**. Initiation of a service appeal does not preclude ongoing discussion between the parties to resolve the appealed issues. If mediation resolves the issues, an agreement is drawn up with some assistance of the mediator and signed by the parties. In some instances, the issue on appeal is too immediate to await the final administrative decision on the action. An **emergency review** may be held in lieu of mediation on the specific issues, and an interim decision will be issued by the reviewer pending the fair hearing and final administrative decision.

> **Emergency review** is a limited review of the actions or decisions of the Department or provider agency that may adversely affect an individual served by the Department. An emergency review provides for an interim decision pending a fair hearing.

Fair hearing, as used in Rule and Procedure 337, is a formal review of the action or decision of the Department or provider agency. The fair hearing determines whether such action or decision was in compliance with applicable laws and rules and in the best interest of the child.

Mediation is a meeting open to all parties affected by the decision being appealed to attempt to reach an agreement on the issue in dispute with a mediator who assists the parties in resolving issues and drawing up an agreement. (Rule 337)

Opening the Case/Case Assignment

As soon as the Child Protection Specialist (CPS) determines there is a "service need" (counseling, daycare, protective custody, etc.), the CPS completes a case opening registration form (CFS 1410). The case will be opened and if applicable, assigned to an intact or placement team.

Case Handoff and Transitional Visits

If cases proceed for intact or placement services, the Child Protection Specialist must handoff the case to the intact or placement supervisor and transition the case with family members.

Case Handoff/Case Transfer – The Child Protection Specialist supervisor must provide information about the case, including the necessary safety and risk assessments and screens completed.

Transitional Visit – The transitional visit is held with the Child Protection Specialist, the intact or placement worker who is receiving the case and the family members. The main goal is to transition the relationships between the various helping professionals working with the family. The Child Protection Specialist introduces the intact or placement worker to the family. This ensures that everyone hears the same information at the same time.

The **transitional visit** signifies one of the first opportunities for the Child Protection Specialist, the Permanency Worker, and the family to work as a team providing for the safety, well-being, and permanence of the children. Together, they should discuss the primary reason(s) for the case opening and include the family's input in identifying the issues facing the family. They should address the child's current safety status and identify what behaviors, decisions, and/or conditions need to be changed/adjusted in order to protect the child. A visitation plan (if applicable) needs to be developed. The family's participation in developing this assessment and all decisions, including the family's service appeal rights, should be documented.

Child and Family Team Meetings

Frequent meetings with families and those involved with serving families are required to plan, assess progress, and decide permanency direction.

Family meetings are a tool intended to engage the family in the planning process. Therefore, caseworkers shall make intensive efforts to persuade and encourage parents to attend the family meetings, especially during the first 90 days, by explaining to them the importance of the family meeting and of attending and cooperating with the process. Casework staff should make every effort when planning family meetings to be flexible and attempt as much as possible to schedule meetings at a time and place where parents can attend, preferably in the parent's home. Staff shall take into consideration parents' work schedules, transportation issues, availability of interpreters (if the parents' primary language of communication is other than English), and any other barriers that might prevent parents from participating. After reaching agreement with the parents on the date, time, location, and participants of the family meeting, the caseworker shall send a confirmation letter to the parents. Caseworkers shall document in the case file all attempts to include parents in the family meetings. Failure to attend family meetings shall also be documented in the case file." (Procedures 315.120)

Initial family meetings must occur within 40 days after temporary custody hearings and include the required persons as outlined in Rule 315, Section 315.120. In addition, as outlined in Rule 315, at the supervisor's discretion and with the signed consent of the parents, other persons may be invited.

Before inviting foster caregivers to initial family meetings, child welfare professionals must consider the statutory requirement that protects foster caregivers' addresses and telephone numbers from disclosure. Such information should not be disclosed to the children's parents at initial family meetings that occur within the first 30 days after temporary custody hearings. In deciding whether to invite foster caregivers to the meetings, child welfare professionals also take into consideration the level of violence or tendency toward violence displayed by the children's parents. This determination is made during the first 30 days and the completion of comprehensive assessments. Information concerning the level or tendency toward violence of the parents may be shared with the foster caregivers to help them decide whether to attend the initial family meetings. For subsequent family meetings, the same violence factor should be considered when determining whether the foster caregivers should attend.

After the initial family meeting, **family meetings occur at least quarterly**--more frequently if needed. At these meetings, the participants review the parents' progress toward reunification, and discuss improvements made by the parents, as well as any problems related to visits, provision of services, barriers to services and other matters. The potential for reunification and whether families are on target must be discussed. Full disclosure requires that information related to the parents' progress is

fully discussed, and parents are again advised that alternative permanency plans will be implemented if progress is not consistent and ongoing.

Participants in family meetings will attempt to reach decisions and agree on recommendations by consensus. If a consensus cannot be reached, final decisions rest with the assigned supervisor. Documentation of meetings and reports of recommendations/ decisions should be included in case records. As stated above, parents have the right to appeal decisions with which they disagree in accordance with 89 Ill. Adm. Code 337 (Service Appeal Process).

Culturally Informed Practice

In the broadest sense of the term, culture includes all the things about how a person was raised and currently lives. It includes the history of a person's family and challenges they have faced, who raised them and the communities/society that impact them. Like the families we serve, each child welfare professional is influenced by their own culture and needs to be aware of their own values and beliefs. The presence of bias and prejudice may negatively affect how they engage children and families when providing services. As a result, child welfare professionals need to be "culturally competent" and their practice "culturally informed" when working with children and families.

Cultural Diversity

People come from very different cultural backgrounds and their customs, thoughts, ways of communicating, values, traditions, and institutions vary accordingly. Understanding culture informs how we interact with each other. Often a discussion of culture is limited to discussing "race". In fact, the term "race" refers to a social construct that people use to associate behaviors and attitudes with physical characteristics. Due to the legacy of racism in the United States, we have to acknowledge that the concept "race" is a current reality. Though there are many ethnicities, however, all human beings are part of one race, the **human race**.

We need to have a broad concept of culture and what it means to those individuals within different ethnic groups. Being a member of a cultural group becomes a part of our personal identity. We may define ourselves as part of a culture of the hearing or visually-impaired, as developmentally disabled or as members of other groups. Members of religious communities may develop their own cultural identity. Members of the Lesbian, Gay, Bisexual, Transgendered and Questioning communities may also be considered as having their own culture.

Members of groups may face or have faced experiences such as racism, anti-Semitism, anti-immigrant or other oppression. The challenges individuals, families, and groups of people have faced affect their perspective of the world. The choices that individuals make are powerfully affected by their backgrounds; culture determines even how one chooses to define "family".

Children of all races are equally as likely to suffer from abuse and neglect, according to the U.S. Department of Health and Human Services' (HHS) National Incidence Study of Child Abuse and Neglect.[1] Therefore, child welfare professionals need to be prepared for work with families and children from various backgrounds and in diverse communities.

[1] "African American Children in Foster Care," Highlights of the GAO-07-816 Report to the Chairman, Committee on Ways and Means, House of Representatives, 2007.

Valuing Cultural Diversity

Culture influences all systems, including the agencies and institutions that deliver child welfare services. Child welfare professionals must understand the importance of considering cultural differences and of establishing conceptual frameworks for engaging in the helping process with families of different races, cultures, and ethnic backgrounds. Good communication with children and families always requires being culturally sensitive.

Valuing cultural diversity means accepting and respecting differences. Diversity among cultures must be recognized, as well as the diversity within them. Individuals are exposed to many different cultures in a variety of ways. Travel, school, television, books, and other activities present opportunities for multicultural exposure. People generally assume a common culture is shared between members of the same racial, linguistic, and religious groups. The larger group may share common historical and geographical experiences; however, individuals within the group may share nothing beyond similar physical appearance, language, or spiritual beliefs.

It is only through being **culturally-informed** that we can view the family's experience from their perspective, providing emotional support and advocating on their behalf. Child welfare professionals must:

- Learn about human development and behavior to understand what may be common to all people.
- Learn how memberships in certain groups may impact families in similar ways as members of the same group. Through this learning, professionals can develop general understanding that can inform the plan for intervention services.
- Learn about each family and individual, recognizing that different types of group memberships shape an individual's culture and experiences, personality and behaviors.[2]

Alfred Kadushin states that every person is in certain respects like:
All people
Some other people
No other person

Definitions

It is important to have a common language when talking about culture.

- **Culture** is the totality of learned behaviors. Culture is based on values, beliefs, and assumptions derived from shared experiences, history, and geographic proximity. re provides the backdrop or context for our interpretation of life experiences and development of coping strategies for day-to-day living.[3]

[2] Kadushin, A. The Social Work Interview: A Guide for Human Service Professionals. New York: Columbia University Press, Third Edition, p. 304.)

[3] Falicov, C.J. "Learning to Think Culturally," Handbook of Family Therapy Training and Supervision. NY: The Guilford Press, 1988.

- **Race** is a contrived system of categorizing people according to observable physical attributes that have no correspondence to genetic or biological reality. [4]

- **Ethnicity** pertains to those distinctive elements of a people, such as dress, food, religious practices, ceremonies, traditions, celebrations, language, etc., which can be traced to religious, national, or cultural groups.[5]

- **Bias/Prejudice** is "preconceived judgment or opinion; an adverse opinion or learning formed without just grounds or before sufficient knowledge; an irrational attitude of hostility directed against an individual, a group…" [6]

- **Racism is** "any attitude, action or institutional structure which subordinates a person or group because of their color…Racism is not just a matter of attitudes, actions and institutional structures can also be a form of racism." [7] It brings significant material and emotional advantage to the majority/dominant group.[8]

- **Institutionalized Racism** takes place when the power of control and access to a society's institutions is disproportionately and systematically determined by a dominant racial group, while other racial groups are systematically deprived of this power. These include decisions on who receives training and skills, medical care, formal education, political influence, moral support, productive employment, fair treatment by the law, decent housing and the promise of a secure future for self and children. It includes the exclusion of some members of society from positions of control and leadership.[7]

Despite the assertion of the Declaration of Independence that "all men are created equal," the Constitution denied the slave his human rights. Article 1, Section 2 defined the Black slave as property and equal to three-fifths of a man. This clause legalized institutional racism for almost 100 years, until the 13th, 14th and 15th Amendments to the Constitution defined the Black man as an equal. (Women of all races could not vote until the 19th Amendment in 1920.) Native Americans were written out of the Constitution too.

[4] "Critical Race Theory and Cultural Competence, " Journal of Social Work Education, Vol.45, No. 2.
[5] Falicov, C.J. "Learning to Think Culturally, " Handbook of Family Therapy Training and Supervision. NY: The Guilford Press, 1988.
[6] Websters Ninth New Collegiate Dictionary, Merriam-Webster, 1983.
[7] Racism in American and How to Combat It, U.S. Commission on Civil Rights, 1970.
[8] "Critical Race Theory and Cultural Competence." Journal of Social Work Education, Vol.45, No. 2.

Values, Beliefs and Assumptions

As a result of each person's experiences in their families, communities and society, they acquire their own values, beliefs and assumptions which shape their actions in their home, community and workplace. Child welfare professionals need to be aware of their values, beliefs and assumptions and how their experiences influence their perceptions of the families they serve.

- **Values** are those beliefs and qualities that persons hold in esteem or are of significance and worth in their lives.
- **Assumptions** are ideas, beliefs, predictions, suspicions, and inferences about various aspects of life, e.g. experience, people, religion, policies, justice, etc.
- **Beliefs** are the convictions, expectations, faith, hopes, and assurances people have about various aspects of life.

Culture and Parenting

Families in the United States have been largely defined based on white, middle-class values, beliefs and assumptions. These messages do not reflect the cultural-diversity found in the society today. The changing demographics in the U.S. reveal that the fastest growing groups are children of color and children of immigrant parents. Culture plays a key role in how children are raised. It influences what values parents teach their children, what behaviors are appropriate, and how those values and behaviors are transmitted.

While individuals often reflect aspects of their culture, people are not static. Culture changes across time and among individuals based on geography, social networks, new information or other factors. People also change. For example, a person who was raised with corporal punishment may decide to discipline their own children using different methods. Therefore, it is important to distinguish between what may be a historic or broad cultural practice to what that individual parent personally believes or practices.

It has been expressed that "if you don't recognize or embrace the social construct of race, you can't help me." A child welfare professional must be informed about what shaped our clients' responses and how society responded to them. If professionals only judge families from their own experiences, they will find it difficult to find strengths in other families.[8]

[8] Lubell, K.M., Lofton, T., Singer, H.H., "Promoting Healthy Parenting Practices Across Cultural Groups: A CDC Research Brief." Atlanta (GA): Center for Disease Control and Prevention. National Center for Injury Prevention and Control, 2008.

Ethnographic Interviewing

Ethnographic interviewing is a model for interviewing families whose cultural influences differ from your own. It involves demonstrating culturally sensitive behaviors, being willing to focus on the client's cultural perspective and demonstrating non-judgmental attitudes during the interviewing process. In an **ethnographic interview**, we learn to guide the discussion using language patterns supplied by the family members. While the child welfare professional controls the structure of the interview (e.g. the agenda, the amount of time allotted for the interview, etc.), the person(s) being interviewed controls the cultural content. The professional becomes a learner, the client a teacher or *cultural guide*, in an open-ended, structured interview format.

A very critical aspect of culture is language. It provides a "window" to the reality defined and experienced by others. Language is the most important vehicle for a child welfare professional in understanding the strengths, needs and desires of the families served.

The intent of ethnographic interviewing is to help you:

1. Equalize the differences between yourself and a family/individual that has a different cultural background.
2. Begin the relationship with a willingness to focus on the family/individual's cultural perspective.
3. Accept the family/individual by viewing them as experts on their own problems.
4. Demonstrate non-judgmental attitudes.
5. Demonstrate to the family/individual and acknowledge a willingness to enter and acknowledge their world.

Culturally Competent Child Welfare Professionals

Cultural competence has been defined as having four levels – attitude, knowledge, skills and reflection.[9]

Attitude describes an openness to interacting with individuals from different cultures in an receptive, curious and unprejudiced manner. Being open can produce uncertainties, fear and anxiety which may lead to defending one's self and offending others. To be culturally competent is to remain open to unknown situations and continue to reflect on the experience.

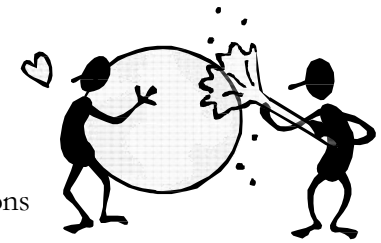
Knowledge about cultural elements that influence one's own and the other's interaction is important for cultural competence. Learning about others' world views, values, norms and ways of life is critical in understanding how cultural elements influence behavior and communication.

[9] Stiftung, B. and Cariplo, F., "Intercultural Competence – The key competence in the 21st century?" 2008.

Skills are the ability to handle situations, to acquire and process knowledge about one's own as well as others' way of life. The core skills are to listen, observe and to interpret.

Reflection is the ability to change perspective and expand one's own frame of reference. This includes being adaptable and flexible in new situations. One does not see one's own way of life as an absolute but reflects upon it. This reflection can lead to expanding one's own world view and developing new communication and cooperation styles.

A culturally competent child welfare professional:



- Respects people who are culturally different from themselves.
- Appreciates and encourages cultural diversity.
- Advocates for social justice and equal opportunity for all families.
- Has an awareness of their own potential cultural biases.
- Approaches relationships with culturally-different persons with openness and a willingness to learn.
- Learns as much as possible about specific cultural groups with whom they work and how their diversity can affect their life experience.
- Understands how cultural differences can affect the helping process.
- Develops a set of skills to form helping relationships and intervene effectively with families who are culturally different from themselves.

Culturally Informed Practice with Families

Cultural memberships can, in many ways, affect how child welfare professionals approach families and what they may see or not see. This may influence the assessment process and the way making decisions affecting the family are made.

A family's cultural membership can directly relate to:

- Strengths and resources available to families.
- How problems are defined and identified.
- How individuals and families perceive their relationship with the agency in general and with child welfare professionals in particular.

How families may feel:

- Threatened by DCFS intervention or by other formal helping systems in their lives, which they find very disruptive.
- Lacking power or control and thus unable to enter a mutual assessment and helping process.
- Embarrassed, hesitant to identify problems and threatened by agency efforts to create changes.
- That their priorities and goals are not those of the child welfare professionals or the agency.
- The professionals' solutions are unrealistic or not achievable.

How workers may feel:

Child welfare professionals' cultural experiences can shape how they view families. When there may be cultural similarities between the professionals and families, these experiences can provide significant understandings; they can cause barriers to understanding (or blind spots) in other situations.

These barriers may be even greater when workers are part of the dominant culture and have little experience with other cultures.

- The work ethic that many professionals have grown up with in the dominant culture, and their more positive experiences in negotiating the larger institutions of society, may lead them to see a family's or individual's problems and needs as primarily caused by deficiencies within individuals.
- Professionals may fail to recognize important support networks that are different from those they use.
- An effective family structure, with many inherent strengths, may be seen as inadequate or dysfunctional and targeted for change.
- Professionals may tend to focus on nuclear families rather than extended families as "primary units."
- Strong hierarchies in which older generations (grandparents, great grandparents) assume a great deal of control may be perceived as infringing on the independence of children's parents.
- Rules that demand respect and obedience of children to their parents may be seen as stifling the necessary expression of children's feelings.
- Rigid gender relationships, culturally acceptable and functional for the family, may be seen as overly restrictive and needing to be restructured.
- Professionals may see physical discipline culturally appropriate in the family's country of origin, as something that "has to stop" without helping the family fully understand why or helping parents learn alternative methods of discipline. Parents can feel disempowered and threatened.

Disproportionality and Disparity in Illinois

Illinois is one of many states looking at the disproportionate number of children of color involved in the child welfare system, especially African American children. In 2007, African American children made up 19% of Illinois' general population but accounted for 59% of the population in the child welfare system. It is important for child welfare staff to understand the differences between these two terms:

Disproportionality refers to the difference in the percentage of children of a certain racial or ethnic group in the country compared to the percentage of children of the same group in the child welfare system. [10]

Disparity refers to the unequal treatment when comparing a racial or ethnic minority to a non-minority. Disparity can be examined in different ways, such as treatment, services, resources and decision points. [11]

Research indicates that African American children are:

1) disproportionately represented in the Illinois child welfare system
2) more likely to be removed from their families
3) remain in substitute care for longer periods
4) more likely to "age out" of substitute care than children from other racial or ethnic groups.

Research studies have been conducted to determine what contributes to disproportionate number of children of color, particularly African American children, in the child welfare system. Some of the factors identified include:

- Family's socio-economic status
- Geographic location
- Department policies and procedures
- Personal and professional decision making by child welfare staff and administrators

Permanency Enhancement Initiative

The Illinois Department of Children and Family Services Permanency Enhancement Initiative began as a discussion between the DCFS African American Advisory Council, DCFS Central Regional staff, and the Illinois African American Family Commission. The discussion focused on the impact of current child welfare practices on permanency outcomes and service provision to African American families, and the racial disproportionality and disparity in the child welfare system.

[10] Casey-CSSP Alliance for Racial Equity in the Child Welfare System.
[11] Casey-CSSP Alliance for Racial Equity in the Child Welfare System.

Permanency Enhancement Symposiums were held with the goal of sharing information on the importance of building a partnership with birth and foster parents, community-based organizations, private and public child welfare professionals and court personnel to improve permanency outcomes, safety and stability for children in the care of the state.

As a result, the **Permanency Enhancement Initiative** has led to the creation of Action Teams and Transformation Teams throughout Illinois.

- The **Action Teams** consist of child welfare professionals and community members who educate the community as to how and why children enter the child welfare system. Together they build a safety network to support families and children and develop a community response to address issues.
- The **Transformation Teams** comprise a multi-disciplinary group of stakeholders and include child welfare professionals, lawyers, judges, court personnel, health providers, school personnel, parents, former youth in care and advocates. The Team is charged with examining the role that institutional racism contributes in the overrepresentation of children of color, particularly African American children in the child welfare system. The Team develops strategies to ensure equitable outcomes for all children in the Illinois child welfare system.

DCFS is committed to providing services that promote racial equality and eliminating disparities in how children enter care, receive care and exit from care. Child welfare professionals are critical to building a partnership with parents, community providers and other stakeholders that ensures children are safe, in their homes with their families whenever possible. When we work as a team in partnership based on honest communication, as culturally informed and culturally competent professionals, we can achieve safety, permanency and well-being for children.

The following groups advise the DCFS Director in provision of child welfare services, recruitment, employment, professional development and community relations:

African American Advisory Council
Asian American Advisory Council
Indian Child Welfare Advocacy Program
Latino Advisory Council

Assessment

In child welfare, assessment focuses on the child's safety, well-being, and the need for permanency planning and intervention. Assessment provides the basis for determining if the family's care of the children is at or above an established threshold for safety and developmental opportunity. The Illinois Model of Integrated Assessment is the process for capturing assessment data throughout the life of the case. Consistently formulated assessments are the backbone of effective social work practice. The Child Endangerment Risk Assessment Protocol has been developed to assist in assessing for safety and the Child and Adolescent Needs and Strengths to assess risks. These tools list factors to consider when making decisions about planning and interventions with families.

Assessment Process: Four Stages

Stage 1 Information Gathering

The first stage of assessment, information gathering, is an ongoing, dynamic task that begins at the time of the first call or referral and continues until the case is closed. Because families' circumstances change over time, ongoing assessment is necessary to accurately inform and facilitate service planning and treatment interventions.

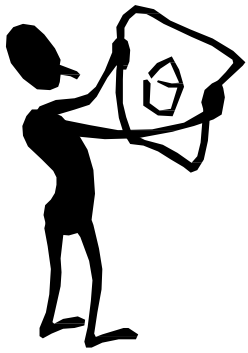
Children and families are the primary sources of information, but formal and informal collateral sources can play extremely useful roles. For instance, child welfare professionals observe the children in the parents' or foster parents' homes and notice interactions between the children and caregivers. Professional reports, such as psychological evaluations, school evaluations, and medical reports, provide additional information and are integrated into the overall assessment.

Factors that influence information gathering include:

- Existing information regarding circumstances and conditions of families and children, including the potential of extended families to provide support.
- Dynamics of similar cases such as, the common dynamics in sexual abuse cases.
- Knowledge of human development.
- Knowledge of human behavior and how individuals change.

Stage 2 Information Analysis

Information gathering and information analysis go hand-in-hand. In the early stages of assessment, analysis is necessary to determine the need for additional information or referral for professional evaluation. As information gathering and analysis proceed, child welfare professionals begin to focus on problem areas and increase the specificity of the information collected. Each family's situation must be fully considered from an ecological perspective that includes individuals, family systems, and its environmental context. Cultural diversity, the characteristics of special populations, and societal factors, such as poverty, oppression, and deprivation, must be considered in relation to their implications for practice.



Information analysis involves:

- Identifying patterns of behavior.
- Grouping information within themes.
- Relating information collected within the child protection mandate.
- Addressing protection issues holistically, while focusing on the specific issues of the children's risk of abuse and neglect.

Stage 3 Drawing Conclusions

While gathering and analyzing information, child welfare professionals are also drawing conclusions based on comparisons of behaviors and circumstances against a standard. The standard is what has been defined as "normalcy" by experts or society. The Minimum Parenting Standards provide an example of such a standard. Child welfare professionals draw conclusions regarding parents' and children's behaviors, strengths and needs, and about the prognosis for change in behaviors and circumstances.

Stage 4 Decision-Making

Decision-making follows the gathering of sufficient information about and from family members, analyzing the information as it is collected, and reaching conclusions about their behaviors and circumstances, strengths and needs. Based on the clients' understanding of their strengths and needs, child welfare professionals can make informed case decisions and recommendations. The information collected and analyzed, the conclusions drawn, and the case decisions or recommendations must be articulated in consistent formats, whether orally or in writing.

Illinois Model of Integrated Assessment

The **Illinois Model of Integrated Assessment** was developed to improve the capacity to address not only critical safety and risk factors, but also the medical, developmental, behavioral and emotional needs of children. This is accomplished by a three phase model, including the initial assessment, front-end assistance during the first 45 days, and a process for ongoing assessment. This model meets the requirements of the Council of Accreditation for a thorough and complete process to capture assessment data throughout the life of a case.

The Illinois Model of Integrated Assessment has the following goals:

- Emphasis on Prevention and Early Intervention
- Coordination of Medical and Behavioral Health Services
- Timely Service Delivery
- Decrease Secondary Impact of Child Welfare System
- Delivery of Social Work Practice by Qualified Professionals
- Timely Movement towards Least Restrictive Services
- Integration of Services with Overall Case Planning

Historically, assessment efforts have been directed towards adults to assess risk of harm to children. The Integrated Assessment process improves the assessment of a child's needs, providing case work staff with clinical information related to a child's functioning, along with identification of client and family members' strengths, support systems, and needed areas for services.

First Phase: Initial Assessment prior to Case Opening

The Initial Assessment is conducted by the Child Protection Specialist. They collect information related to immediate threats to child safety and the ongoing potential of risk.

Second Phase: Integrated Assessment

During the first 45 days after case opening Child Welfare Specialists (intact and placement) conduct assessments of children and family members. If possible, they are assisted by a Clinical Screener, a licensed clinical professional. These assessments provide casework staff the information needed to identify client service needs in a variety of domains early in the case. The Integrated Assessment process provides decision-making criteria, treatment paths, and objective findings to assist staff in ensuring a child's safety, permanence and well-being.

Throughout the process, the Child Welfare Specialist, Supervisor and Clinical Screener will collaborate to synthesize all information gathered and generate one **Integrated Assessment Report**. The Integrated Assessment Report will be presented and discussed with the family. Recommendations from the report will enable the child and family team to make better decisions about safety, risk, placement, service needs, concurrent planning, and planning for permanency.

Third Phase: Ongoing Integrated Assessment

The Child Welfare Specialist, with guided support from their Supervisor, will continue to gather information, analyze the information, and incorporate decisions into family service plans throughout the life of the case.

Minimum Parenting Standards

Child welfare staff must assess whether parents demonstrate minimum parenting standards for children to remain at home and before children can return home. Minimum parenting standards are defined by policy and law as the parenting capacity birth parents must exhibit and maintain in order for their children to be returned to them. Meeting the **minimum parenting standards** simply means that parents or the persons responsible for the children's welfare see that the children are:

Adequately fed.

Clothed appropriately for weather conditions.

Provided with adequate shelter.

Protected from severe physical, mental, and emotional harm.

Provided with necessary medical care and education as required by law.

Minimum Parenting Capacities

- The capacity of a parent to carry out parenting responsibilities. *Examples: feeding, changing, and clothing.*
- Social skills and adaptive capabilities, not IQ, are relevant. *Examples: appropriately interacting with friends, family, and strangers.*
- The capacity to be aware of and respond to the child's physical needs and the ability to provide a safe environment. *Examples: know how to prevent child injuries, recognize when a child is injured, and know how to take a child for care of their injury.*
- The capacity to be aware of and respond appropriately to the child's psychosocial needs, including sensory stimulation. *Examples: expose the child to other children and other environments, interact, talk, and play with the child.*
- The capacity to love and invest emotionally in the child and to invest emotional energy in caretaking. *Example: have feelings for and about the child.*
- The ability to experience the child as a separate person with his or her own needs, not as an extension of the caregiver. *Example: dress and treat the child appropriately for their age.*
- The capacity to realize that the child cannot produce gratification and self-esteem for the parent. *Examples: have relationships outside of the child and reasonable expectations for the child.*
- The ability to recognize when assistance may be needed and to accept help when offered. *Example: have a network of support that is ready to provide assistance when needed.*
- The ability to respond appropriately to emergency situations. *Example: know who to contact and how to access emergency assistance.*

Assessing for Safety and Risk

Definition of Safety

A child is considered to be safe when an assessment of available information supports the belief that a child in a household or in custodial care is not in immediate (near future) danger of moderate to severe harm.

Definition of Safety Concern

A safety concern is about potential harm to the child which could be **immediate or in the very near future** and **moderate to severe** if an **intervention** is not made to **control** the situation.

Definition of Risk

Risk is the likelihood of any degree of longer-term future harm/maltreatment. It does not predict when the future harm might occur, but rather the likelihood of it happening at all.

When are Children Considered Safe?

Children are considered safe when there are no safety threats present or when the family's strengths are capable of controlling any identified safety threat,

When are Children Considered Unsafe?

Children are considered unsafe when identified safety threats cannot be controlled by the family strengths.

Comparing Safety and Risk

Safety concerns can best be understood by comparing them directly with **risk.** Risk refers to the likelihood of any degree of longer-term future harm or maltreatment. It does not predict when the future harm might occur, rather the likelihood of it happening at all. "Safety concern" is used to describe a situation where moderate to severe harm is likely and imminent. It is a subset of the broader concept of risk. Therefore, all factors related to safety concerns also apply to risk, but not all risk factors may apply to safety.

Another distinction between safety and risk can be seen in the intent of the intervention. With a safety concern, the primary purpose is to control the situation and prevent harm from occurring in the short-term. With risk, the purpose is to reduce or resolve the problems that led to the future risk of harm.

The degree of harm is also different for safety and risk concerns. Risk is from low to severe, safety from moderate to severe. Moderate to severe harm is defined as "danger to the children's life or health," "impairment to the child's physical or mental well-being," and "disfigurement."

Assessing for safety and risk concerns is an ongoing process from case opening to case closure. It includes providing a rational basis for making decisions regarding the future of abused and neglected children and their families.

Similarities and Differences of Safety and Risk Concerns

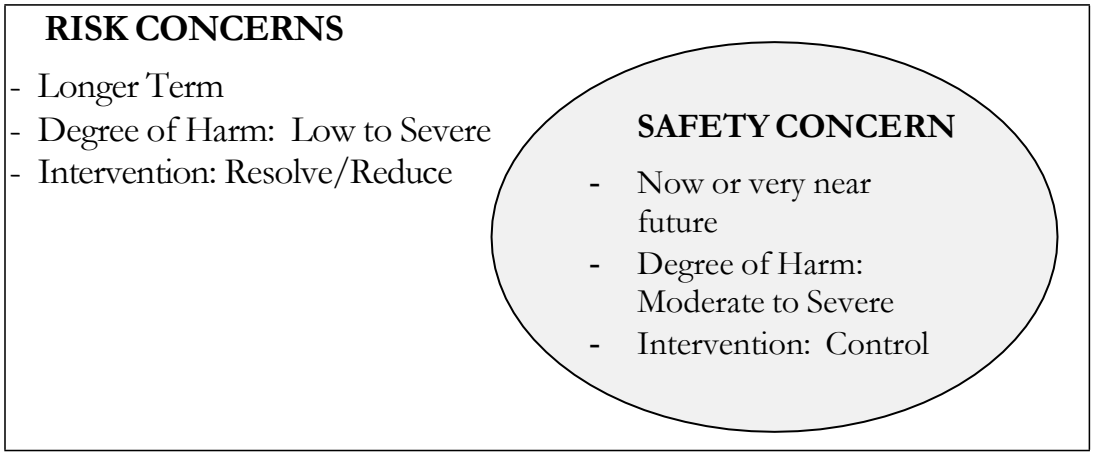
There are many similarities between safety and risk concerns. Both:

- Concern a prediction of harm
- Describe potentially harmful home conditions
- Describe potentially harmful family member/caretaker behavior
- Describe potentially harmful family interactions
- Can change quickly
- Can often be controlled by family strengths or change in circumstances
- Can be addressed with interventions
- May require alternate placement

There are also differences between safety and risk concerns:

- Time
- Degree of Harm
- Purpose of Intervention

Safety is a Subset of Risk



Determining Safety and Risk

	Safety	Risk
Time	Now or very near future	Longer term
Degree of Harm	Moderate to Severe	Low to severe
Purpose of Intervention	Control	Resolve or reduce

Responding to Safety Threats and Risk Concerns

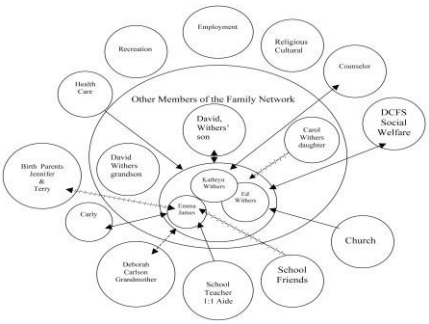
Safety Threats
Make one visit for safety.
Make immediate safety decision.

Risk Concern
Gather information.
Determine recurrence of maltreatment.
Review changes in circumstances.
Design interventions.

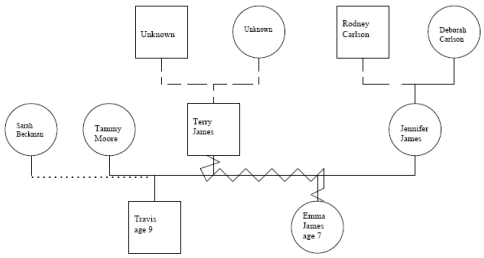
Assessment Tools

Ecomap and Genogram

Two valuable assessment tools are the ecomap and genogram.



An **ecomap** is a pictorial representation of family connections. It is a means to identify significant people and/or systems in the world around the family. It can be used to illustrate the strength, impact and quality of each connection. Ecomaps help you better understand how the demands and/or resources that are affecting the child. It can help look for community resources available to support the child and family.



A **genogram** is a visual, inter-generational presentation of the family, like a family tree. It helps the worker organize the child's family history and identify patterns across generations that may impact the child's functioning and development. Genograms identify patterns of behavior, health conditions, and relationships. Genograms serve as a resource in making placement and other critical decisions by identifying potential kinship or other caregivers.

Home Safety Checklist

Child welfare professionals must take a leadership role in preventing even one child death from household accidents or homicide. Every year hundreds of children in Illinois are seriously injured or killed, often in their own home, from accidents and violent acts.
The Home Safety Checklist was designed to address some of the leading causes of these injuries and deaths. The checklist pays special attention to preventing injury to the most vulnerable of our children those under age five, and any child who is at risk of a violent death.

National child safety organizations and health care professionals agree that educating parents and caregivers about common household dangers significantly reduces the occurrence of unintentional injuries to children. Child welfare professionals are in a unique position to educate families about dangers facing their children and steps they can take to reduce the risk of accidents and violence.

The following are home safety tips for the leading causes of child death in Illinois:

- **Fire and Burns** - The single most important factor in reducing child fire fatalities is the presence of a working smoke detector. In addition, all families should have a fire escape plan.
- **Automobiles -** As of January 1, 2004 Illinois state law requires any child under age 8 to be secured in a car or booster seat; older children must be secured with a seat belt.
- **Sleeping/Suffocation -** To reduce the incidence of Sudden Infant Death Syndrome (SIDS) a baby should always be placed to sleep on his/her back. American Academy of Pediatrics and National Institute of Health brochures about SIDS should be shared with families. Risk factors for SIDS and suffocation include: stomach sleeping position, sleeping on soft surfaces, smoking, overheating, later or no prenatal care, young maternal age, prematurity or low birth weight and male children.
- **Drowning** - Babies and toddlers should not be left alone in or near a bathtub, toilet, bucket of water, or swimming pool. Children should always be supervised near water. Children can drown in as little as 1 inch of water. More than half of the drowning of children under age one occur in bathtubs. Drowning and near drowning typically occur during a brief lapse in supervision. A child will lose consciousness 2 minutes following submersion.
- **Violence** - No firearms/weapons in the home. Caregivers know to never shake a baby. Parents leave their children with responsible caregivers.

Safety Assessment Protocol (CERAP)

The **Child Endangerment Risk Assessment Protocol (CERAP)** is the tool used to assess for safety. The CERAP is a structured approach to decision-making designed to guide, support, and document professional judgment in situations in which children are potentially in danger immediately or in the very near future. It offers sound common sense guidelines for assessing potentially dangerous situations. It also guides the development and implementation of any actions that may be needed to immediately protect a child.

The Child Endangerment Risk Assessment Protocol includes a set of good practice guidelines and the "Safety Determination Form." The child welfare professional uses this form to document their findings, decision-making and actions. It focuses the assessment on a set of **safety threats** and **family strengths**. The decision making is focused on whether a child is "safe" or "unsafe" and, if unsafe, what measures need to be taken.

In child welfare, assessing for safety and risk is an ongoing process. It begins with the first contact with the family and continues until case closure. Throughout the life of the case the steps of **critical thinking** are implemented. The protocol:

- ❖ Requires that we intervene with families when they most need our services (at designated milestones in a case)
- ❖ Increases the safety of our most vulnerable children
- ❖ Increases and enhances the services that we provide
- ❖ Offers an extra measure of protection by requiring specific supervisory involvement in decision-making early in a case at specified milestones.

Criteria for Safety Threats

Child Vulnerability: Each safety threat must be considered from the perspective of the threat it poses for the particular children involved. Some children are more vulnerable than others. Factors that influence a child's vulnerability include, but are not limited to:

- Younger children who lack good verbal skills, in particular, non-verbal children.
- Children affected by developmental disabilities/deficits.
- Children who have serious medical, psychological/emotional, or behavioral problems

Severity of the Behavior/Condition: Severity of a safety threat must be considered within the context of the other safety threat criteria, child vulnerability and the history of safety threats. Severity may refer to the degree or extent of an alleged maltreatment incident e.g., a child with multiple and/or serious injuries or it may refer to the degree to which a caregiver's behavior threatens child safety, e.g., a caregiver whose substance abuse is severe enough to threaten child safety.

History: A safety threat must be considered in the context of any known or alleged previous examples of safety threats. Anecdotal reports about safety threats must be considered, but attempts must be made to verify the information with credible sources. Chronic safety threats must be assessed as posing greater danger to children. Any prior child abuse/neglect history and/or criminal arrest and conviction records, if available, must be evaluated and taken into consideration with respect to child safety.

Completing the Safety Assessment

The Safety Determination form divided into sections. In the first section, the required milestone is identified. There are particular times in a case that a safety assessment must be completed. The milestones differ for child welfare professionals in different child welfare roles.

Milestones for Child Protection Service Workers

CERAP safety assessments must be conducted on the child's home environment, at a minimum, at the following case milestones:

1. Within 24 hours after the investigator first sees the child.
2. Whenever evidence or circumstances suggest that a child's safety may be in jeopardy.
3. Every 5 working days following the determination that a child is unsafe and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe, the investigation is completed or all children assessed as unsafe are removed from the legal custody of their parents/caregiver and legal proceedings are being initiated in Juvenile Court. This assessment should be conducted considering the child's safety status as if there was no safety plan (i.e., would the child be safe **without** the safety plan?).
4. At the conclusion of the formal investigation, unless temporary custody is granted or there is an open intact case or assigned caseworker. The safety of any children in the home, including alleged victim and non-involved children, must be assessed.

Milestones for Intake Evaluation

CERAP safety assessments must be conducted on the child's home environment when the investigative specialist makes contact with the family, at a minimum, at the following case milestones:

1. Within 24 hours of seeing the children, but no later than five working days after assignment of a Prevention Services referral.
2. Before formally closing the Prevention Services referral, if the case is open for more than 30 calendar days.
3. Whenever evidence or circumstances suggest that a child's safety may be in jeopardy.

Milestones for Intact Family Workers

The safety assessment is completed:

1. Within 5 working days after initial case assignment and upon any and all subsequent case transfers. **Note:** if the child abuse/neglect investigation is pending at the time of case assignment, the Child Protection Specialist remains responsible for CERAP safety assessment and safety planning until the investigation is complete. When the investigation is completed and approved, the assigned intact workers have 5 work days to complete a new CERAP.
2. Every 90 days from the case opening date.
3. Whenever evidence or circumstances suggest that a child's safety may be in jeopardy.
4. Every 5 working days following the determination that any child is unsafe and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe, the investigation is completed or all children assessed as unsafe are removed from the legal custody of their parents/caregivers and legal proceedings are being initiated in Juvenile Court. The assessment should be conducted as if there was no safety plan (i.e., would the child be safe **without** the safety plan?).
5. Within 5 calendar days of a supervisory approved case closure.

Milestones for Placement Workers

For cases with a reunification goal, CERAP safety assessments must be conducted considering children's safety as if they are to be returned to the caregivers from whom they were removed. At a minimum, the safety of children placed in substitute care must be assessed at the following case milestones:

1. Within 5 working days after a worker receives a new or transferred case, when there are other children in the home of origin.
2. Every 90 calendar days from the case opening date.
3. When considering the commencement of unsupervised visits in the home of the parent or guardian.
4. Within 24 hours prior to returning a child home.
5. When a new child is added to a family with a child in care.
6. Within 5 working days after a child is returned home and every month thereafter until the family case is closed.
7. Whenever evidence or circumstances suggest that a child's safety may be in jeopardy.

Safety Threats

The following is a list of **safety threats;** behaviors or conditions that may be associated with a child or children being in immediate danger of harm. On the safety determination form a "Yes" or "No" is indicated for each threat. If the threat is present mark a "Yes" for that threat and enter the names of the involved child or children.

If there is no indication that the safety threat is present, mark a "No" for that threat. When there are no safety threats marked "Yes", summarize the available information which indicates that no child is likely to be in immediate danger of moderate to severe harm. The term **"caregiver"** refers to parents, guardians, paramours or any adult in the home responsible for care of the children.

1) A caregiver, paramour or member of the household whose behavior is, or has been, violent and out of control.
2) A caregiver, paramour or member of a household suspected of abuse or neglect that resulted in moderate to severe harm to a child or who has made a plausible threat of such harm to a child.
3) A caregiver, paramour or member of the household who has a documented history of perpetrating child abuse/neglect or any person for whom there is a reasonable cause to believe that he/she previously abused or neglected a child. The severity of that maltreatment, coupled with the caregiver's failure to protect, suggests that child safety may be an urgent and immediate concern.
4) Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern.
5) A caregiver, paramour or member of the household is hiding the child, refuses access, or there is some indication that a caregiver may flee with the child.
6) Child is fearful of his/her home situation because of the people living in or frequenting the home.
7) A caregiver, paramour, or other member of the household describes or acts toward the child in a predominantly negative manner.
8) A caregiver, paramour, or member of the household has dangerously unrealistic expectations for the child.

9) A caregiver, paramour or member of the household expresses credible fear that he/she may cause moderate to severe harm to a child.
10) A caregiver, paramour or member of the household has not, will not, or is unable to provide sufficient supervision to protect a child from potentially moderate to severe harm.
11) A caregiver, paramour or member of the household refuses to or is unable to, meet a child's medical or mental health care needs and such lack of care may result in moderate to severe harm to the child.
12) A caregiver, paramour or member of the household refuses to or is unable to meet the child's need for food, clothing, shelter, and/or appropriate environmental living conditions.
13) A caregiver, paramour or member of the household whose alleged or observed substance abuse may seriously affect his/her ability to supervise, protect or care for the child.
14) A caregiver, paramour or member of the household whose alleged or observed mental/physical illness or developmental disability may seriously impair or affect his/her ability to provide care for a child.
15) The presence of violence, including domestic violence, that affects caregiver's ability to provide care for a child and/or protection of a child from moderate to severe harm.
16) A caregiver, paramour, member of the household or other person responsible for the child's welfare are engaged in or credibly alleged to be engaged in human trafficking poses a safety threat of moderate to severe harm to any child in the home.

Family Strengths or Mitigating Circumstances

Most often when a safety threat has been identified as present, children must be assessed as unsafe. When families are themselves able to control behaviors or conditions that would otherwise render their children unsafe, the safety threat is mitigated.

In order for a family strength or action to constitute mitigation, it must take place **on the initiative of family members** and **not** at the suggestion or instigation of the Department. When the Department suggests or instigates an action in response to an identified safety threat, the action is part of a safety plan.

For each safety threat checked "yes", describe in detail any family strengths or actions that mitigate the identified behavior/condition. If one or more safety threats have been identified and **all** identified safety threats are adequately controlled by family strengths or actions, all involved children must be assessed as safe**.** Identify family members and others responsible for assuring that each mitigating action or circumstance occurs/continues.

Safety threats may be mitigated when:

1.Caregivers acting on their own initiative take reasonable action(s) to correct dangerous behaviors/conditions. For example, a family may move in with relatives while dangerous conditions in the home are corrected.

2. There is an adult caregiver residing in the home who is willing and able to control the identified behavior/condition. This may be a parent, relative, or other adult who is present in the home (who is not the source of the safety threat) *whenever* affected children are there.

In order for a caregiver to be deemed willing and able to control an identified safety factor, he/she must:

- Demonstrate an understanding of the identified safety threat(s) and the need for protection.
- Believe that maltreatment may have occurred, is serious, and that the alleged perpetrator(s) may have been responsible.
- Believably express a willingness and commitment to act to protect all involved children and has not demonstrated an unwillingness or lack of commitment to act to protect all involved children in the past.
- Believably express a willingness to communicate with Department staff about the family's situation with particular regard to identified safety threats.
- Display the physical, intellectual, and emotional capacity to ensure the child(ren)'s protection.

3. The caregiver(s) responsible for the safety threat are removed from the home. In order to be considered mitigation, this action must be done *on the initiative of the family*. The absence of an alleged perpetrator because of outside intervention (i.e., arrest) does not constitute *initiative of the family* unless they actively sought law enforcement intervention. As an example of *initiative*, a mother may obtain an order of protection requiring that a violent father leave the home, a substance abusing parent may enter inpatient substance abuse treatment without the intervention of the Department.

When Safety Threats are Mitigated

When safety threats are mitigated, the assigned worker, in consultation with his or her supervisor, shall ensure the mitigated circumstances remain mitigated through the course of his or her work while assigned to the case. If a safety threat is no longer able to be mitigated, this change in status would require the completion of a new CERAP.

The strengths component of safety decision-making can include consideration of:

- Extended family networks
- Shared parenting practices
- A broad range of people as potential resources
- Tangible resources e.g., car, income, working utilities, housing
- Willingness to accept help
- Religion and values

Safety Decision

The safety decision is indicated by checking the appropriate box, either **safe** or **unsafe.**

SAFE There are no children likely to be in immediate danger of moderate to severe harm at this time. No safety plan shall be done.

UNSAFE A safety plan must be developed and implemented or one or more children must be removed from the home because without the plan they are likely to be in immediate danger of moderate to severe harm.

Safety Plan

If the safety decision is **UNSAFE**, a safety plan must be developed. The safety plan must be related to the safety threats identified on the safety assessment. The plan is developed with the family and their support network. The plan controls and manages the situation until a more complete risk assessment can take place and more permanent change can occur.

Safety plans:

- are voluntary, temporary and short term measures designed to control serious and immediate threats to children's safety.
- must be adequate to ensure the child's safety
- should be as minimally disruptive to the child and family as is reasonably possible.
- will indicate which Safety Threat or Threats have led to the need for a Safety Plan according to the completion of the CERAP.
- are written descriptions of what will be done or what actions will be taken to protect children, who will be responsible for implementing the components of the safety plan and how/who will monitor it and how it will be monitored.
- are developed with the family to control specific threats. The family must understand the mechanism for ending each safety plan.
- may not serve as the solution to a long-term problem.
- may be modified or terminated at any time.

Once developed, the safety plan must be immediately implemented to ensure that all designated tasks are completed effectively. The safety plan should contain timeframes for implementation and continued monitoring.

Non-Custodial Parents

Consideration should be given to a non-custodial parent when developing the safety plan. The worker must consider the legal relationship between the alleged perpetrator and the alleged child victim and other children in the home who will be involved in the safety plan. Persons legally responsible for the child (this includes biological parents) have the right to make decisions with respect to their child, even when this person is the subject of a child abuse or neglect investigation. When developing a safety plan with the family, the worker should include those legally responsible for the child in every aspect of safety planning when possible. If the worker is unable to include an individual who is legally responsible for the child, the worker will make every effort to contact the individual as soon as possible to discuss the safety plan.

Implementing the Safety Plan

When the safety plan is developed, the worker must explain it to the family and must inform the family about the potential consequences if the safety plan is refused or violated. If the family refuses to accept the safety plan or if the safety plan is violated, the worker must reassess the situation. Upon reassessment, the worker shall inform the family of the need to develop a new safety plan, possible protective custody and/or a referral to the State's Attorney's Office for a court order. The worker shall document the family's agreement and commitment in the appropriate case record as described below under Signatures and Distribution of Safety Plan.
The actions taken are focused on ensuring that a child will not be moderately to severely harmed now or in the very near future. Without safety interventions, the unsafe behaviors or conditions would still be present.

Placement is not always needed to control the potential for harm, even in unsafe situations. Often, concrete, immediate services (such as those obtained through Norman referral, crisis counseling or bringing a relative in to care for children) can prevent placement. In other situations, these temporary interventions likely will not work or are not available and the child must be placed. In those cases, reasonable efforts to avoid placement must be documented.

Safety plans are expected to manage threats continuously until a change in the plan can resolve the conditions that create and sustain the safety threats within the family.

Safety plans must address specific threats with interventions only as restrictive as necessary to control the threats. Depending on how safety threats are operating in the family, an in-home safety plan or out-of-home safety plan needs to be created.

Types of Safety Plans

- **In-home Safety Plans -** plans may be implemented with family members remaining together.
- **In-home Safety Plan: Protective Caregiver -** plans may include the introduction of a protective caregiver into the home.
- **In-home Safety Plan: Removal of Alleged Perpetrators -** plans may include the **voluntary** removal of the caregiver responsible for the safety threat.
- **In-home or Out-of-Home Safety Plan: Requirements for Alternate Protective Caregivers -** plans may include stipulations that children be temporarily and voluntarily moved to the home of a protective caregiver, e.g., the home of a relative or friend.

The plan must be adequate in providing safety for the child(ren). The adequacy of a safety plan is usually dependent on one or more of the variables listed below:

- **Responsiveness** – is intervention related to the identified safety concerns?
- **Participation** – is family willing to cooperate?
- **Input** – where appropriate, has family helped construct the safety plan?
- **History** – what is past behavior and/or effectiveness of similar services?
- **Effectiveness** – ability to control the unsafe situation right away?
- **Intrusiveness** – are reasonable efforts commensurate with protection needs?
- **Availability** – is safety intervention an option in your community?

- **Selection** – has most appropriate service provider been chosen?
- **Timeliness** – how quickly can implementation begin?
- **Coordination** - can the case transfer or "handoff" be made appropriately/quickly?
- **Danger** – will safety of service providers be jeopardized?
- **Frequency** – how often is the intervention service needed?
- **Intensity** – what degree of activity is needed?
- **Accessibility** – what is proximity of services and are services easy to use?

Signature and Dates for Safety Plan

When a Safety Plan is in effect, signatures must be obtained from all of those responsible for carrying out the plan. This includes parents, other relatives, or members of the family's support network.

Monitoring and Managing Safety Plans

When safety plans include removal from the home of a caregiver responsible for a safety threat, staff must monitor the safety plan in person every 5 working days in order to maintain sufficient contact to ensure that the caregiver responsible for the safety threat has not returned to the home. Staff may seek assurances that a caregiver responsible for a safety threat has not returned to the home by talking with children or other adults in the home, visiting where the alleged perpetrator currently resides, speaking to school staff, etc.

A new CERAP safety assessment must be completed every five working days following the determination that any child in a family is unsafe and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe, the investigation is completed or all children assessed as unsafe are removed from the legal custody of their parents/caregiver and legal proceedings are being initiated in Juvenile Court. This assessment should be conducted considering the child's safety status as if there were no safety plan, i.e., would the child be safe without the safety plan?

When a worker implements a safety plan and discovers through the course of his or her work that a safety threat has been eliminated, the worker should immediately discuss this with his or her supervisor in order to assess the need to modify or end the safety plan. **Under no circumstance may safety plan monitoring be delegated to family members or any other persons.**

Ending Safety Plans

Safety plans are terminated:

- When the family no longer wishes to participate voluntarily in the safety plan.
- When the safety threats are no longer present and the safety plan is no longer needed.
- At the conclusion of the investigation, regardless of the final finding, unless a service case is opened.
- When the safety plan implemented is not sufficient to control safety threats and an alternate safety plan must be developed.

Child and Adolescent Needs and Strengths (CANS)

One tool for assessing risk is the Child and Adolescent Needs and Strengths (CANS).

CANS:

- Gathers information about the child, not the services they may need.
- Assesses or identifies the need and level of intervention needed for treatment.
- Enables communication about the needs and strengths of our clients with colleagues and programs that have been using it for years.
- Provides us with the information we need to make trauma-informed decisions, plan for services, and track progress.
- Provides us with data needed to document the impact of our decisions, the delivery of services, and the progress of our clients toward reaching their goals.

CANS is an item-level tool. Descriptors are provided for each item and a definition is found for each rating. The CANS is meant to be descriptive (i.e., describing behaviors or history that evidence shows is present) and not explanatory (i.e., not inferring etiology or causality based on our clinical judgment if we have no evidence). Adjustment to trauma is the only item with cause and effect; every other item is descriptive. Responses to items lead directly to decisions about interventions.

There is a defined window (timeframe) for most ratings, designed to keep the assessment current and fresh. The timeframe is thirty days for everything except the Trauma Experiences. Trauma Experiences are scored based on lifetime exposure.

The CANS items are grouped into domains. These domains relate to various aspects of a child's life and a parent or caregiver's ability to meet the child's needs. One of the domains relates to trauma experiences and tracks the child's trauma over their lifetime. All other domains relate to current needs and strengths.

Not all items are scored for each child. Some items are specific to a child's age or special needs. The items related to parents or caregivers are answered depending on the permanency goal.

Note: The CANS was originally created based on the Total Clinical Outcomes Management (TCOM) philosophy articulated by Dr. John Lyons. Dr. Lyons is one of the primary authors of the CANS that Illinois uses and led the focus groups that included families, representatives of the provider community, caseworkers, and staff from all over the State. CANS training, testing and certification are required before using the CANS.

SACWIS Risk Assessment

The SACWIS Risk Assessment used by the Child Protection Specialist includes selected CANS items. It is a family-based assessment so factors are rated once for the entire family. Individual members are not selected and assessed. It is a ***global*** assessment so that the highest score for one factor as it pertains to a specific child/adult in the home is applied to the entire family. All subjects of the investigation and all case members are included as participants in the CANS Risk Assessment.

Screenings

In addition to the assessment tools above, there are screenings for substance abuse and domestic violence. There are also developmental screenings for children such as those related to early childhood development.

Integrated Assessment Report

The information gathered from the first contact with the family through the first few weeks after case opening is included in the Integrated Assessment Report. The report is the result of the interviews with children, parents, and caregivers; review of the assessment tools and case documentation. Based on the information gathered and analysis of the information, services are recommended for each family member.

Underlying Conditions

Some specific conditions in families increase the likelihood of child abuse and neglect. These conditions may negatively impact a parent's ability to meet his/her child's needs. The underlying conditions found in many families are:

- **Substance Abuse/Chemical Dependence**
- **Domestic Violence**
- **Parental Mental Illness**
- **Parental Developmental Disabilities**

Substance Abuse/Chemical Dependence

Chemical dependence can be either psychological or physiological, and both often co-exist. **Psychological dependence** is characterized by the compulsive misuse of a substance, using it longer than planned, intense craving, unsuccessful efforts to cut down and preoccupation with obtaining it, often at the expense of psychological, occupational, social, medical or financial considerations. **Physiological** dependence is the repeated use of a drug to avert physical withdrawal reaction or the need to take larger amounts to get the same effects (tolerance).

Chemical dependence is influenced by an interrelationship of three factors:

Host: Genetic factors may predispose individuals to chemical dependence. Personality, temperament, and physical or mental health problems can predispose individuals to be more susceptible to chemically dependence.

Environment: Susceptibility to chemical use, abuse, and dependence is influenced by factors in the environment such as poverty, social isolation, peers, life stresses, racism, unemployment, inadequate health care, poor housing, etc.

Agent: Chemical dependence is heavily related to the addictive properties of the substance and the changes it produces in the user's central nervous system. For example, crack is dangerous because it is so addictive, and the high is so quick and powerful. The affordability and availability of the drug influences how potentially addictive it is. Crack entices people into dependence because it is so affordable.

Progression of Chemical Dependence

There are four main stages in an individual's progression to chemical dependence. The characteristics in the stages listed below are not comprehensive and do not describe every situation of chemical dependence. Characteristics do not always neatly confine themselves to these stages. The rate of progression depends on the individual involved and on each particular situation.

Stage	Characteristics
WARNING	Increase in tolerance of drug Sneaking of drug Blackouts Avoidance of reference to personal use of drug Guilt Preoccupation with using drug
CRUCIAL	Aggressive and grandiose behaviors Persistent remorse Repeated failures to control drug use Repeated failures to uphold promises and resolutions Short periods of abstention Protection of drug supply Disapproval from others, Avoidance of family and friends Self-pity Work and money problems, Violent acts Loss of interest in matters other than the drug
CHRONIC	Decrease in tolerance of drug Long periods of intoxication Physical, mental, and moral deterioration Vague spiritual desires Exhaustion of excuses
RECOVERY	Admission of defeat Seeking treatment Investment in treatment and rebuilding family

From Michael J. Budlong and John T. Edwards. Child welfare and Substance Abuse Intervention. A training program for the Georgia Division of Family and Children Services. (Atlanta, Georgia: Child welfare Institute, revised 1993). From original material by John Sigmon, Charlotte Council on Alcoholism and Chemical Dependency. Drug and Alcohol Treatment Guide

Drug and Alcohol Treatment Guide

Substance abuse treatment is offered in varying degrees of intensity based on the level of care at which the client is placed and the subsequent treatment plan developed for that client. Research has shown that program compliance and length of stay are the keys to success in treatment. Clients who complete the treatment program and fully participate in aftercare are most likely to abstain from the use of substances.

DCFS partners with the Department of Alcohol and Substance Abuse (DASA) to ensure that DCFS clients receive priority for treatment. Standard referral forms and protocols must be followed.

Clients progress through different treatment settings as they show behavioral and psychological changes. The level of care provided is in accordance with the patient placement criteria of the American Society of Addiction Medicine (ASAM).

Alcohol and drug treatment services typically include:

Assessment/Diagnosis: evaluation of the severity of an individual's disease. Includes consultation with family members and typically lasts 1-2 hours. Encompasses substance abuse history, medical history, family dynamics, employment history. Leads to proper referral and treatment.

Substance Abuse Education: classes to reduce resistance and denial, combat myths, present lifestyle options and provide accurate and current information.

Life Skills Group: group sessions to support the client's recovery from addiction and enhances daily living skills. Clients typically require intervention in all areas of life – housing, finances, parenting, employment, stress management, nutrition, decision-making and communication skills.

Detoxification: medical management while the client withdraws from substances.
Medication: examples include methadone maintenance or Antabuse.

Inpatient Treatment: variable lengths of residential stay based on clinical evaluations. Includes 24 hour services for clients in need of a more intensive setting.

Outpatient Treatment: variable lengths of stay based on clinical evaluations. The least restrictive environment for the delivery of treatment services when the client does not require residential treatment.

Individual Counseling: client meets with a therapist to review the treatment plan and discuss issues the client is not comfortable disclosing in a group setting.

12 Step Groups: a key component of permanent recovery, consisting of a fellowship of men and women who share their experiences, strengths and hopes. The only requirement for membership is a desire to stop using.

Family Therapy: client and family meet with therapist to discuss effects of client's substance abuse. A family receiving therapy is better able to support clients after treatment.

Aftercare: on-going attendance at 12-Step meetings to maintain support and encouragement. This helps the client adjust to a new way of life within the culture of the larger community. (from SAF Policy Guide Training)

Recovery Matrix

For parents who have been identified as needing Alcohol and Other Drug (AODA) intervention, the worker's responsibilities do not end at referral—they begin there. Child Welfare Specialists complete and review the **Recovery Matrix** with all parents who have been identified as having an AODA issue that may, or does negatively impact their parenting. The Recovery Matrix lists progress in substance abuse treatment and in parent responsibilities. Workers must use the parent's self-report, monthly AODA treatment provider reports, urine toxicology testing reports, reports from other service providers, and information obtained from family members when completing the matrix worksheets.

Domestic Violence

Domestic violence is a pattern of coercive control involving intimidation and domination that an abuser utilizes over their victims. Studies in the field of child welfare increasingly point to the prevalence of domestic violence in families where there is suspected child abuse or neglect. Major aspects of domestic violence are power and control and a specific cycle of violence.

Power and Control Tactics

Isolation: Abuser controlling what victim does, whom she/he talks to, where she/he goes.

Intimidation: Abuser makes victim fearful by using looks, actions, gestures, loud voice; smashing things; destroying the victim's property.

Emotional Abuse: Abuser puts victim down or makes her/him feel bad about themselves by calling them names; making them think their crazy; playing mind games.

Economic Abuse: Abuser tries to keep victim from getting or keeping a job; makes her ask for money, gives her an allowance.

Using Male Privilege: Abuser treats victim like a servant; makes all the "big" decisions; acts like the "master of the home."

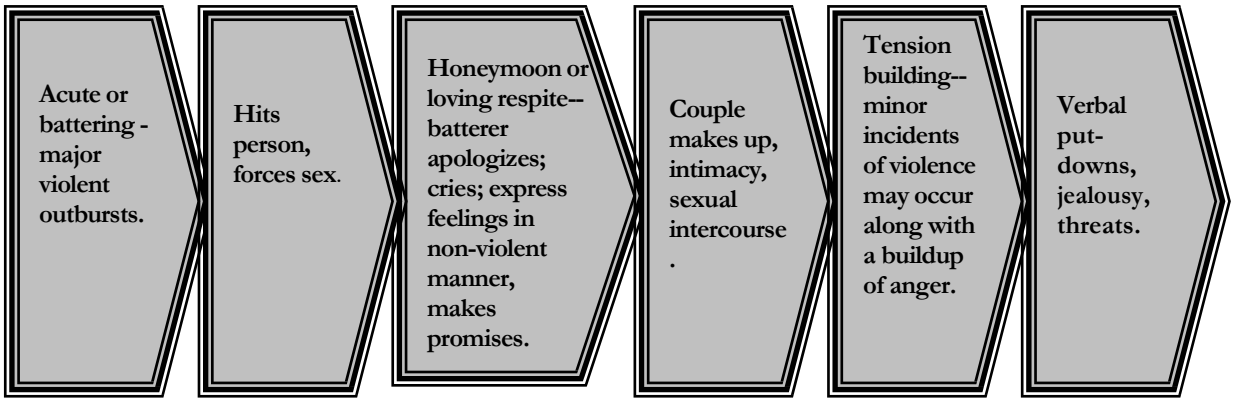
Threats: Abuser makes and/or carries out threats to do something to hurt a person emotionally or physically; threatens to take the children, commit suicide, or report them to welfare.

Sexual Abuse: Abuser makes victim do sexual things against their will; physically attacks the sexual parts of their body; treats them like a sex object.

Using the Children: Abuser makes victims feel guilty about the children; uses the children as messengers; uses visitation as a way to harass family members

Adapted from "Module IC: Special Consideration - Abuse of Women," Common Core Curriculum for the State of Illinois (Chicago, Illinois: Department of Children and Family Services, 1994).

Cycle of Violence



Characteristics of Men Who Batter

- Believes in the right to control his possessions and uses a variety of controlling behaviors.
- Self-centered; feels it is his right to have his needs met at any cost.
- May manipulate his children to control the wife or partner.
- Blames the victim for causing the violence.
- Minimizes and denies the seriousness of his abusive behavior.
- Displays different public vs. private behavior.
- May abuse substances at a high rate.

Adapted from "Module IC: Special Consideration - Abuse of Women," Common Core Curriculum for the State of Illinois (Chicago, Illinois: Department of Children and Family Services, 1994).

Practice Principles Regarding Domestic Violence

- ❖ No battered women should ever be encouraged to stay in situations that are abusive or dangerous.
- ❖ Family units to be considered for preservation or reunification may need to include only the children and the non-abusing parent.
- ❖ Inquiries about domestic violence should be made of all female clients, and never when their partners are present.
- ❖ If victims disclose domestic violence, child welfare professionals must keep that disclosure confidential from the perpetrators, unless requested otherwise, and then only after the possible consequences of such disclosures have been discussed with the victims.
- ❖ The autonomy of the women to decide their own lives and courses of action must be respected. They also have a right to know how the decisions they make may or may not affect the placement of their children.
- ❖ If the perpetrators reveal the presence of domestic violence, the child welfare professional should confidentially discuss this with the victims and initiate safety planning. The professionals should never agree with the perpetrators to keep such disclosures confidential.
- ❖ Perpetrators of violence are accountable: victims must never be blamed for abuse they have experienced.
- ❖ Safety plans should be developed for adult and child victims. The most effective way to protect the children is usually through assuring protection to the women.
- ❖ Child welfare professionals should not recommend interventions that explore domestic violence issues with both abusers and victims present, such as joint interviews, couples counseling, or mediation.

Impact of Domestic Violence on Children

When a parent is abused, the children see it, hear it, and sense it. It becomes a part of their lives and their fears. To keep the children safe, an abusive parent may have to leave the home and children may feel responsible for the family breakup. There are other consequences of domestic violence for children.

- Girls from homes with domestic violence are 6.5 times more likely to be sexually assaulted and more likely to become pregnant as a teen.
- Boys from domestic violence homes are 4 times more likely to abuse in a dating relationship and 1000 times more likely to commit violent acts against an adult partner or their own children.

Child welfare professionals must focus on whether the minimum parenting standards, minimum parenting capacities and the safety and well-being needs of children are being met. Safety planning may be difficult for domestic violence cases. The plans need to be carefully developed with input from supervisors.

Mental Illness

Ample evidence indicates that serious mental illness can profoundly affect an individual's ability to parent. The mental health professional has the responsibility of diagnosing and treating persons with mental illness. Currently, there is no single accepted protocol for assessing parent competency in individuals with mental illness. Traditional evaluative procedures vary significantly in their soundness and application in child welfare.

Child welfare professionals assess the birth parents' behaviors and functions based on the parent's ability to meet the minimum parenting standards. The professionals must then evaluate whether the birth parent's mental illness is affecting the parent's ability to provide care at or above the minimum parenting standards.

It is important that the child welfare professional understand that not all mental illnesses lead to an inability to parent adequately. The professional also must consider that the onset of a mental illness may require the hospitalization of a birth parent or other caregiver, and alternative placements needed for the children.

Definition of Mental Illness

- A significant behavioral or psychological syndrome (that is, a group of signs and symptoms) or pattern that occurs in an individual and is
- Associated with present distress (e.g. a painful syndrome) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

When we say "impairment in one or more important areas of functioning" these areas include:

Social functioning: how the person relates to others

Psychological functioning: emotional stability and well-being

Occupational functioning: purposeful, goal-directed work

Adapted from: DSM-IV-TR, Diagnostic and Statistical Manual of Mental Disorders. Copyright American Psychiatric Association, Washington, 2000.

The National Institute of Mental Health has published the following information about parenting and mental illness:

- Children whose parents have mental illness are themselves at increased risk for mental health problems.
- Maternal depression and schizophrenia are associated with other risk factors (such as psychosocial stress, poverty or marital difficulty).
- Depressed mothers are more negative when interacting with their infants.
- Infants of depressed mothers are likewise more negative when interacting with their mothers and, perhaps, when interacting with other adults.
- Insecure attachment is more common in children of mentally ill parents.
- Conflict between parents and children is more prevalent in families where a parent is mentally ill.
- Young children of depressed mothers tend to be more impulsive and to have more difficult peer interactions.
- Depressed mothers view their children's behavior more negatively than do well mothers. This may result from depressed mothers having children who in fact demonstrate more difficult behavior.

It is important to have a definition of normal behavior before determining what abnormal behavior is. Individuals might be considered normal when their moods, behavior, and thinking fall within a range of acceptable standards for the culture and/or larger society in which they live.

Behavior Assessment

In assessing whether behavior is normal or not, child welfare professionals should:

- Observe behavior carefully and objectively, noting patterns in behavior.
- Understand the behavior in context of the individual's setting and culture.
- Be able to identify pertinent developmental and cultural norms and compare them with the individual's observed behaviors.
- Compare the behavior with an established, professionally-recognized definition of mental health.

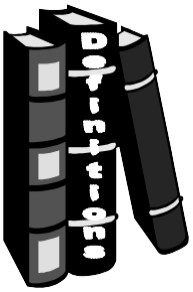
Some observed behaviors may be misinterpreted, depending on circumstances and cultures. For example, it might be normal to be depressed, given a particular situation or event. Distinguishing what is known as "psychopathology," or a mental illness, from normalcy can be difficult. Whether a person is behaving in a normal or abnormal manner depends upon many variables. The Diagnostic and Statistical

Manual (DSM-IV), used by mental health professionals to diagnose mental illness, has extensive lists of criteria for every kind of mental disorder recognized by the American Psychiatric Association. According to the DSM-IV, mental disorders must produce clinically significant impairment or distress in one's personal, social, or occupational life. Biological factors changes may or may not be involved.

Though a parent with a mental illness may have challenges with parenting, children are not always negatively impacted by a parent's mental illness.

Mental Disorders

Personality disorders are longstanding conditions beginning in adolescence or early adulthood that typically cause functional impairment or distress.



Schizophrenia literally means "emotionally cut-off," a disorder of the brain that interferes with an individual's ability to think clearly, know what is real, manage emotions, make decisions and relate to others. One of the more severe forms is known as paranoia. An individual who is a paranoid schizophrenic may hallucinate and have delusional thinking. Schizophrenia is a highly treatable disease. Left untreated, it can devastate the lives of individuals and families.

Psychosis exists when reality is grossly impaired. Persons who are psychotic may not know who they are, where they are, what year it is etc., and may sometimes hear and see things that are not there. They can grossly misinterpret events. Thus the person's behaviors can be completely unpredictable. Psychosis can involve a wide range of symptoms of varying duration. Precipitants to psychotic episode vary from individual to individual. However, psychosis can be treated. Some indicators of psychosis are:

- Confused thinking: Everyday thoughts become confused. Sentences are unclear and do not make sense. A person may have difficulty following a conversation, or remembering things. Thoughts seem to speed up or slow down.
- Delusions: It is common for a person experiencing a psychotic episode to experience delusions or false beliefs. The person is so convinced of the delusion; that the most logical argument cannot make the person change his or her mind. For example, someone may be convinced from the way cars are parked outside his house that the police are watching him.
- Hallucinations: In psychosis, the person sees, hears, feels, smells, or tastes something that is not actually there. For example, the person may hear voices that no one else can hear, or the person may see things that are not there. Things may taste or smell as if they are spoiled or even poisoned.
- Changed feelings: The person may feel strange and cut off form the world, with everything moving in slow motion. Mood swings are common, and the person may feel unusually excited or depressed. The individual's emotions seem dampened; they feel less than they used to or show less emotion to those around them.
- Changed behavior: Persons experiencing and acute psychotic episode behave differently from the way they usually do. They may be extremely active or lethargic, sitting around all day. They may laugh inappropriately or become angry or upset without apparent cause. Often, changes in behavior are associated with the symptoms already described above. For example, someone may stop eating because they believe that the food is poisoned.

Common Disorders of Parents involved with the Child Welfare System:

Post-traumatic Stress Disorder (PTSD) is an anxiety disorder that can occur after someone experiences a traumatic event that caused intense fear, helplessness, or horror. PTSD can result from a person witnessing or learning of a violent or tragic event (e.g. rape, war, natural disasters, abuse, captivity). While it is common to experience a brief state of anxiety or depression, a person with PTSD continually re-experiences the traumatic event; avoid individuals, thoughts or situations associated with the event; and has symptoms of excessive emotions. PTSD can often be effectively treated with psychotherapy, medication or both.

Dual Diagnosis of Mental Illness and Substance Abuse is when a person struggles with both mental illness and substance abuse. Substance abuse complicates almost every aspect of care for the person with mental illness. Treatment programs designed for people whose problems are primarily substance abuse are generally not recommended for people who have a mental illness. These programs tend to be confrontive and coercive and most people with severe mental illness are too fragile to benefit from them. Desirable programs take a gradual approach. Abstinence may be a goal of the program but should not be a precondition for entering treatment.

Depression is a debilitating sense of hopelessness and sadness. A depressive disorder is a "whole-body" illness, involving one's body, mood, and thoughts. There are several different forms of depression: major depression, dysthymia and bipolar disorder.

- **Major Depression** is a combination of symptoms that interfere with the ability to work, sleep, eat, and, in general, enjoy life. Episodes can occur once, twice, or several times in a lifetime.
- **Dysthymia** is a less severe form of depression but it is long-term and chronic.
- **Bipolar Disorder** is not as prevalent as other forms of depression. It involves cycles of depression and mania. Persons with bipolar disorders have extreme mood shifts. Sometimes the mood switches are dramatic and rapid, but most often, they are gradual. When in the depressed cycle, the person may have some or all of the symptoms of a depressive disorder; when in the manic cycle, some or all of the mania symptoms. Mania often affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment. Bipolar disorder is often a chronic, recurring condition.

Borderline Personality Disorder is characterized by impulsivity and instability in mood, self-image, and personal relationships. It is diagnosed more often in females than males. The causes of BPD are unclear, although psychological and biological factors may be involved. Originally thought to "border on" schizophrenia, BPD now appears to be more related to serious depressive illness. In some cases, neurological or attention-deficit disorders play a role. Biological problems may cause mood instability and lack of impulse control, which in turn may contribute to troubled relationships. Difficulties in psychological development during childhood, perhaps associated with neglect, abuse or inconsistent parenting, may create identity and personality problems. A combination of psychotherapy and medication appears to provide the best results for treatment. Medications can be useful in reducing anxiety, depression and

disruptive impulses. Medications do not correct ingrained character difficulties. Long-term outpatient psychotherapy and group therapy can be helpful. Short-term hospitalization may be necessary during times of extreme stress, impulsive behavior and substance abuse.

Developmental Disabilities

Parents with developmental disabilities may or may not have the necessary capacity to parent their children. Each parent must be assessed individually. In some cases children may be able to remain in their parent's care, especially if there is assistance available. In some cases the children will require out of home placement. People with developmental disabilities are **physically** and **emotionally** challenged – they are significantly limited in two or more of the following ten skill areas:

Communication	Self-Care	Home Living
Social Skills	Community Use	Self-Direction
Health and Safety	Functional Academics	Leisure
Work		

Criteria to Receive Services for Developmental Disability

In most states, a person shall be determined to have a developmental disability and be found **eligible to receive services if the disabling condition meets all of the following criteria:**

- Is manifested before an individual attains age 22;
- Continues, or can be expected to continue, indefinitely;
- Constitutes a substantial handicap for such an individual;
- Is attributable to mental retardation or to related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation;
- Or, if under age five, the person is determined to be at risk of such, and require treatment or services similar to those required by children with mental retardation

What constitutes a "substantial handicap"? A "substantial handicap" is one of such severity that, along or in connection with social, legal or economic constraints:

- prohibits the individual from living independently without assistance when appropriate to their age level, and
- requires the provision of a specialized program of developmental services.

This does not include handicapping conditions that are:

- solely physical in nature
- psychiatric disorders without the presence of a developmental disability
- specific learning disabilities, in areas such as reading or mathematics

Reproduced without alteration. "Working with Families with Children/Parents with Developmental Disabilities". Developed by Virginia Cruz, D.S.W., The Social Work Program, Metropolitan State College of Denver, P.O. Box 173362, Campus Box 70, Denver, Colorado 80217.

Culture and the Assessment Process

Generally, cultural considerations have less impact on assessment of safety than on the assessment of risk. Unsafe situations are generally unsafe regardless of the culture. Culture guides people's interpretation of life experience and development of coping strategies for day-to-day living. Culture affects our work at various points in the assessment process:

- Misinterpreting verbal threats, parenting responsibilities of children, living arrangements, physical marking and healing practices.
- Decision-making
- Development of the safety plan. Lack of knowledge may affect our decision-making.

Strategies for Cultural Competence

Engage families - Engage family members in planning how the child can best be protected.

Use the relevant broader social network of the family - Some cultures rely heavily on an extended family, clan or other broader social network to make decisions. Safety protection plans often involve temporary placement with the family or family members.

Use culturally relevant services - Churches, community centers, and other service organizations often offer a range of useful services such as food banks, crisis counseling, respite care, and others.

Clinical Intervention for Placement Preservation (CIPP)

Assessment is sometimes required when determining the best placement for a child or youth. The Clinical Intervention for Placement Preservation (CIPP) is a facilitator-guided, team decision-making process to improve placement preservation and increase placement stability. A CIPP staffing is conducted to determine the array and intensity of services needed for a child or youth whose current placement is threatened with disruption or whose care cannot be provided for in his/her current placement.

In a CIPP staffing, the caseworker brings together key people in the child/youth's life, with the assistance and support of a trained facilitator who leads a discussion sensitive to the individual needs, motivation and capabilities of the child/youth. Participants are encouraged to offer their assessment of the child/youth's wishes, needs and strengths and to generate ideas on how those wishes, needs and strengths can be best addressed, ideally in the child/youth's current placement.

When the services needed cannot be provided in the current placement, staffing participants will determine the setting best suited to meet the child/youth's individual needs. In these situations, matching the child/youth with placement resources that can meet the identified needs will be initiated by members of the Centralized Matching Team during the staffing, whenever possible. Additionally, caregivers will be encouraged to participate in the treatment and to remain a placement and/or visiting resource for the youth when residential, group home care or a transitional living or independent living program is warranted.

Permanency Planning

Providing safety, permanency, and well-being for children are the cornerstone and primary outcomes of child welfare services. Service plans identify the permanency goal and lay the foundation for providing services. Service plans direct the delivery of services to children and their families by establishing written plans with the actions needed to achieve the goal.

Permanency Planning

Permanency planning begins with the first contact with a family and extends through the life of a case: intake, investigation, and case management follow-up and closure. Effective permanency planning requires uniform implementation of social work practice fundamentals and permanency principles.

Social Work Principles that Guide Permanency Planning

Decision-making based on the child's sense of time and a sense of urgency

Permanency decisions integrate the children's sense of time, and their urgent need for stable, caring, permanent families. Children need stability to accomplish the essential developmental tasks that are critical to a long-term sense of self-worth and security. With these concepts in mind, the law designates clear time limits. These time limits and the "crisis" of placement must be maximized as a motivator to engage families in planning for the children, resolving issues that brought the children into care, and rapidly working toward permanence.

As soon as it becomes apparent that permanency goals are neither appropriate nor achievable within firm and reasonable timeframes, an understanding of these concepts provides the rationale to quickly shift permanency plans to meet the children's needs.

Services focused on achieving health, well-being and safety for children

Clinical intervention and social services must focus on the needs, conditions, and behaviors resulting in the maltreatment of the children. The intervention and subsequent services must emerge from the assessment process. Foremost, the parents' behavior that resulted in maltreatment must change to ensure the safety, health, and well-being of the children. Interventions must also focus on eliminating or reducing contributing factors that affect the parents' ability to provide for the children. These include such factors, but are not limited to, a parent's substance abuse, mental illness, developmental disability or involvement in domestic violence. The identified need for change (of conditions, behaviors, or parental abilities) is always tethered to the health, safety, and well-being needs of the children related to maltreatment. When the children's health, safety, and well-being can be assured, reunification should be considered. When these needs cannot be assured, alternate permanency plans must be pursued.

Respect for the children's families and valuing the importance of family connectedness regardless of case outcome

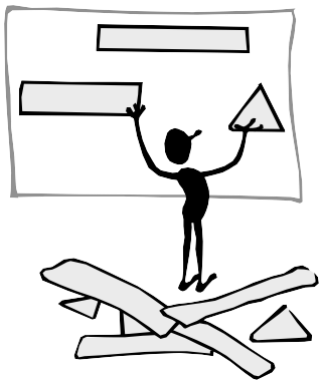
Permanency planning requires child welfare professionals to be diligent in seeking alternatives for permanent placement of the children, when necessary. Child welfare professionals must be able to elicit information about extended family members and assess their potential as permanency providers. Non-custodial parents (legal and putative) must be notified, their interest in the children determined, and their ability to provide for their children assessed so that planning occurs as quickly as possible.

Birth families should be provided opportunities to continue in the role of parent while their children are in substitute care. Parents need opportunities to act in parental roles that enhance relationships while assuring the continued safety and well-being of their children. The range of opportunities may include involvement in health care, medical treatment; school meetings, recreational activities, athletic events; social events; shopping, budgeting for expenditures for clothing or personal items; and participation in parent-child learning programs. As with visitation, supporting the connection between parents and children can reassure the children, provide assessment opportunities, support parent-child relationships, build skills, and provide documentation to support permanency decisions.

It is also critical to maintain as much continuity as possible for the children with their siblings and extended family. Community-based relationships and opportunities are extremely important, especially for older children and adolescents.

Ongoing, thorough, and complete assessment of the children and families

Child welfare professionals must identify the central problems that brought the children to the attention of DCFS. The central problem is frequently distinct from any other problems that may exist within the families. Through the process of assessment, child welfare professionals work with the families to determine what factors must change in order for the children to return or remain home. These factors determine the focus of intervention with the parents.



The risk to the children must be identified and minimized in order for the children to safely remain or return home. As soon as risk is minimized, and safety can be assured, the children should be returned home quickly, with ongoing planning to monitor and support continued safety and well-being. If the risk cannot be minimized and safety cannot be assured within a reasonable time (nine months mandated by Illinois law), alternative permanency plans must be considered.

Shared decision-making

Shared decision-making requires intensive involvement of family teams comprised of the parents, children, foster parents or other caregivers, child welfare professionals, extended family members and others involved with the families. In shared decision-making, each team member supports and works toward the permanency plan for the child. Incarcerated parents are provided the opportunity to consider permanency options for their children.

Full disclosure

When children are removed from the home, both the parents and children receive a copy of the Parent and Child Handbook, which the child welfare professionals sit down and review with them. Parents' right to appeal services or when decisions are made or changed are explained to them. The parents, foster parents, or caregivers and the court must have clear, candid information about case prognosis and progress.

Permanency planning interventions require sensitive, empathic and direct communication with parents. Through such communication, parents begin to understand that it is their behavior, rather than their stated intentions, that determines the direction of the case and makes the difference for their children. The children's need for stability and permanency is emphasized as of primary importance.

Parents must be kept informed of the agencies' activities and the reasons for them. Frank discussion must also be initiated regarding the effects of parental inaction, lack of progress, or disappearance. Parents should know that agencies will proceed with alternative plans if they are not available or cooperative Full disclosure is also critical with other parties involved, including the children, court, foster parents, attorneys, and relatives.

Frequent reviews

Full disclosure will assist families in understanding what is necessary to reunite with their children. A key to this understanding is frequent review of progress, frequent decision points, and action. Formal, frequent review is essential to promoting open communication and evaluating progress. The formal review process provides an opportunity for the children and family team to: evaluate progress; identify the breadth and depth of the changes needed; determine the continued appropriateness of the plan, relevancy of the intervention and services, and frequency and duration of child-parent contact.

Thorough assessment and matching

Timely permanency can be facilitated by matching the best possible placement to the children's needs and the most effective and efficient services to the families' assessed problems in accordance with the Interethnic Placement Act (IEPA). Using a strengths-based approach and recognizing and applying the families' strengths, talents, and uniqueness to accomplishing service goals significantly contributes to achieving permanency.

Intensive involvement of caseworkers as change agents working closely with the children, the families, and child-family team

For timely and effective permanency planning to occur, and the children's health, safety, and well-being to be assured, child welfare professionals must work intensively and closely with the children and families. Child welfare professionals and supervisors make decisions with the families and teams for case and permanency planning.

Based on information received through the assessment process, observation of family visits, frequent involvement with the children and families, and direct supervisory conferences, child welfare professionals and supervisors make decisions related to case and permanency planning.

Behavior: Actions Speak Louder Than Words

The parents' behavior is the ultimate determinant of permanency outcomes. Parents must be fully informed and explicitly empowered to make choices about their own actions and abilities.

To facilitate the necessary behavioral change on the part of the parents, child welfare professionals provide timely, effective, and culturally sensitive services within mandated time limits. If parents visit the children frequently and regularly, take full advantage of rehabilitative services, and make substantial and meaningful progress, their children will be returned home. If they do not, alternative permanency plans, already identified, will be quickly implemented.

Service Planning

The **Service Plan** is the **contract** between the family and the agency. The assessments that identified the safety threats and risk concerns that need to be addressed. Recommendations have been made through the Integrated Assessment process, building on strengths the family can use to reach their goals.

Service plans are required by State (20 ILCS 505/6a) and Federal law (42 USCA 675) regardless of whether children and families are served directly by the Department or through private agencies contracted by the Department. Service plans must ensure that the health and safety of children are the paramount concerns that guide all service, placement, and planning provisions.

When developing the plan with the family, give priority to the needs the family should address first. Some outcomes may have to be deferred until a future service plan.

Timeframes

Initial service plans should be completed within 45 days after case openings and must be reviewed at least once every three months. Most accreditation bodies for child welfare agencies require completing service plans every three to six months. Service plans are reviewed and revised if necessary:

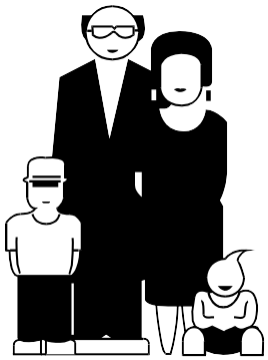
- When current permanency goals are no longer appropriate.
- When current service plans do not address the children's or families' needs.
- Before permanency hearings.
- Before administrative or regular case reviews.
- When there are substantial changes in family's circumstances.

Purposes of an Effective Client Service Plan

- ⌦ Structures the relationship between the child welfare agency and the client, defining required action steps and timeframes.
- ⌦ Documents "reasonable efforts" on the part of the child welfare agency and other service providers in delivering services and providing supports to clients.
- ⌦ Documents "reasonable progress" on the part of the parents/family.
- ⌦ Helps determine future legal direction.
- ⌦ Documents ongoing assessment of the child and family.

- Provides documentation and a basis for decision-making to achieve permanency.
- Helps prevent "foster care drift" in placement cases.

Involving Families



Service plans are based on information gathered during the assessment process and other contacts between child welfare professionals, children, and families. **Service plans are developed in consultation with families and the child welfare professionals' supervisors.** Families participate in identifying their strengths and needs and how the children's needs for health, safety, well-being, and permanency will be met. Generally, children age ten and over are expected to contribute to developing service plans.

Engaging Involuntary Clients

Engagement and permanency planning is often difficult with involuntary clients. Child welfare professionals must find successful ways to deal with the clients' anger, which is often quite intense during the investigation and early stages of intervention and placement. Child welfare professionals can facilitate engagement with involuntary clients by being sensitive and recognizing the:

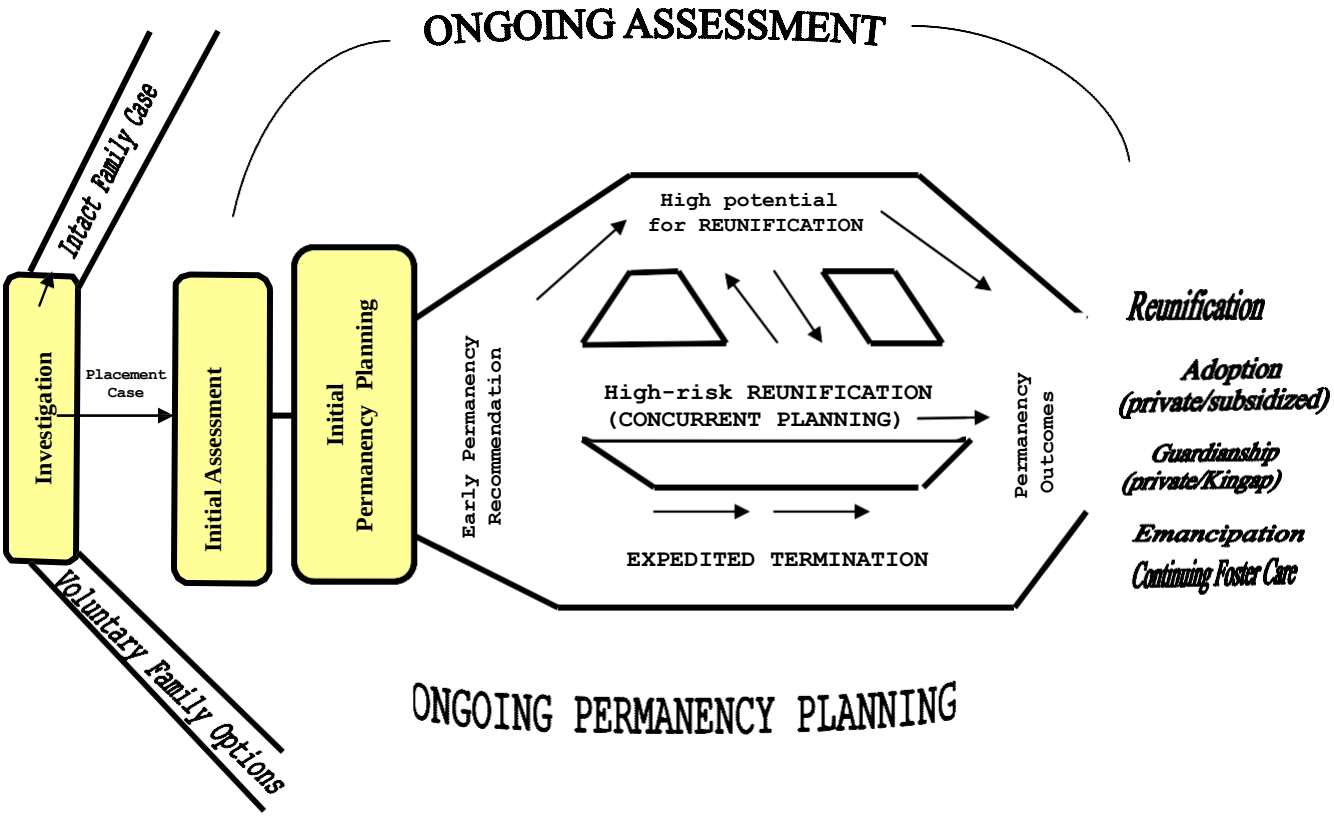
- Impact that agency involvement can have on both children and birth parents by allowing expressions of anger and frustration.
- Impact that the children's out-of-home placements have on the children and birth parents.
- Need for awareness of self, own culture, and feelings in working with families.
- Fact that both families and child welfare professionals are "involuntary participants" in the process.
- Stigma or sense of failure associated with receiving child welfare services.
- Value of providing concrete, tangible assistance, such as transportation and housing.
- Families as the experts on their family issues and supporting their articulation of strengths and needs.
- Need to avoid using jargon, acronyms, and coercive language.
- Cultural context in which families function.

Permanency Goals

Permanency goals are the desired outcomes of intervention and services that are determined to be consistent with the health, safety, well-being, and best interests of the children. The permanency goals guide the development of the service plan.

Permanency Pathways

The Permanency Pathways are the various routes to permanency goals for children in placement. The pathways depict the various junctures along the child welfare continuum where casework practices would be needed to strengthen reunification and concurrent planning practices.



The preferred choice is that permanency be reached through reunification with the family. When that is not possible Adoption and Guardianship are pursued. When these goals are not possible, the goal may be for Independent Living through Emancipation.

Notice the back and forth arrows from "High Potential for Reunification" and "Concurrent Planning". Cases sometimes move in a different direction than the initial permanency plan.

Selecting the Permanency Goal

Within 45 days after the case is opened, initial assessments have been completed and initial family meetings held, agency professionals with approval of their supervisors, establish initial permanency goals. For placement cases, permanency goals may be changed by child welfare professionals, with approval of their supervisors, only within the first twelve months following case openings. After permanency hearings the goal is selected by the court and cannot be changed without the approval of the court.

Intact Family Cases Goal

Remain Intact

This goal is selected for children who remain at home and are served as intact families. These cases sometimes have particular challenges for workers as children remain in homes that have been determined to be "unsafe." In those cases there is a "Safety Plan" which provides for the children in their parents' care as long as they follow this plan.

Permanency Goals for Children in Placement

The goals that may be selected for children in substitute care are:

- Return home within five months
- Return home within twelve months
- Return home pending status hearing
- Substitute care pending court determination on termination of parental rights
- Adoption, provided that parental rights have been terminated or relinquished
- Guardianship
- Independence
- Cannot be provided for in a home environment.
- Continuing foster care

Return Home Within Five Months

Children will be returned home by a specific date within five months from the date of case opening or court permanency hearings where goals are set by the court. This permanency goal is established when:

- On the basis of current assessments and/or history of service delivery, parents are willing and able to correct the conditions that led to their children's removal from the home by a date within five months; and
- The children's best interests will be served by reunification within five months; or
- The goal has been ordered by the court.

Return Home Within One Year

Children will be in short-term substitute care with continued goals to return home within a period not to exceed one year after the date of case openings or court permanency hearings, and the parents' progress is reasonable. Particular consideration is also given to the age and individual needs of the children. This permanency goal is established when:

- Based on current assessments and family history, parents are making substantial progress in correcting the conditions or behaviors that necessitated the child's removal from the home.
- Parents were not initially cooperative with services, but are now progressing well in services.
- Parents are cooperating with services, but the need for services is so great that additional time is required.
- Goal has been ordered by the court.

Return Home Pending Status Hearing

Children will be in short-term substitute care with a continued goal to return home pending status hearings. When the court finds that parents have not made reasonable progress to date, the court identifies what actions the parents, the Department, and/or agencies must take in order to justify findings of reasonable progress and sets dates for a status hearing. This goal may be selected only by the court. It is not available for selection by caseworkers. It is selected when:

- Parents have not substantially fulfilled their obligations under their service plans, nor corrected the conditions or behaviors that brought their children into care.
- Nine months have not yet elapsed since adjudication.

If the court finds that the parents have failed to make reasonable efforts or progress, the court may select the goal "substitute care pending court decision regarding termination of parental rights." This determination is based on the parents' failure to make reasonable efforts to correct the conditions that were the basis for removal of the children or to make reasonable progress toward the return of the children to the parents within nine months of an adjudication of neglected, abused or dependent minor." [750 ILCS 50/1D(m)]

When the court selects this goal and the case is approaching nine months since adjudication, or more than nine months have passed since adjudication, caseworkers may request a legal screening to determine whether the parents have failed to fulfill their obligations under the service plan and failed to correct the conditions or behaviors that brought the children into care.

Substitute Care Pending Court Determination on Termination of Parental Rights

This permanency goal may be selected when decisions have been made to pursue Termination of Parental Rights (TPR). The child will continue in substitute care pending the court's determination on TPR. This goal **must** be established when:

- A request for termination of parental rights has been filed with the court.
- The court has set the goal.
- Cases successfully pass legal screenings conducted by the Department to determine whether sufficient grounds for termination of parental rights exist and whether it is in the best interest of the child to empower the guardians to consent to adoption.

This goal **may** be selected when TPR is in the children's best interests because of safety concerns, even if the children may not be adopted. If the court grants termination of parental rights, this goal is changed to the appropriate goal, as directed by the court, and further services directed toward family reunification are not offered.

Adoption

This goal is selected as an adoptive home is sought for the children. The parental rights of both parents must be terminated or relinquished through adoptive surrenders or consents, including consents to adoption by specified persons. The court terminates parental rights with the appointment of the Department as guardian with the power to consent to the children's adoption. Adoption needs to be determined to be in the best interest of the children. Children, age fourteen years or over, are to consent to adoption.

Guardianship

Guardianship of the children is permanently transferred to individuals or couples. This permanency goal may be selected when:

- Reunification and adoption goals have been ruled out as permanency goals, but the children reside with relatives or foster home caregivers with whom they have formed emotional attachments. These caregivers are willing to accept legal responsibility for the children and assume commitments to permanent relationships that meet the children's needs.
- The court has ordered the goal.

Independence

Independence may be selected as the permanency goal for minors age fifteen years or older provided that:

- Goals of return home, adoption, and guardianship have been ruled out.
- Either assessments have been made; or the children have demonstrated the ability, capability, and willingness to care for themselves, have become economically self-sufficient, and/or are establishing families of their own.
- Assessments have been made that children who have physical or mental disabilities demonstrate the ability, capability, and willingness to care for themselves with proper support.
- Children demonstrate the ability to achieve and maintain progress towards independence through continued cooperation with their service plan.
- The court has ordered the goal.

Cannot Be Provided for in a Home Environment

Children will be in substitute care because they cannot be cared for in a home environment due to extreme or complicated physical or mental disabilities that cannot be sufficiently controlled in a home environment. This permanency goal may be selected, provided that the goals of return home, adoption, and guardianship have been ruled out, for those children:

- who have extreme or complicated physical or mental disabilities as diagnosed by physicians and/or psychiatrists, when no responsible adults who are able and willing to care for the children have been identified. A few children, due to their disabilities, need continued care in intermediate or skilled nursing facilities, or in child care institutions, provided that goals for return home, adoption, guardianship, and independence have been ruled out.
- for whom the goal is ordered by the court.

Children with extreme or complicated physical or mental disabilities who require long-term care should not be confused with children who are in group homes or institutions to receive intensive, short-term treatment directed toward correcting problems that significantly interfere with life outside the institution. Substitute care for children who cannot be provided for in a home environment is not an appropriate permanency goal for these children.

Continuing Foster Care

This goal may be selected if all other permanency goals have been ruled out. Guardianship of the minor will remain with the Department and the minor will be in continuing foster care. This goal may be selected when:

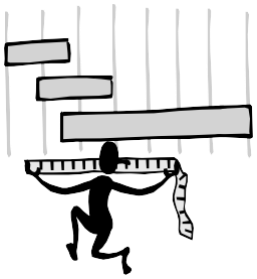
- The Department of Children and Family Services has custody and guardianship of the minor;
- All other permanency goals have been ruled out based on the minor's best interest;
- The court has selected the goal, having found compelling reasons to place the minor in continuing foster care;
- The minor has lived with the relative or foster parent for at least one year; and
- The relative or foster parent currently caring for the child is willing to provide, and capable of providing, the child with a stable and permanent environment for the foreseeable future.

Compelling reasons must be documented, reviewed and considered by the court, and include:

- the minor does not wish to be adopted or to be placed in the guardianship of his or her relative or foster caregiver;
- the minor exhibits an extreme level of need such that the removal of the minor from his or her placement would be detrimental to the child; or
- the minor has existing close and strong bonds with a sibling, and achievement of another permanency goal would substantially interfere with the minor's sibling relationship, taking into consideration the nature and extent of the relationship, and whether ongoing contact is in the minor's best interest, including long-term emotional interest, as compared with the legal and emotional benefit of permanence.

Permanency Initiative

Concurrent Planning



Concurrent planning is a process in which the Department or purchase-of-service agencies will make reasonable efforts to return children home within nine months after the children's placement in substitute care. At the same time, they will make it clear to the children's families that alternative permanency plans are being developed that will take effect if they do not make sufficient progress to enable the return home of their children within nine months.

Poor Prognosis Cases

While social work practice dictates the use of concurrent planning in all cases, additional concurrent planning elements are required for families who are assessed to be at high risk of further abuse, have a poor prognosis for change, or who have not made substantial progress in accomplishing service plan goals for reunification.

Illinois statute and Department policy specifies poor prognosis cases as those in which the family "demonstrates patterns of behavior, of commission or omission, which indicate a poor prospect for safe reunification." Cases that are assessed as having "poor prognosis" (at high risk for long-term placement) require:

- Written, detailed, and specific alternate permanency plans.
- Earlier placement of the children (post-assessment) into permanent homes.

If, upon assessment, there is a determination that families and children are poor prognosis cases, the child welfare professional must consult with their supervisors.

Select and place the children in (potentially) permanent homes by the 90th day of placement.

Early in cases, while providing services to parents, child welfare professionals simultaneously pursue possible kinship options, determine if the Indian Child Welfare Act applies to the children, and/or identify possible adoptive or foster/adopt families as concurrent plans. For these cases, the children are quickly placed in permanency planning foster homes so that, if plans to return home fail, the children will not have to move again into adoptive placements. The children are placed in homes where they can reasonably be expected to remain until adulthood. Every effort will be made to minimize the number of moves children must make while in care. Consistent with the best interest of the children, once thorough assessments are complete, placements should provide for long-term permanency needs.

Develop and document detailed and specific alternate permanency plans, including specific permanent placement options.

Be particularly aware of and make clear to parents the need to meet established timeframes for progress on service plan goals.

Select permanency goal of "Return home within 12 months.

Full disclosure to biological parents is very important with this permanency goal. Child welfare professionals must inform parents that progress toward reunification will be evaluated during client service planning in preparation for the Administrative Case Review. If sufficient progress has not occurred, the child welfare professional will inform the parents and will prepare the case for legal screening.

Families must be fully informed of the consequences of their failure to quickly resolve their problems. With the exception of expedited termination cases, families must receive services, including visitation, until parental rights are terminated.

Concurrent planning is an essential part of quickly moving children from the uncertainty of foster care to the security of permanent families.

Expedited Terminations

Expedited termination involves moving children's cases directly from temporary custody to termination of parental rights and adoption. It is appropriate when "the maltreatment of children is so egregious that efforts should not be made to preserve the family." When this occurs, the child welfare professional should request a legal screening, and the children should be placed with families committed to permanency. Upon approval at permanency staffings, the goal of "substitute care pending court determination of termination of parental rights" should be selected. Contact between the children and parents should focus on therapeutic needs of the children around maltreatment, the transition of relationships to other caregiving families, and closure with the birth families with emphasis on the needs of the children. The parental behaviors that require pursuing expedited termination are specified in Illinois law.

Mandated to Screen for Termination:	May consider Screening for Termination:
• Extreme and repeated cruelty to the children. • Findings of physical abuse and criminal conviction of aggravated battery of the children. • Conviction of parents for murder of the children's other parents. • Conviction of parents for first degree murder. • Conviction of first or second degree murder of any children. • Criminal conviction of aggravated sexual assault. • Criminal conviction for attempted murder or conspiracy to commit murder. • Abandonment of newborns in a hospital or in other settings where the evidence suggests that parents intended to relinquish parental rights. • Incarceration of parents because of criminal convictions in which, prior to incarceration, the parents were not involved with the children, and the parents will be incarcerated for two years after filing termination petitions.	• Abandonment of the children (other than newborns). • Desertion • Inability to discharge parental responsibility due to mental illness, mental impairment, or developmental disability. • Findings that their children were born with controlled substances in their blood or urine, and the mothers already have children who were adjudicated neglected minors, provided that the mothers were offered drug treatment and rehabilitation after the birth of the first child.

Service Plan Contents

Service plans contain information as outlined in the Department's Rule and Procedures 315:

- Names of the children for whom the Department is legally responsible or to whom the Department is providing services.
- Health and safety factors of the children that are causing continued need to provide services.
- If children are in placement, the reasons for out-of-home placements and why the children have been put in their current placements; the resources or other support necessary to maintain the placements; and, when residential placements are deemed necessary, descriptions of how and when plans for moving the children to the least restrictive, most homelike placements consistent with the children's best interest can be developed. Reasons why the placements are in the best interests of the children if the children are placed a substantial distance (more than 150 miles) from their parents' home.
- Where applicable, reasons why siblings are placed apart and what efforts are being made to find sibling group placements.
- Statements that the parents or children may disagree with the service plans and that they may have their disagreement recorded.
- Explanations of how parents or children may request appeals and fair hearings.

Permanency Goals:

- Permanency goals and reasons for selecting the goals.
- Timeframes for achieving permanency goals, objectives to resolve identified problems, and specifications of any consequences to the children and families if the timeframes are not met.

Outcomes and Action Steps:

Once the goal has been established the **Outcomes** to achieve the goal and the **Action Steps** to reach the outcomes include:

- Health care and mental health care to be provided to the children, as well as a description of any physical, developmental, educational, or mental disability and any non-educational specialized services the children are or should be receiving for each disability. To the extent available, the service plan should incorporate the health records of the children, including names and address of health providers, immunization record, known medical problems and medications.
- Description of the educational program/services the child is receiving or needs to receive (including information regarding Early Intervention, Head Start, or Pre-Kindergarten services for preschool children). If Individualized Education Plans (IEP) or an Individualized Family Service Plans (IFSP) exist, they should be included in the record. To the extent available, the service plan shall incorporate education records, including names and addresses of the child's educational providers, grade level performance and school record.

- Names of service providers, service frequency, and explanation of why services will meet the needs of the children.
- Where applicable, steps the Department is taking to find adoptive families or other permanent living arrangements.
- Where applicable, written descriptions of programs and services that will prepare children for transition from foster care to independent living.
- Responsibilities of families and children (when appropriate) in fulfilling service plans.
- Responsibilities of the Department and purchase of service providers, if any, to assist families in fulfilling service plans.
- Outcomes that would be considered resolution to these problems and the strengths the families have to achieve these outcomes.
- Services to be provided to the parents (when applicable) that may best resolve these problems.

Visitation Plan:
Parent-child and/or sibling visitation plans developed with families in accordance with 89 Ill. Adm. Code 301 (Placement and Visitation Services) when children and families are separated if visitation is not prohibited by court order. These plans should include the times and places, frequency, length of visits, and who should be present.

Evaluating Progress

The outcomes and interventions are evaluated on a regular basis. If progress is being made, an outcome or individual intervention may be marked as completed. If there is no progress, outcomes or individual interventions may be marked as unsatisfactory progress. Progress toward a permanency goal or a change in permanency goal needs to be reported. This evaluation process is completed with the parents.

Administrative Case Review (ACR)

The Administrative Case Review (ACR) is required for placement cases every six months by DCFS policy and procedures (Procedure 305.60). Intact cases are reviewed with the supervisor every three to six months per policy. The Administrative Case Reviewer convenes and conducts a review with the assigned caseworker along with parents, foster caregivers and older youth. The reviewer is to encourage discussion and participation while respecting the rights of all participants. They must advise the clients of their rights, exclude or limit participation as needed and maintain the focus on the service plan.

The child welfare specialist prepares the Service Plan prior to the ACR for discussion at the case review. All records for the children and parents should be updated to see that it is up to date prior to the review. Any diligent search for missing parents should be completed prior to the review.

At the review the following are discussed:

1) Whether there has been progress toward achieving the outcomes defined in the prior service plan and resolving the problems identified in the plan;
2) Whether there are any barriers that have prevented the achievement of the outcomes and how those barriers can be reduced;
3) Whether the services are appropriate and what additional services may be needed to move toward the permanency goal;
4) Whether the permanency goal has been achieved and/or whether it continues to be appropriate;
5) What objectives should be established for the next six months;
6) If the child(ren) and family have not substantially complied with the service plan, what alternatives should be considered.

Principles for Working with Clients

Client Self-Determination

The involuntary nature of the child welfare professional/client relationship often limits options available to clients, but does not eliminate their right to self-determination. Client self-determination refers to the clients' right to make self-determined choices and to freely act upon those choices without undue influence or coercion. It also refers to the clients' right to receive information necessary to make a self-determined choice. Child welfare professionals:

- Evaluate the decision-making capacity of clients and reevaluate appropriately as circumstances change.
- Ensure that clients, whatever their age, have the opportunity to make self-determined choices according to their level of understanding and decision-making capacity
- Ensure that clients have available information necessary to make self-determined decisions.
- Ensure that clients have the opportunity to make self-determined choices from among options available free from external coercion.
- Ensure that psychological constraints to self-determined decision-making are addressed and, if possible, eliminated or reduced.
- Ensure, if appropriate, that the extended families are involved in the service planning.

Informed Consent

Informed consent emanates from the principle of client self-determination. When child welfare professionals discuss the nature and possible consequences of the intervention with clients, the clients can make informed decisions. Child welfare professionals have the responsibility to engage in this process with mandated clients who have not chosen to become clients, but who have options to consider and decisions to make within the framework of a mandated intervention.

Inform clients as soon as feasible and in understandable about:

- Nature of the professional relationship.
- Nature of professional intervention.
- Professionals' delegated authority and limits of that authority.
- Decisions the clients can make and decisions the child welfare professionals will make.
- The role of the court, if any, and of their legal and procedural rights.
- Keep clients informed about case plans throughout the entire intervention.
- Obtain permission for interventions from legally authorized persons when clients are legally incapable of giving informed consent, e.g., minors or legally incompetent individuals.

Residual Rights of Birth Parents

Birth parents retain some rights when their children are in foster care, if their rights have not been relinquished or terminated by the court. These residual rights constitute the role and responsibilities of birth parents as members of the child welfare team.

The parent's residual rights include:

- The right and duty to support the children.
- Reasonable visitation, unless a judge says they cannot.
- The right to be informed about their children, including where the children are placed. (*NOTE: Effective 7/24/98, prior written notice to foster parents is required before disclosing their names, addresses and telephone numbers. (20 ILCS 505/Children and Family Services Act))*
- The right to determine the children's religious affiliation, including the right to allow baptism.
- Participating in making decisions about the children.
- Consent to the children's adoption.

Juvenile Court System

The court process involves the delivery of testimony and recommendations in an effective and competent manner. This section identifies the knowledge necessary to participate in the juvenile court process in a professional manner to support achievement of preferred permanency outcomes in a timely fashion, to demonstrate respect for the authority of the court, and to adhere to the decorum of the court. This includes the ability to understand court proceedings and the roles and responsibilities of court personnel and child welfare professionals.

Juvenile Court

The Juvenile Court Act governs the majority of court actions concerning children and their families. The Juvenile Court plays a significant role on the child welfare team. Therefore, it is crucial that child welfare professionals maintain positive working relationships with judges, attorneys, and other court participants. In fact, child welfare professionals should view participation in Juvenile Court as a positive opportunity to further the best interest of children, families, and community.

Child Welfare Professional's Role in Juvenile Court

The primary role of the child welfare professional in Juvenile Court is to advocate for the best interests of children. It is imperative that professionals attend all court proceedings scheduled for assigned cases. Failure to attend the court proceedings impedes the delivery of services to children and families and can jeopardize the working relationships with judges, attorneys, and other participants. Child welfare professionals should always attend court on time, be appropriately dressed, and be fully knowledgeable about their cases.

Court Personnel

In Illinois, child protection investigators, physicians, and police officers have been delegated the authority to intervene on behalf of children who need protection by removing children from their homes to ensure their safety. The legal system is in place to provide checks and balances to that authority and ensure it is used responsibly. It is important to understand who the key personnel are, their responsibilities, and the documents utilized by the court.

Personnel

Judges preside over hearings, determine questions of fact and law, and make final determinations of case issues.

(Assistant) State's Attorneys have the discretion to determine whether petitions will be filed and what allegations will be included. They are also responsible for prosecuting cases; establishing whether abuse, neglect, or dependency occurred; and the prosecution of termination of parental rights.

Guardians Ad Litem: Guardians ad litem represent the best interest of children, while attorneys represent the children's legal interests. Children in Illinois are entitled to both attorneys and guardians ad litem.

Respondents' Attorneys represent the parents or legal guardians. The families may privately hire them. If families are financially unable to hire attorneys, the court may appoint Public Defenders.

Court Reporters take official notes of court proceedings.

Court-Appointed Special Advocates (CASA) are trained volunteers, appointed by judges, to work with other court personnel to protect children's' best interests and ensure proper delivery of child welfare services. At the discretion of the court, CASA volunteers may testify pertaining to the well-being of children and, in Illinois counties with populations under three million, may also be appointed to serve as guardians ad litem.

Circuit Clerks accept and file documents and reports for the court record.

Juvenile Court Documents

Subpoenas Writs issued by the Clerk of the Court that are served on witnesses. Subpoenas typically are issued to people who do not automatically attend court, such as doctors who are called as expert witnesses. Subpoenas compel attendance at trials or depositions to give testimony or produce documents, including notes. Failure to comply with subpoenas may result in a contempt of court (Rule to Show Cause) proceeding.

Petitions Documents filed by attorneys alleging specific violations/conditions of the law and requesting judicial action.

Juvenile Court Orders of Protection Set forth reasonable conditions of behavior to be observed for a specified time. They may be requested at any time. There are also Domestic Violence Orders of Protection.

Motions to Compel Court orders used primarily to inform persons who have missed appearing in court. They are sent to persons such as caseworkers and attorneys. Subsequent failures to appear may result in sanctions or DCFS or private agency managerial staff being compelled into court.

Court Orders Requires persons named to do or refrain from doing something as specified. These orders are issued by judges, have the force of law, and remain effective until vacated. The consequences for non-compliance with a court order include civil and criminal penalties, such as fines or imprisonment.

Summons Orders for someone to appear and answer a petition before the court.

Legal/Court Process

Best Interest of the Minor is a standard judges use in making decisions about children's welfare in abuse, neglect, and dependency cases. It is determined by considering the following factors, within the context of children's ages and developmental needs:

- Physical safety and welfare, including food, shelter, health, and clothing.
- Development of identity.
- Background and ties, including familial, cultural and religious.
- Children's sense of attachments, including:
  - Where the child actually feels love, attachment, and a sense of being valued (as opposed to where adults believe the child should feel such love, attachment, and a sense of being valued).
  - The child's sense of security.
  - The child's sense of familiarity.
  - The continuity of affection for the child.
  - The least disruptive placement alternative for the child.
- The child's wishes and long-term goals.
- The child's community ties, including church, school, and friends.
- The child's need for permanence which includes the child's need for stability and continuity of relationships with parent figures, siblings and other relatives.
- The uniqueness of every family and child.
- The risks attendant to entering and being in substitute care.
- The preferences of the persons available to care for the child. *(IL 705 ILCS405/1-3)*

Urgent and Immediate Necessity is the legal standard used by judges at temporary custody/shelter hearings to decide if children should be removed from home for their own protection.

Stipulations are agreements by the parties that certain facts are true. Stipulations are presented in court to the judges, and the judges decide whether to accept them. If the stipulations are accepted, the parties are relieved of the burden of presenting evidence on the factual issues at the hearings.

Protective Custody/Temporary Protective Custody: DCFS child protection investigators, law enforcement officers, and physicians may take protective custody of children when they determine the children are at risk of harm if allowed to stay in their immediate environment.

Hearings are court proceedings regarding cases that take place before judges.

Legal Screenings occur when:

- State's attorneys decide whether enough evidence of abuse, neglect, or dependency exists to support filing Petitions for Adjudication of Wardship after consulting with child protection investigators.
- In Cook County, the State's attorneys decide whether case documentation and evidence support filing motions to request termination of parental rights after consulting with DCFS legal staff, guardians ad litem, and the child welfare professional. Other counties have variations that may or may not include state's attorneys.
- Legal screenings outside of Cook County cases occur before the caseworker recommends a goal change to the Court.

Juvenile Court Hearings

Temporary Custody Hearings

Temporary Custody Hearings (referred to as Shelter Care Hearings in Illinois counties outside Cook) occur within 48 hours, excluding weekends and holidays, after children are taken into protective/temporary custody. Temporary custody hearings are the first hearings in Juvenile Court. Judges hear summaries of the evidence and determine:

- Whether there is **probable cause** to believe that the children are abused, neglected or dependent. (Evidence presented is enough to make a reasonable person believe the actions were necessary.)
- Whether there is **urgent and immediate necessity** to place the children away from their parents.
- Whether **reasonable efforts** were made by DCFS to prevent the children's placement away from their parents.
- What are the **best interests** of the children.

Abuse is the commission or omission by a parent, immediate family member or any person responsible for the child's welfare, which involves physical injury, such as bruises, human bites, bone fractures; substantial risk of physical injury, such as choking, shaking or violently shoving, domestic violence; torture, such as systematically inflicting cruel and unusual treatment toward a child; excessive corporal punishment and/or sexual abuse, including penetration, exploitation, molestation.

Neglect is behavior by the parent, immediate family member or any person responsible for the child's welfare in which that person fails to provide food, clothing, shelter, education, or medical care; provides inadequate supervision; creates an environment injurious to the child's welfare; exposes an infant to a controlled substance or demonstrates a blatant disregard for the child's safety, including situations where a caregiver should take safeguards and does not. A child who is abandoned by their parent or responsible person is considered neglected.

Dependency includes situations where the child is without a parent, guardian or legal custodian; without proper care because of parent's mental or physical disability; without proper medical care through "no fault" of parent or the parent has "good cause" to want to be relieved of parental rights and responsibilities (i.e., child has medical problems and the parent cannot physically care for her).

NO PROBABLE CAUSE	PROBABLE CAUSE, BUT NO URGENT AND IMMEDIATE NECESSITY	PROBABLE CAUSE– URGENT AND IMMEDIATE NECESSITY
Petitions are dismissed, and the children are returned to their parents or guardians.	It is in the best interests of the children to return home. Children are returned to their parents or guardians under Orders of Protection to protect them from alleged offenders. A court date is set for adjudicatory hearing.	It is in the children's best interest to be placed or have them remain in placement away from their parents or guardians. Judges appoint DCFS guardians as temporary custodians, with the right to place the children away from home, pending adjudicatory hearings.

Adjudicatory Hearings

Adjudicatory Hearings are trials. Statutorily, the adjudicatory hearing should occur within 90 days after temporary custody hearings. At this hearing, the Judge decides if the evidence presented shows that the child was abused, neglected or is dependent. If the Judge makes this finding, he/she must also determine whether the child was abused or neglected by the parent(s) or legal guardian. The abuse, neglect or dependency must relate to the time frame when the case first came into court. The Court can only receive information about this time frame. The Judge will not hear anything about things that happened after the temporary custody hearing. This hearing has a higher standard of evidence or burden of proof than the temporary custody hearing and hearsay is not allowed. There must be a "preponderance of the evidence", the evidence is probable to be true than not.

Pursuant to statute, certain things constitute prima facie evidence of abuse or neglect. Prima facie means that the evidence is sufficient without explanation or "on its face." Besides this evidence the Judge may hear other evidence and make findings.

(2) In any hearing under this Act, the following shall constitute prima facie evidence of abuse or neglect, as the case may be:

(a) proof that a minor has a medical diagnosis of battered child syndrome is prima facie evidence of abuse;
(b) proof that a minor has a medical diagnosis of failure to thrive syndrome is prima facie evidence of neglect;
(c) proof that a minor has a medical diagnosis of fetal alcohol syndrome is prima facie evidence of neglect;

(d) proof that a minor has a medical diagnosis at birth of withdrawal symptoms from narcotics or barbiturates is prima facie evidence of neglect;
(e) proof of injuries sustained by a minor or of the condition of the minor of such a nature as would ordinarily not be sustained or exist except by reason of the acts or omissions of the parent, custodian or guardian of such minor shall be prima facie evidence of abuse or neglect, as the case may be;
(f) proof that a parent, custodian or guardian of a minor repeatedly used a drug, to the extent that it has or would ordinarily have the effect of producing in the user a substantial state of stupor, unconsciousness, intoxication, hallucination, disorientation or incompetence, or a substantial impairment of judgment, as a substantial manifestation of irrationality shall be prima facie evidence of neglect;
(g) proof that a parent, custodian or guardian of a minor repeatedly used a controlled substance, as defined in subsection (f) of Section 102 of the Illinois Controlled Substances Act (720 ILCS 570/102), in the presence of the minor or a sibling of the minor is prima facie evidence of neglect. "Repeated use", for the purpose of this subsection, means more than one use of a controlled substance as defined in subsection (f) of Section 102 of the Illinois Controlled Substances Act (720 ILCS 570/102);
(h) proof that a newborn infant's blood, urine or meconium contains any amount of a controlled substance as defined in subsection (f) of Section 102 of the Illinois Controlled Substances Act (720 ILCS 570/102), or a metabolite of a controlled substance or metabolites of those substances, with the exception of controlled substances or metabolites of such substances, the presence of which is the result of medical treatment administered to the mother or the newborn, is prima facie evidence of neglect.
(i) Proof that a minor was present in a structure or vehicle in which the minor's parent, custodian, or guardian was involved in the manufacture of methamphetamine constitutes prima facie evidence of abuse or neglect.

(3) In any hearing under this Act, proof of the abuse, neglect or dependency of one minor shall be admissible evidence on the issue of the abuse, neglect or dependency of any other minor for whom the respondent is responsible. 705 ILCS 405/2-18(2) and (3)

- **If the allegations are not proven** by preponderance of evidence at the adjudicatory hearing, the petitions are dismissed, and the children are returned to their parents or guardians.
- **If the allegations are proven** by a preponderance of evidence--there are findings of abuse/neglect/dependency. Children continue in DCFS temporary custody pending dispositional hearings. The judge may send the children home under an Order of Protection with services in place. The judge is required to admonish parents to **cooperate, comply, and correct** the conditions that require the children to be placed outside the home.

The 3 C's of Admonishment:
Cooperate
Comply
Correct

Dispositional Hearings

Dispositional Hearings occur within 30 days of adjudicatory hearings with one opportunity for continuance not to exceed 30 days, unless all of the parties agree to waive the 30 day time limit. The judge:

- **Hears testimony** about efforts made to reunify the children and families.
- **Considers reports** submitted by caseworkers and other service providers.
- **Reviews evidence** as to the services delivered or to be delivered under the family's service plans, placement alternatives (including return home), and the best interests of the children.

The judge may decide that:

- It is appropriate to consider termination of parental rights when parents are unknown, parents' whereabouts remain unknown, or parents have not responded by appearing in court after receiving notice of court proceedings.
- If sufficient progress has been made by the parent(s) or legal guardian to correct the circumstances that brought the case into court, the Judge may return the child to his/her parent(s) or legal guardian and close the case.
- If sufficient progress has been made by the parent(s) or legal guardian to correct the circumstances that brought the case into court, the Judge may return the child to his/her parent(s) or legal guardian, make the child a youth in care of the Court and continue the case for further monitoring. In Cook County, the child is usually allowed to remain with a parent or guardian under an Order of Protection, listing certain terms and conditions the parents must follow. In other counties children are often returned without an Order of Protection. The case is usually continued for progress reports.
- If sufficient progress has not yet been made for return home, the Judge may make the minor a youth in care of the Court and grant guardianship of the child to the DCFS Guardianship Administrator. The parents are admonished that they must cooperate with DCFS to correct the conditions that caused the case to come into the system or risk termination of their parental rights. The case is continued for the Permanency Hearing
- If sufficient progress has not yet been made for return home, the Judge may make the minor a youth in care of the Court and grant guardianship of the child to a private guardian. If guardianship is granted to a private guardian, the Judge sometimes closes the case. If not closed, the case is continued for the Permanency Hearing.

The judge also sets future dates for progress or permanency hearings.

Status/Progress Hearings

Status Hearings inform the court about the status of particular aspects of cases and can occur at any time.

Progress Hearings inform the court about the progress of cases, including such matters as:

- Parents' progress toward being ready for their children to return home.
- Parents' progress under Orders of Protection, where increased contact with the children has been granted by the judge.
- Caseworkers' progress in preparing cases for termination of parental rights.

Permanency Hearings

Permanency Hearings must be held within at least twelve months of temporary protective custody and at least every six months thereafter. Timeframes for permanency hearings are mandatory.

The judge:

- Reviews service plans and reports submitted by caseworkers and service providers.
- Hears evidence regarding efforts made to reunify the children and families and services delivered or to be delivered under the family's service plans.
- Considers placement alternatives (including return home).
- Considers the best interests of the children.

The judge then determines the children's future status by setting permanency goals. The Judge can set one of these goals: however, the Court has to rule out each goal in order before entering a goal other than Return Home.

Hearings for Termination of Parental Rights

In a **Termination Hearing**, the Court decides, based on the facts and evidence presented, whether there is clear and convincing evidence, as defined in the Adoption Act, to find the parent(s) unfit and whether it is in the child's best interest to terminate parental rights. The Court can terminate parental rights even if an adoptive family has not yet been located. This hearing can occur in conjunction with the Adjudicatory and Dispositional phase of the case but usually happens in a separate hearing after the Dispositional Hearing.

Grounds

The State files a petition alleging grounds for termination and presents evidence supporting them. Some of the more common grounds alleged are abandonment; failure to maintain a reasonable degree of interest; concern or responsibility in the child; substantial continuous or repeated neglect; extreme or repeated cruelty; and failure of the parent to make reasonable progress nine months after adjudication.

Consents and Surrenders

A **general consent or surrender** is a document that a parent signs before a judge or specified caseworker that terminates his/her parental rights to a child. The parent is generally signing over their parental rights to DCFS. DCFS determines who will be the adoptive parent. The parent has no say over who adopts the child. Absent fraud or duress, it is final and irrevocable and does not allow the parent to name a specific person who will adopt the child.

A **specific consent** is a document that a parent signs before a judge, hearing or specified caseworker when the parent wants to consent to the adoption of his/her child by a specific caretaker. Absent fraud or duress, it is final and irrevocable to the adoption by the specific caretaker. Specific consents are good for one year. If the Adoption Petition is not filed within the year the consent becomes revocable and the parent could ask to become part of the case again.

Possible Results

There are two parts to the termination trial.

- The first portion determines whether a parent is unfit. If the State **cannot** prove that the parent is unfit parental rights will not be terminated; the child will remain under guardianship and the case will be set for a new permanency hearing to determine the appropriate goal. If the parent(s) **are** found unfit, then the State must prove that it is the best interest of the child to terminate the rights of the biological parent(s).
- If the State **cannot** prove that it is in the child's best interest to terminate parental rights; the child will remain under guardianship and the case will be set for a new permanency hearing to determine the appropriate goal. If the State **does** prove it is in the child's best interest to terminate parental rights, the Court will terminate the rights and give the DCFS Guardianship Administrator the right to consent to adoption of the child. The case remains open in Juvenile Court until the adoption is finalized. The adoption usually occurs in a different court.

Adoption

In an **Adoption Hearing**, the Court grants legal custody of the minor child to his/her adoptive parents. The child and parents assume all rights and responsibilities as if this were a biological child.

Expedited Adoption: This program allows a case to by-pass a Juvenile Court termination trial and proceed to adoption court for termination and adoption. The termination must not be contested because one of the following is true for each of the biological parents: parent has signed a consent or surrender; parent's whereabouts are unknown after a diligent search; one parent's rights are terminated; parent(s) identity is unknown; or the parent(s) are deceased.

In Cook County the caseworker refers the case through the DCFS regional pre-screening unit and the Adoption Hearing is in the County Division. In **other counties** the hearing may or may not be in a different court.

The DCFS Guardianship Administrator consents to the adoption. The prospective adoptive parent(s) hire a private attorney, although there is a DCFS reimbursement policy. The child usually is appointed a new GAL in the hearing. If successful, the Court grants the adoption and the adoptive parents become the new parents with all the rights and responsibilities as if they were biological parents. The last name of the child may be changed and a new birth certificate will be issued. The Juvenile Court case remains open until a final decree of adoption. The caseworker should submit a copy of the final decree to DCFS legal which will redact the necessary information and submit it to the Court.

Reinstatement of Parental Rights

The law allows for a parent's rights to be reinstated under certain circumstances. Only the DCFS attorney may file a motion to reinstate parental rights if all of the following are true:

- The minor is thirteen years old or older or is the younger sibling of a child who meets the criteria and the younger sibling independently meets the criteria (except for age).
- More than three years have elapsed since the parent's rights were terminated.
- The minor is not currently in a placement likely to achieve permanency.
- The minor has remained a youth in care of the court or was placed in private guardianship and that guardianship has been vacated OR.
- The minor was adopted and the adoptive parent(s) are deceased, signed a surrender or the adoptive parent's rights were terminated.
- It is in the minor's best interest that parental rights be reinstated.
- The parent wishes parental rights to be reinstated and is currently appropriate to have rights reinstated. 705 ILCS 405/2-34.

DCFS is required to make reasonable efforts to locate parents whose rights have been terminated unless the Court says efforts will be futile or inconsistent with the child's best interest. The Department must assess the appropriateness of the parent and if appropriate, foster and support connections between the parent and the youth. The caseworker must provide documentation regarding their recommendation as to reinstating parental rights and their efforts to foster connections in the child's service plan.

Guardianship

Private Guardianship is a proceeding by which an individual other than the parent obtains legal custody of a youth in care. The parents' rights are not terminated and if circumstances change the parents can seek to vacate the private guardianship. Private guardianship is often used in Juvenile Court to obtain permanency for a child. After private guardianship is granted the case is closed. Because the parents' rights are not terminated, the parents may come into court and seek to change visitation or seek custody of their child any time prior to the minor's eighteenth birthday.

KinGap refers to the Department's subsidized private guardianship program**.** After the guardianship is granted, DCFS will pay a monthly subsidy to the guardian. The requirements for KinGap are:

- Minor must be placed with a licensed relative caregiver who has been licensed for six months.
- Return home or adoption is not an appropriate permanency option.
- A minor 14 years old or older can receive a KinGap subsidy if placed with a licensed non-relative caregiver.

In a guardianship proceeding, the **parties** are the proposed private guardian, usually the current caregiver, DCFS legal, the youth in care represented by the GAL, the ASA and the parents, if their rights have not been terminated. The caseworker needs to be present and testify.

Guardianship **screening** is a process used by DCFS legal to determine whether a case is ready for the filing of Petition For Guardianship. DCFS legal drafts, files and presents these cases. The worker makes an appointment with the regional office and the screening with the caseworker is conducted by a paralegal with an attorney's assistance if necessary. Specific information, which is needed for the screening, is available from DCFS legal.

Possible Results:
The Court can decide whether to grant private guardianship. Once the petition is filed, the case is set for a hearing date. A party, usually the parents, can contest private guardianship. If the **Court grants private guardianship** the case is closed. Even though closed, the Court retains jurisdiction. At a future date, the guardian or the parent can petition the Court to vacate the guardianship. If the **Court does not grant private guardianship** the child will remain under his/her current guardianship, usually DCFS, and the case will be set for a new permanency hearing to determine the appropriate goal.

Case Closure by Age

A minor must be under the age of eighteen to be the subject of a Petition for Temporary Custody. Many court youth in care return home or are adopted or placed under private guardianship. These proceedings close the case. If the case is not closed for one of these reasons once wardship is granted it statutorily ends at age nineteen unless expressly continued by the Court prior to the youth in care's nineteenth birthday. If wardship is continued it can extend to age twenty-one. A party can ask for case closure prior to age nineteen, but it is not the practice to request case closure or for the Court to grant it unless the youth in care is at least eighteen.

Possible Results:
At age nineteen the minor's case will close automatically unless the Court extends wardship. Wardship and guardianship can be extended until the age of twenty-one. There is no circumstance in which a court case can stay open past the age of twenty-one. If a minor is approaching his/her nineteenth birthday and the worker believes that wardship and/or guardianship should be extended the worker should notify the GAL and DCFS legal to ensure that the proper motion is filed.

A party can bring a motion for closure before age nineteen. These motions are generally not brought before the eighteenth birthday and involve youth who are mature enough to live on their own and express a desire to leave the DCFS system. This motion is usually brought by DCFS legal on the recommendation and appropriate documentation from the caseworker.

A minor may come back into DCFS care. The court may reinstate wardship any time prior to the minor's 21st birthday and open a previously closed case when a minor's case closed without the minor being adopted or being appointed a legal guardian. The minor must not be currently a youth in care of the court for delinquency matters and it must be in the minor's best interest for wardship to be reinstated. 705 ILCS 405/2-33

Adult Guardianship

Some youth in care are not able to live independently when they reach adulthood because of mental illness and/or developmental disabilities. DCFS Policy Transmittal 99.14, Procedures 302, Appendix N – Transition Planning For Youth in Care With Developmental Disabilities, coordinates the transition of youth age 17 ½ and older with developmental disabilities to DHS funded adult living arrangements.

A youth in care who needs an Adult Guardian must meet specific criteria. The Petition for Adult Guardianship is filed in the Probate Division of the county in which the youth in care resides. Generally, the petition must be filed before the youth in care is 20 ½ to ensure completion before the 21st birthday.

In **Cook County**, the DCFS Guardianship Administrator's attorney prepares and files the petition. In **other counties** contact the DCFS regional counsel.

The caseworker should gather the following information and documents and present them to the DCFS attorney:

- A Physician's Report which attests to the mental and/or physical condition which render the youth in care incapable of making his/her own life decisions.
- A suitable guardian must be identified; this is usually a private citizen or the Office of the State Guardian.
- The youth in care must have an ensured continuity of funding, this is usually SSI or another DHS funding source.
- The youth in care must have a place where he/she can reside as an adult, such as a private home, institution or group care facility.

Return Home Motions

A **Return Home Motion**, whether written or oral, can be brought anytime during the life of the case. The motion can be brought by one parent or as a joined motion if the parents are living together. If the motion is made after the first permanency hearing, a return home goal is necessary. When a child is returned home, the custody transfers from the DCFS Guardianship Administrator to the parent. The child will usually remain a youth in care of the court during the monitoring period.

Parties

In a return home case the **parent** is usually the movant; his/her attorney brings the oral or written motion to return home. The parent is usually represented by the Office of the **Public Defender**. The **child** is also a party and represented by his/her GAL. The **ASA** participates in the case and **DCFS legal** may participate in these cases.

Child Protection Warrants

The DCFS Procedure for Reporting and Locating Missing, Runaway and Abducted Children is set out in Policy Transmittal 2004.08, Procedure 329.30. A **Child Protection Warrant** is a warrant issued by the Judge in an abuse and neglect court cases which directs a law enforcement official to take the juvenile named in the warrant into protective custody wherever the juvenile is found. In Cook County, if the juvenile is a DCFS youth in care he is brought to the Emergency Shelter, and the caseworker must pick up the youth in care and place him/her in an appropriate placement. If a child is suspected to be living out of Illinois then DCFS regional counsel must be contacted for an inter-state warrant.

Procedure 329.30 requires the worker to:

1. Contact law enforcement;
2. Contact the child location and support unit for Missing Children Helpline;
3. Contact the National Center for Missing and Exploited Children;
4. Notify the child's legal parents, guardian or legal custodian (prior to DCFS custody), the juvenile court of jurisdiction and the Guardian ad litem;
5. Complete the Unusual Report;
6. Once the child is missing for 24 hours, complete the 906 form and call the regional 906 hotline;
7. Request a Child Protection warrant for youth 17 years of age or younger.

Juvenile Arrest Warrant (JAW)

A Juvenile Arrest Warrant (JAW) is a warrant issued by a delinquency judge for the arrest of a minor. A JAW may be issued when the minor misses a court date or violates probation.

Parents' Rights in Juvenile Court

Parents have the right:

- To be represented by lawyers of their choice or, if parents cannot afford lawyers,
- To have them appointed by judges.
- To attend court hearings.
- To receive written petitions containing the allegations against them.
- To receive written notices/ summonses indicating what kind of court hearings are scheduled, the locations, dates, and times.
- To have others testify on their behalf or testify on their own behalf about:
- What is best for their children.
- With whom they want their children to live.
- What conditions are like in their home.
- Whether their children are safe at home.
- Adequacy of their parenting and child care.
- Whether their children have been abused, neglected, or dependent.
- To present evidence and to question all those who give evidence or testimony in court.
- To see their court files and know the contents of most reports given to the courts.
- To have language or sign interpreters.
- To have visits with their children, unless judges order otherwise.
- To have copies of judges' written decisions.
- To request continuances for their cases from judges.

Children's Rights in Juvenile Court

Children have the right:

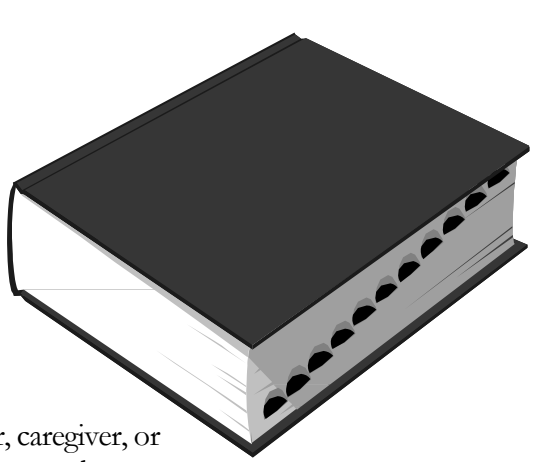
- To be present at hearings. Children may be excluded from dispositional hearings at the discretion of judges and, with the consent of parents, guardians, or counsel, from adjudicatory hearings.
- To have their own lawyers, usually the guardians ad litem, represent them.
- To see almost anything in their court files or almost anything that is given to the judges.
- To have someone explain what is happening at hearings and what the court orders mean for them.
- To have language or sign interpreters.
- Children who are old enough to understand what is happening can ask questions of judges and others and can tell judges:
- If they were abused, neglected, or dependent.
- If they feel there are important reasons for them to be taken out of their homes.
- Where they want to live.
- What they think would be best for them.

Foster Parents' Rights in Juvenile Court

- The foster parent has a right to be heard at any court proceeding and may speak to the judge directly.
- Under some circumstances, a foster parent can request to become a party to the case.

The Length of Time Reports are Kept on File

50 YEARS AFTER REPORT INDICATED	20 YEARS	5 YEARS
• Reports in which allegations regarding the death of children or penetration were indicated	• Indicated reports involving serious physical injury, sexual molestation, or sexual exploitation of children.	• All other indicated reports



Child Welfare Definitions

Abused child – Child whose immediate family member, caregiver, or person residing in the same home as the child inflicts, causes to be inflicted, or allows to be inflicted a physical injury that allows impairment of physical or emotional health or loss or impairment of any bodily function. (DCFS Rules & Procedures 300)

Best Interests – Care and guidance, preferably in his or her own home, as will serve the safety and moral, emotional, mental, and physical welfare of the minor. (Juvenile Court Act)

Caregiver – Individual twenty-one years old or over whom is directly responsible for the care of a child. (Department Rules & Procedures, Guide for the Utilization of DCFS Policy Documents)

Child – Person under the age of eighteen. (Department Rules & Procedures, Illinois Juvenile Court Act)

Concurrent Planning – Process by which the child welfare professional develops a plan and works toward family reunification while, at the same time, developing an alternative plan for a target case for a child who has been identified as unlikely to be reunified with its parents, in an effort to provide a permanent home for the child. (Department Rules & Procedures, Policy Guide 98.1)

Degree of Harm – The severity of harm which could range from slight to moderate to severe.

Dependent – Child under eighteen years of age who, as a result of the physical or mental disability of a parent or legal guardian, is not receiving necessary care and guardianship or whose birth parents' or guardians' wish is to consent for the child's adoption. (Department Rules & Procedures 304 ANCRA/Juvenile Court Act)

Diligent Search – Search for a missing parent that must be conducted within 48 hours after protective custody is taken of a child or prior to the protective custody hearing. (Illinois Juvenile Court Act)

Dispositional Hearing – Hearing at which a judge, following adjudication, determines the subsequent care, custody, and supervision of a child and what obligations are incumbent upon the parents. (Illinois Juvenile Court Act)

Guardianship/Legal Custody – Process by which a court may take a child from the custody of his/her parents and place him/her in the care of a suitable relative or other person or agency. (Illinois Juvenile Court Act)

Immediate – An incident can happen now or in the very near future.

Indicated Finding - Indicated: official conclusion, after investigation of allegations, that there is credible evidence that a child has been abused or neglected.

Mandated Reporter – Persons required by law to report suspected child abuse or neglect to the Department of Children and Family Services. (DCFS Rules & Procedures 300)

Minimum Parenting Standards – Minimum standards a parent must meet in providing adequate food; ensuring a child is appropriately clothed for weather conditions; providing adequate shelter, providing protection from severe physical, mental, and emotional harm; and providing necessary medical care and adequate education as required by law. (Department Rules & Procedures Rules 302, 304, 305, Transmittal 99.3)

Moderate to Severe Harm – The threat of danger to a child's life or health, impairment to his or her physical or mental well-being, or disfigurement.

Near Future – The time period immediately after contact with a child during which a child would be likely to suffer moderate to severe harm (i.e. be in danger) if NO protective action is taken to ensure the child's safety.

Neglected Child – Child whose family member or caregiver fails to provide proper or necessary support, or medical or remedial care necessary for the well-being of the child. (DCFS Rules & Procedures 300)

Order of Protection – Order issued by the court that seeks to guarantee the health, safety, and best interests of the minor. Such an order may require a person to prevent, prohibit, or refrain from certain acts of commission or omission. (Illinois Juvenile Court Act)

Paramour – A significant other (e.g. boyfriend, girlfriend, lover, partner, friend, or putative father) who is involved in an intimate/romantic relationship with one of the custodial parents of the children who come to the official attention of the Department through a child abuse or neglect investigation and/or open case; does not have a legally recognized and/or *significant, continuous and stable* relationship with *all* of the children; and may or may not live in the same household of the custodial parent of the involved children.

Parental Rights – Rights that are afforded all parents. These rights derive from natural law, as well as constitutional law; however, they are not absolute and can be taken away when society determines that the responsibility that goes with them has not been met by the parent. (Clinical Practice Training Resource Guide)

Permanency – Continuous living arrangement designed to meet a child's developmental needs, increase his/her sense of emotional well-being and establish legal bonds to a place and family. (Illinois Juvenile Court Act, Department Rules & Procedures, Policy Guide 98.1)

Protective Custody – Temporary placement of a minor and removal of the minor from the custody of his/her guardian or parent (also known as Temporary Protective Custody). (Department Rules & Procedures – Juvenile Court Act)

Relative/Kinship/Caregiver – Person having any of the following relationships to a child: parent, step-parent, grandparent, sibling, great-grandparent, uncle, aunt, nephew/niece, first cousin, great-uncle or great-aunt, step-brother, or step-sister. (Department Rules & Procedures, Guide for the Utilization of DCFS Policy Documents)

Residual Parental Rights and Responsibilities – Rights and responsibilities remaining with the parents after the transfer of legal custody or guardianship. (Juvenile Court Act)

Risk – Likelihood of any degree of long-term future harm or maltreatment to the child. It does not predict the future or when future harm might occur, rather the likelihood of it happening at all. (DCFS Rules & Procedures 300)

Safety – Status when an assessment of available information supports the belief that a child is not in immediate danger of moderate to severe harm. (Ref: "Procedures")

Safety Plan – Plan that ensures a child is safe after an assessment of available information supports the belief that a child is not in immediate danger of moderate to severe harm. (Department Rules & Procedures 300)

Safety Threats – Those conditions which are directly associated with immediate harm and are likely to predict when the child could be in immediate danger of moderate to severe harm if an intervention is not made.

Soundex – Exhaustive search of the DCFS database based upon spelling or phonetic rendition of last name. Identifies persons, service history or license vendors.

Unfounded – Official conclusion, after investigation of allegations, that there is no credible evidence to substantiate allegations. (DCFS Rules & Procedures 300)

ILLINOIS STATUTORY DEFINITIONS OF ABUSE AND NEGLECT

Definition: Abuse

The Juvenile Court Act defines an abused minor as follows:

Any minor under 18 years of age whose parent or immediate family member, or any person responsible for the minor's welfare, or any person who is in the same family or household as the minor, or any individual residing in the same home as the minor or a paramour of the minor's parent:

(i) Inflicts, causes to be inflicted, or allows to be inflicted upon such minor physical injury, by other than accidental means, which causes death, disfigurement, impairment of physical or emotional health or loss/impairment of any bodily function;
(ii) Creates a substantial risk of physical injury to such minor by other than accidental means which would be likely to cause death, disfigurement, impairment of emotional health or loss/impairment of any bodily function;
(iii) Commits, or allows to be committed, any sex offenses against such minor, as such sex offenses are defined in the Criminal Code of 1961, as amended, and extending those definitions of sex offenses to include minors under 18 years of age;
(iv) Commits, or allows to be committed, an act or acts of torture upon such minor; or
(v) Inflicts excessive corporal punishment.
(705 ILCS 405/2-3)

Definition: Neglect

Neglect is defined by the Juvenile Court Act as:

a) Any minor under 18 years of age who is not receiving the proper or necessary support, education as required by law, or medical or other remedial care recognized under state law as necessary for a minor's well-being, or other care necessary for his or her well-being, including adequate food, clothing, shelter, or who is abandoned by his or her parents or other person responsible for the minor's welfare without a proper plan of care; or
b) Any minor under 18 years of age whose environment is injurious to his or her welfare; or
c) Any newborn infant whose blood or urine contains any amount of a controlled substance as defined in subsection (f) of Section 102 of the Illinois Controlled Substances Act, as now thereafter amended, or a metabolite of a controlled substance, with the exception of controlled substances or metabolites of such substances, the presence of which in the newborn infant is the result of medical treatment administered to the mother or the newborn infant; or
d) Any minor under the age of 14 years whose parent or other person responsible for the minor's welfare leaves the minor without supervision for an unreasonable period of time without regard for the mental or physical health, safety or welfare of the minor.

Whether the minor was left without regard for the mental or physical health, safety or welfare of that minor or the period of time was unreasonable shall be determined by considering the following factors, including but not limited to:

(1) the age of the minor;
(2) the number of minors left at the location;
(3) the special needs of the minor, including whether the minor is physically or mentally handicapped, or otherwise in need of ongoing prescribed medical treatment, such as periodic doses of insulin or other medications;
(4) the duration of time in which the minor was left without supervision;
(5) the condition and location of the place where the minor was left without supervision;
(6) the time of day or night when the minor was left without supervision;
(7) the weather conditions, including whether the minor was left in a location with adequate protection from the natural elements such as adequate heat or light;
(8) the location of the parent of guardian at the time the minor was left without supervision, the physical distance the minor was from the parent or guardian at the time the minor was without supervision;
(9) whether the minor's movement was restricted or the minor was otherwise locked within a room or other structure;
(10) whether the minor was given a phone number of a person or location to call in the event of an emergency and whether the minor was capable of making an emergency call;
(11) whether there was food and other provisions left for the minor;
(12) whether any of the conduct is attributable to economic hardship or illness and the parent, guardian or other person having physical custody or control of the child made a good faith effort to provide for the health and safety of the minor;
(13) the age and physical and mental capabilities of the person or persons who provided supervision of the minor;
(14) whether the minor was left under the supervision of another person;
(15) any other factor that would endanger the health and safety of that particular minor. (705 ILCS 405/2-3)

Where the circumstances indicate harm, or substantial risk of harm to the child's health or welfare and the necessary medical care is not being provided to treat or prevent that harm or risk of harm, because such parent or other person responsible for the child's welfare depends upon spiritual means alone for treatment or cure, such child is subject to the requirements of this Act for the reporting of, investigation of, and provision of protective services with respect to such child and his/her health needs, and in such cases spiritual means, through prayer alone for the treatment or cure of disease or for remedial care, will not be recognized as a substitute for such necessary medical care, if the Department or, as necessary, a juvenile court, determines that medical care is necessary.

SUBTYPES OF MALTREATMENT

Subtypes of Physical Abuse

- Slapping
- Whipping, strapping, switching
- Hair pulling
- Throwing
- Punching
- Shaking – Whiplash: Shaken Infant Syndrome – caused when a child is grabbed by the arms or trunk and severely and repeatedly shaken. A medical evaluation will determine this injury.
- Poisoning – sometimes a child may be forced to ingest a drug, food or spice as a form of punishment. Nausea, vomiting and eye tearing may indicate poisoning.
- Munchausen's Syndrome by Proxy – a parent reports fictitious illnesses in their child by either inducing or fabricating the signs or symptoms. This necessitates hospitalization and/or a battery of unnecessary medical tests. Chronic doctor visits with no resolution of the presenting illness may be the first clue to suspect Munchausen's Syndrome by Proxy.
- Burning – immersion burns, splash burns, contact burns, chemical burns, electric burns, microwave burns are examples of abusive burns and tend to exhibit distinct patterns.

Subtypes of Sexual Abuse

- Fondling a child
- Intercourse, rape, sodomy
- Exhibitionism, masturbation in front of a child
- Cunnilingus (oral stimulation of female genitals)
- Fellatio (oral stimulation of male genitals)
- Child forced to touch a perpetrator in a sexual manner
- Commercial exploitation

Subtypes of Emotional Maltreatment

- Rejection – parent consistently does not acknowledge the child's worth and validity of child's needs
- Terrorizing – parent verbally assaults the child, instills fear through bullying and threatening. The world is defined as a hostile and frightening place.
- Ignoring – the child is deprived of emotional stimulation and interaction.
- Isolating – the child is separated and cut off from normal social relationships. The child is prevented from forming friendships and is made to feel alone.
- Corrupting – the child is directed to engage in anti-social and destructive behaviors. Deviance is reinforced and a normal social experience is prevented.

Subtypes of Neglect

- Medical Neglect – important medical care necessary of the child's well-being and health is withheld from the child.
- Lack of Supervision – a parent or caregiver leaves a minor child under the age of 14 alone for an unreasonable period of time. Lack of supervision occurs when a child is put at risk; e.g. a child is left in the bathtub alone or left at home while a parent goes out to a bar.
- Non-organic Failure to Thrive – this is a broad term to describe infants and children who do not gain weight and grow. Failure to thrive may be the result of organic deficiencies and in these cases is not neglect. When, however, failure to thrive is diagnosed and no underlying disease or physical condition can be detected, lack of growth is non-organic and psycho-social in nature, meaning it is due to neglect.
- Safety Neglect – when the parent or caregiver neglects important safety issues. For instance, a parent may leave a child unattended in a hot car or fail to safely store weapons or toxic materials.
- Abandonment – a child is abandoned when a parent intends to permanently leave a child. For instance, a newborn is left in a garbage can or a child is left at a bus station with a note pinned to his/her shirt.
- Maternal Substance Abuse – a pregnant woman who abuses substances while pregnant passes the substance via the bloodstream to her unborn child. A baby who is born with drugs in his/her system is considered to be neglected.

Child Endangerment Risk Assessment Protocol (CERAP)
Safety Threats

Safety Threat Assessment

Safety threats are behaviors or conditions that may be associated with a child or children being in danger of moderate to severe harm immediately or in the near future**.** All children residing in the home are to be seen, and if verbal, interviewed out of the presence of the caregiver and alleged perpetrator, if possible. When completing the CERAP, consider the effect any adult or other member of the household could have on a child's safety. Identify the presence of each threat by checking "Yes" on the **CERAP,** which is defined as there is **"clear evidence or other cause for concern."**

Safety Threat Criteria

The simple presence of any one of the below listed behaviors and/or conditions does not, in and of itself, mean that a child should be determined to be unsafe. When considering the listed behaviors and/or conditions, the following criteria must be considered when assessing the presence of a safety threat:

- **Child Vulnerability:** Each safety threat must be considered from the perspective of the threat it poses for **the particular children involved.** Some children are more vulnerable than others. Factors that influence a child's vulnerability include, but **are not limited to**:
  - Younger children who lack good verbal skills, in particular, non-verbal children.
  - Children affected by developmental disabilities/deficits.
  - Children who have serious medical problems.
  - Children who exhibit psychological, emotional, or behavioral problems.

- **Severity of the Behavior/Condition:** Severity of a safety threat must be considered within the context of the other safety threat criteria, child vulnerability and the history of safety threats. Severity may refer to the degree or extend of an alleged maltreatment incident e.g., a child with multiple and/or serious injuries or it may refer to the degree to which a caregiver's behavior threatens child safety, e.g., a caregiver whose substance abuse is severe enough to threaten child safety.

- **History:** A safety threat must be considered in the context of any known or alleged previous examples of safety threats. Anecdotal reports about safety threats must be considered, but attempts must be made to verify the information with credible sources. Chronic safety threats must be assessed as posing greater danger to children. Any prior child abuse/neglect history and/or criminal arrest and conviction records, if available, must be evaluated and taken into consideration with respect to child safety.

  When there are no safety threats that were checked "YES", the worker is to summarize the available information which indicates that no child is likely to be in immediate danger of moderate to severe harm.

Safety Threat Identification

Once a safety threat has determined that a child is not safe, identify:

- All children affected.
- The caregiver(s) responsible for creating or allowing the safety threat.
- The source of information identifying the safety threat.

Safety Threats

1) **A caregiver, paramour or member of the household whose behavior is, or has been, violent and out of control.**

   Examples of such behavior include, but are not limited to:

   - A documented or credibly alleged history of violent activity, the nature of which constitutes a threat to a child.
   - Hostile physical or verbal outbursts directed at a child.
   - Behavior that indicates a serious lack of self-control, e.g., acting reckless, unstable, a volatile or explosive temperament.

2) **A caregiver, paramour or member of a household suspected of abuse or neglect that resulted in moderate to severe harm to a child or who has made a plausible threat of such harm to a child.**

   Examples of such include, but are not limited to:

   - Any caregiver who may have caused or allowed moderate to severe injury to a child.
   - A child who has injuries and reasonable information suggests that they may be non-accidental.
   - An infant with an unexplained injury.
   - Direct or indirect threats, that are believable, to cause harm to a child.
   - Plans to retaliate against a child for causing or cooperating with a CPS investigation.
   - Torture or excessive physical force or punishment beyond the duration of the child's endurance.

3) **A caregiver, paramour or member of the household who has a documented history of perpetrating child abuse/neglect or any person for whom there is a reasonable cause to believe that he/she previously abused or neglected a child. The severity of that maltreatment, coupled with the caregiver's failure to protect, suggests that child safety may be an urgent and immediate concern.**

   Examples of such include, but are not limited to:

   - Previous abuse or neglect that was serious enough to cause or could have caused moderate to severe harm.
   - A caregiver is known to have retaliated or threatened retaliation against a child.
   - An escalating pattern of maltreatment.

- A caregiver who does not acknowledge or take responsibility for prior moderate to severe harm inflicted to a child or tries to explain away prior incidents of moderate to severe harm.
- Unreported, but credible, anecdotal accounts of prior maltreatment.
- Efforts to conceal evidence of moderate to severe harm, e.g., child required to wear long pants, long sleeved shirts to conceal bruises or other marks or caregiver applies makeup to conceal marks.

4) Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern.

Examples of such include, but are not limited to:

- A child forced or encouraged to engage in sexual performance or activity, including, e.g., sexually gratifying a caregiver or others.
- A possible or confirmed perpetrator who continues to have access to
- a child.
- The caregiver does not believe or support the allegations of sexual abuse made by a child.
- The child is allowed or forced to watch or read pornographic materials.

5) A caregiver, paramour or member of the household is hiding the child, refuses access, or there is some indication that a caregiver may flee with the child.

Examples of such include, but are not limited to:

- A family has previously fled in response to a CPS or police investigation.
- A family has removed child from a hospital against medical advice.
- A family has history of keeping a child at home and/or away from peers, school or other outsiders for extended periods.
- The family says they may flee or it appears as they are preparing to flee.

6) Child is fearful of his/her home situation because of the people living in or frequenting the home.

Examples of such include, but are not limited to:

- A child cries, cowers, cringes, trembles or otherwise exhibits fear in the presence of certain individuals or verbalizes such fear.
- A child exhibits severe anxiety (e.g., nightmares, insomnia) that appears to be associated with someone in the home.
- A child has reason to expect retribution or retaliation from caregivers.
- A child is isolated from extended family members or others with whom the child feels safe.

7) A caregiver, paramour, or member of the household describes or acts toward the child in a predominantly negative manner.

Examples of such include, but are not limited to:

- Describing a child in demeaning or degrading terms, such as evil, stupid, ugly, a liar, a thief, etc.
- Cursing at a child in a demeaning, degrading, and/or hostile manner.
- Using a particular child as a scapegoat.

8) A caregiver, paramour, or member of the household has dangerously unrealistic expectations for the child.

Examples of such include, but are not limited to:

- The child is expected to perform or act in a way that is impossible or improbable for the child's age, e.g., babies and toddlers expected not to cry or to be still for extended periods; young children to be toilet trained, eat neatly or take responsibility beyond their years.
- Appearing to interpret child's non-compliance as defiance of caregiver/paramour's authority.

9) A caregiver, paramour or member of the household expresses credible fear that he/she may cause moderate to severe harm to a child.

Examples of such behavior include, but are not limited to:

- The caregiver making a credible statement that he/she may seriously harm a child.
- A credible statement made when mental illness or extreme stress is a factor in the life of the caregivers.

10) A caregiver, paramour or member of the household has not, will not, or is unable to provide sufficient supervision to protect a child from potentially moderate to severe harm.

Examples of such behavior include, but are not limited to:

- The caregiver places a child in situations that are likely to require judgment or actions greater than the child's level of maturity, physical condition, and/or mental abilities. e.g., although caregiver present, child can wander outdoors alone, play with dangerous objects, play on an unprotected window ledge or be exposed to other serious hazards.
- A caregiver leaving a child alone longer than would be safe, given the child's age and developmental state.
- A caregiver makes inadequate or inappropriate child care arrangements or demonstrates very poor planning for a child's care, e.g., a two-year old who is left home alone, a seven-year old who is left to care for his one and two-year old sisters.

11) A caregiver, paramour or member of the household refuses to or is unable to meet a child's medical or mental health care needs and such lack of care may result in moderate to severe harm to the child.

Examples include, but are not limited to:

- A caregiver failing to seek treatment for a child's immediate and dangerous medical or mental health condition.
- A caregiver does not follow prescribed treatment for any serious medical or mental health condition.

12) A caregiver, paramour or member of the household refuses to or is unable to meet the child's need for food, clothing, shelter, and/or appropriate environmental living conditions.

Examples of such include, but are not limited to:

- A child denied food and/or drink on a consistent or ongoing basis; or
- A child appearing malnourished.
- A child without adequate warm clothing in cold months or adequate housing or emergency shelter.
- A gas leak from a stove or furnace, peeling lead-based paint accessible to a child, or hot water/steam leaks from radiators.
- Dangerous substances or objects stored in unlocked lower shelves, cabinets, under a sink.
- A significant amount of raw garbage in the household that has not been disposed of properly.

13) A caregiver, paramour or member of the household whose alleged or observed substance abuse may seriously affect his/her ability to supervise, protect or care for the child.

Examples of such behavior include, but is not limited to:

- A caregiver, paramour or household member whose substance abuse significantly impairs their ability, or is likely to impair their ability, to provide care for a child.
- A caregiver, paramour or household member's substance abuse would cause them to inflict moderate to severe harm to a child or allow a child to come to moderate to severe harm.
- A caregiver, paramour or household member's substance abuse extends to selling drugs while a child is present or in proximity.

14) A caregiver, paramour or member of the household whose alleged or observed mental/physical illness or developmental disability may seriously impair or affect his/her ability to provide care for a child.

Examples of such include, but are not limited to:

- A caregiver who hears voices telling them to harm a child.
- A child who has become a part of their caregiver's delusional system.
- A caregiver's behavior that seems out of touch with reality and/or is extremely irrational.
- A caregiver lacking the physical or intellectual capacity to safely care for a child.
- A caregiver who is not able and/or willing to engage in needed supports such as medications or mental health services, resulting in harm to a child or likely harm to a child.

15) The presence of violence, including domestic violence, that affects caregiver's ability to provide care for a child and/or protection of a child from moderate to severe harm.

Examples of such include, but are not limited to:

- A domestic violence abuser who exhibits controlling behaviors.
- A domestic violence abuser who has stalked the caregiver and/or child.
- A domestic violence abuser who has threatened to kill or harm the caregiver and/or child.
- A domestic violence abuser who recently displayed a violent outburst that resulted in injury or threat of injury to a child or the caregiver while child was in his/her care.
- A caregiver who is unable to provide basic care and supervision for a child due to an injury or incapacitating condition, forced isolation or other controlling behavior forced upon them by an a domestic violence abuser.
- A caregiver forced under threat of harm to participate in or witness moderate to severe harm of a child and/or a child being forced under threat of moderate to severe harm to witness or participate in the abuse of the caregiver.
- A caregiver or child who has injuries that the caregiver denies were inflicted by a domestic violence abuser, despite evidence to the contrary.
- A caregiver with a history of abusing a child after they themselves were subjected to domestic violence.

16) A caregiver, paramour, member of the household or other person responsible for the child's welfare engaged in or credibly alleged to be engaged in human trafficking poses a safety threat of moderate to severe harm to any child in the home.

Examples of such safety threats include, but are not limited to:

- Any caregiver who causes or allows a child to be coerced to perform labor.
- Any caregiver causing or allowing a child to be used for domestic servitude or peonage (labor provided to settle a debt).
- Any caregiver who causes or allows a child to be used for commercial sexual exploitation, i.e., prostitution, the production of pornography or for sexually explicit performance.
- Any caregiver who exposes a child to an environment or set of circumstances that places them at risk of being harmed or exploited, in a manner consistent with the definition of human trafficking.

State of Illinois
Department of Children and Family Services

SACWIS Risk Assessment

Trauma Experience:

1. SEXUAL ABUSE – This rating describes the child's experience of sexual abuse.

0	There is no evidence that child has experienced sexual abuse.
1	There is a suspicion that the child has experienced sexual abuse with some degree of evidence. This could include evidence of sexually reactive behavior as well as exposure to a sexualized environment or Internet predation. Children who have experienced secondary sexual abuse (e.g. witnessing sexual abuse, having a sibling sexually abused) also would be rated here.
2	Child has experienced one or more incidents of sexual abuse but this abuse was not chronic or severe. This might include a child who has experienced molestation without penetration on a single occasion.
3	Child has experienced severe or chronic sexual abuse with multiple episodes or lasting over an extended period of time. This abuse may have involved penetration or multiple perpetrators.

2. PHYSICAL ABUSE - This rating describes the child's experience of physical abuse.

0	There is no evidence that child has experienced physical abuse.
1	There is a suspicion that child has experienced physical abuse but no confirming evidence. Spanking without physical harm or threat of harm also qualifies.
2	Child has experienced a moderate level of physical abuse and/or repeated forms of physical punishment (e.g. hitting, punching).
3	Child has experienced severe and repeated physical abuse with intent to do harm and that causes sufficient physical harm to necessitate hospital treatment.

3. EMOTIONAL ABUSE - This rating describes the degree of severity of emotional abuse, including verbal and nonverbal forms.

0	There is no evidence that child has experienced emotional abuse.
1	Child has experienced mild emotional abuse. For instance, child may experience some insults or is occasionally referred to in a derogatory manner by caregivers.
2	Child has experienced moderate degree of emotional abuse. For instance, child may be consistently denied emotional attention from caregivers, insulted or humiliated on an ongoing basis, or intentionally isolated from others.
3	Child has experienced significant emotional abuse over an extended period of time (at least one year). For instance, child is completely ignored by caregivers, or threatened/terrorized by others.

4. NEGLECT - This rating describes the severity of neglect.

0	There is no evidence that child has experienced neglect.
1	Child has experienced minor or occasional neglect. Child may have been left at home alone with no adult supervision or there may be occasional failure to provide adequate supervision of child.
2	Child has experienced a moderate level of neglect. This may include occasional unintended failure to provide adequate food, shelter, or clothing with corrective action.
3	Child has experienced a severe level of neglect including prolonged absences by adults, without minimal supervision, and failure to provide basic necessities of life on a regular basis.

13. PARENTAL CRIMINAL BEHAVIOR (birth parents & legal guardians only) - This item rates the criminal behavior of both biological and stepparents, and other legal guardians, **not** foster parents.

0	There is no evidence that youth's parents have ever engaged in criminal behavior.
1	One of youth's parents has a history of criminal behavior but youth has not been in contact with this parent for at least one year.
2	One of youth's parents has a history of criminal behavior resulting in a conviction or incarceration and youth has been in contact with this parent in the past year.
3	Both of youth's parents have history of criminal behavior resulting in incarceration.

Child Strength:

20. FAMILY - Family refers to all family members as defined by the youth, or biological relatives and significant others with whom the child is still in contact. Is the family (as defined by the child) a support and strength to the child?

0	Significant family strengths. There is at least one family member who has a strong loving relationship with the child and is able to provide significant emotional or concrete support.
1	Moderate level of family strengths. There is at least one family member with a strong loving relationship who is able to provide limited emotional or concrete support.
2	Mild level of family strengths. Family members are known, but currently none are able to provide emotional or concrete support.
3	This level indicates a child with no known family strengths. There are no known family members.

Life Domain Functioning:

32. LIVING SITUATION - This item refers to how the child is functioning in his/her current living arrangement.

0	Child is functioning well in his/her current living environment. Child and caregivers feel comfortable and safe dealing with issues that come up in day-to-day life.
1	Mild problems with functioning in current living situation. Caregivers express some concern about child's behavior in living situation and/or child and caregiver have some difficulty dealing with issues that arise in daily life.
2	Moderate to severe problems with functioning in current living situation. Child and caregivers have difficulty interacting effectively with each other much of the time. Difficulties may create significant problems for others in the residence.
3	Profound problems with functioning in current living situation. Child is at immediate risk of being removed from living situation.

34. DEVELOPMENTAL/INTELLECTUAL - This item rates the presence of Mental Retardation or Developmental Disabilities. All developmental disabilities occur on a continuum; a child with Autism may be designated a 0, 1, 2, or 3 depending on the significance of the disability and the impairment.

0	No evidence of developmental problems or mental retardation.
1	Documented delay, learning disability, or documented borderline intellectual disability, (i.e. FSIQ 70 to 85.)
2	Evidence of a pervasive developmental disorder including Autism, Tourette's, Down's Syndrome or other significant developmental delay or child has mild mental retardation (FSIQ 50 to 69).
3	Moderate, Severe, or Profound developmental disability or FSIQ below 50.

38. PHYSICAL - This item is used to identify physical limitations, including chronic conditions that entail impairment in eating, breathing, vision, hearing, mobility, or other functions.

0	Child has no physical limitations.
1	Child has some physical condition that places mild limitations on activities. Conditions such as impaired hearing or vision would be rated here. Also rate here treatable medical conditions that result in physical limitations (e.g. asthma).
2	Child has physical condition that notably impacts activities. Sensory disorders such as blindness, deafness, or significant motor difficulties would be rated here.
3	Child has severe physical limitations due to multiple physical conditions.

Child Behavioral/Emotional Needs:

54. SUBSTANCE ABUSE - These symptoms include use of alcohol and illegal drugs, the misuse of prescription medications and the inhalation of any substance for recreational purposes. This rating is consistent with DSM-IV Substance-related Disorders.

0	This rating is for a child who has no substance use difficulties at the present time. If the person is in recovery for greater than 1 year, they should be coded here, although this is unlikely for a child or adolescent.
1	This rating is for a child with mild substance use problems that might occasionally present problems for the person (intoxication, loss of money, reduced school performance, parental concern). This rating would be used for someone early in recovery (less than 1 year) who is currently abstinent for at least 30 days.
2	This rating is for a child with a moderate substance abuse problem that impairs his/her ability to function, but does not preclude functioning in an unstructured setting while participating in treatment.
3	This rating is for a child with a severe substance dependence condition that consistently impairs his/her ability to function. Substance abuse problems may present significant complications to the coordination of care for the individual. A substance-exposed infant who demonstrates symptoms of substance dependence would also be rated here.

Child Risk Behaviors:

67. DELINQUENCY - This rating includes both criminal behavior and status offenses that may result from child or youth failing to follow required behavioral standards (e.g. truancy). Sexual offenses should be included as criminal behavior.

0	Child shows no evidence or has no history of criminal or delinquent behavior.
1	History of criminal or delinquent behavior but none in the past 30 days. Status offenses in the past 30 days would be rated here.
2	Moderate level of criminal activity including a high likelihood of crimes committed in the past 30 days. Examples would include vandalism, shoplifting, etc.
3	Serious level of criminal or delinquent activity in the past 30 days. Examples would include car theft, residential burglary, gang involvement, etc.

Safety:

98. CONDITION OF THE HOME - This item refers to the physical condition of the house or apartment in which the parent/caregiver is currently living.

0	No health or safety concerns on property
1	Minor health or safety concerns on property that pose no threat and easily correctable
2	Serious substantiated health or safety hazards, i.e. overcrowding, inoperative or unsafe water and utility hazards, vermin, or other health and sanitation concerns including home where drugs are produced/sold or where there is current drug activity).
3	Substantiated life threatening health or safety hazards, i.e. living in condemned and/or structurally unsound residence; exposed wiring, potential fire/safety hazards, or vermin infestation.

99. MARITAL/PARTNER VIOLENCE IN THE HOME - This rating describes the degree of difficulty or conflict in the parent/caregiver's relationship and the impact on parenting and childcare.

0	Parent/caregiver(s) appear to be functioning adequately. There is no evidence of notable conflict in the parenting relationship. Disagreements are handled in an atmosphere of mutual respect and equal power.
1	Mild to moderate level of family problems including marital difficulties and partner arguments. Parent/caregivers are generally able to keep arguments to a minimum when child is present. Occasional difficulties in conflict resolution or use of power and control by one partner over another.
2	Significant level of caregiver difficulties including frequent arguments that often escalate to verbal aggression or the use of verbal aggression by one partner to control the other. Child often witnesses these arguments between caregivers or the use of verbal aggression by one partner to control the other.
3	Profound level of caregiver or marital violence that often escalates to mutual attacks or the use of physical aggression by one partner to control the other. These episodes may exacerbate child's difficulties or put the child at greater risk.

Knowledge of Parenting and Child Development:

102. DISCIPLINE - Discipline is defined as all parenting behaviors and strategies that support positive behavior in children.

0	Parent/caregiver generally demonstrates an ability to discipline her/his children in a consistent and respectful manner. Parent/caregiver's expectations are age-appropriate and he/she usually is able to set age appropriate limits and to enforce them.
1	Parent/caregiver is often able to set age appropriate limits and to enforce them. On occasion her/his interventions may be too harsh, too lenient, or inconsistent. At times, her/his expectations of her/his children may be too high or too low.
2	Parent/caregiver demonstrates limited ability to discipline his/her children in a consistent and age-appropriate manner. She/he rarely is able to set age appropriate limits and to enforce them. Her/his interventions may be erratic and overly harsh but not physically harmful. Her/his expectations of her/his children are frequently unrealistic.
3	Significant difficulties with discipline methods. Parent/caregiver disciplines her/his children in an unpredictable fashion. There is either an absence of limit setting and disciplinary interventions or the limit setting and disciplinary interventions are rigid, extreme, and physically harmful (such as shaking the child, whipping, etc.).

104. DEMONSTRATES EFFECTIVE PARENTING APPROACHES - This item refers to the parent/caregiver's knowledge of parenting skills and strategies and his/her ability to actually use these skills and strategies with his/her child(ren).

0	Parent/caregiver(s) applies flexibility in parenting role; parent has knowledge of multiple parenting practices and is able to implement them effectively with his/her children in a manner that is consistent with the child's development and needs.
1	Parent/caregiver(s) has knowledge of parenting practices that are consistent with child's needs and development, but may struggle at times to effectively implement them.
2	Parent/caregiver has limited flexibility and/or knowledge of parenting practices; parenting practices are seldom effective and/or consistent with child's development and needs.
3	Parent/caregiver(s) is extremely limited in his/her understanding of parenting practices. May be very concrete or rigid in his/her approach to child rearing.

Identification and Use of Concrete Supports in Times of Need:

107. FINANCIAL STATUS - This item refers to the family's income regardless of its source in comparison to the family's financial needs.

0	Family has financial resources necessary to meet needs or has limited resources but is effectively utilizing those to meet needs.
1	Family has financial resources necessary to meet most needs; however, some limitations exist.
2	Family has financial difficulties that limit their ability to meet significant family needs.
3	Family is experiencing financial hardship that has made them unable to meet family needs.

Positive Family, Community and Social Connections:

113. PARTNER RELATIONS - This item refers to the parent/caregiver's relationship with another adult. If married, this refers to the parent/caregiver's husband or wife.

0	Parent/caregiver has a strong, positive, partner relationship with another adult. This adult functions as a member of the family. A person without a relationship who currently has no interest in one would be rated here.
1	Parent/caregiver has a generally positive partner relationship with another adult. This adult may not function as a member of the family.
2	Parent/Caregiver's current relationship causes distress that may interfere with parent/caregiver functioning.
3	Parent/caregiver is currently involved in a negative, unhealthy relationship with another adult. This would also include a parent/caregiver involved in a relationship with domestic violence issues.

116. NATURAL SUPPORTS - Natural supports refer to help that one does not have to pay for. This could include friends and families or a church or other organization that helps the family in times of need.

0	Parent/caregiver(s) has substantial natural supports to assist in addressing most family and child needs.
1	Parent/caregiver(s) has natural supports but some limitations exist whereby these supports are insufficient to address some family and child needs.
2	Parent/caregiver(s) has limited natural supports.
3	Parent/caregiver(s) has no natural supports.

Ability to Nurture Social and Emotional Competence of Children:

118. PARENT/CAREGIVER'S UNDERSTANDING OF IMPACT OF OWN BEHAVIOR ON CHILDREN - This item is intended to describe the degree to which a parent/caregiver has self-awareness regarding how his/her actions and behavior affect his/her children.

0	Parent/caregiver(s) has a clear understanding of the impact of his/her behavior on children and is able to adjust behavior to limit negative impact.
1	Parent/caregiver(s) has some understanding of impact of his/her behavior but may struggle at times to change behavior to limit negative impact.
2	Parent/caregiver(s) has limited understanding of the impact of his/her behavior on children.
3	Parent/caregiver(s) has no understanding or denies any impact of his/her behavior on children.

119. EMPATHY WITH CHILDREN - This item refers to the parent/caregiver's ability to understand and respond to the joys, sorrows, anxieties and other feelings of children with helpful, supportive emotional responses.

0	Adaptive emotional responsiveness. Parent/caregiver is emotionally empathic and attends to child's emotional needs.
1	Parent/caregiver is generally emotionally empathic and typically attends to child's emotional needs.
2	Limited adaptive emotional responsiveness. Parent/caregiver is often not empathic and frequently is not able to attend to child's emotional needs.
3	Significant difficulties with emotional responsiveness. Parent/caregiver is not empathic and rarely attends to the child's emotional needs.

Factors Contributing to Parent/Caregiver Resilience:

121. PHYSICAL HEALTH - Physical health includes medical and physical challenges faced by the parent/caregiver(s).

0	Parent/caregiver(s) has no physical health limitations that require assistance or impact childcare.
1	Parent/caregiver (s) has some physical health limitations but they do not require assistance or interfere with ability to care for the child at this time.
2	Parent/caregiver (s) has significant physical health limitations that make difficult or prevent them from being able to care for the child without immediate assistance.
3	Parent/caregiver(s) is physically unable to provide care or assistance to the child as needed.

122. MENTAL HEALTH - This item refers to the parent/caregiver's mental health status. Serious mental illness would be rated as a '2' or '3' unless the individual is in recovery or successfully managing illness.

0	Parent/caregiver (s) has no mental health limitations that require assistance or impact childcare.
1	Parent/caregiver (s) has some mental health limitations but they do not significantly interfere with ability to care for the child at this time.
2	Parent/caregiver(s) has significant mental health limitations that make difficult or prevent them from being able to care for the child without immediate assistance.
3	Parent/caregiver (s) is unable to provide any needed assistance or attendant care to child due to serious mental illness.

123. SUBSTANCE USE - This item rates the parent/caregiver's pattern of alcohol and/or drug use. Substance-related disorders would be rated as a '2' or '3' unless the individual is in recovery.

0	Parent/caregiver (s) has no substance-related limitations that impact or impair parent/caregiving ability and childcare.
1	Parent/caregiver (s) has some substance-related limitations that interfere or may interfere with parenting ability and childcare.
2	Parent/caregiver (s) has significant substance-related limitations that make difficult or prevent them from being able to parent and care for their child without assistance.
3	Parent/caregiver (s) is unable to provide any needed assistance or childcare due to serious substance dependency or abuse.

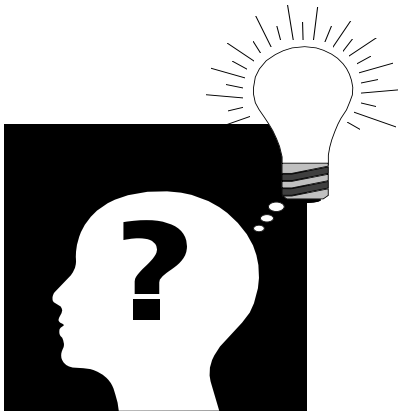
124. DEVELOPMENTAL - This item describes the parent/caregiver's developmental status in terms of low IQ, mental retardation or other developmental disabilities and the impact of these conditions on his/her ability to care for child.

0	Parent/caregiver (s) has no developmental limitations that impact childcare.
1	Parent/caregiver (s) has some developmental limitations that interfere or may interfere with his or her ability for childcare at this time.
2	Parent/caregiver (s) has significant developmental limitations that make difficult or prevent them from being able to parent and care for their child without assistance.
3	Parent/caregiver (s) is unable to provide any needed assistance or childcare due to serious developmental disabilities.

Licensure Exam Practice

In this section are fifteen multiple-choice questions that are written in the style of the licensure exam. These questions are selected from the Foundational Knowledge, Safety and Well-Being, and Coordination of Services sections of the Study Guide. The answers appear at the end of this section.

Questions



1. Attachment is one of the essential concepts of human behavior. Which of the following is **not** correct?
   a. The process of attachment continues throughout the life cycle.
   b. In the normal process of attachment, there are a limited number of attachments people can develop.
   c. Children form attachments to parents, even when needs are not adequately met.
   d. Attachment-disordered children are often severely withdrawn and depressed or very destructive and aggressive.

2. When dealing with clients from different cultures, child welfare professionals need to:
   a. recognize that discrepancies about time can be legitimate cultural differences.
   b. address clients as Mr., Ms., or Mrs. until given permission to use first names.
   c. recognize that handshakes are intimate in some cultures and casual in others.
   d. All of the above.

3. In the delivery of child welfare services, it is the responsibility of the child welfare professionals to understand the organizational structure of DCFS because:
   a. the child welfare professional should know and be able to access information for children and families to guide them through the system.
   b. it will be helpful in the child welfare professional's next annual review.
   c. the supervisor will expect the child welfare professional to know the DCFS structure.
   d. it is always important for the child welfare professional to know the chain of command.

4. The Inter-ethnic Placement Act of 1996 (IEPA) is federal legislation intended to promote the best interests of children by:
   a. decreasing the length of time that children wait to be adopted.
   b. preventing discrimination in the placement of children with families, based on race, color, or national origin.
   c. facilitating the identification and recruitment of foster families and adoptive families that are able to meet children's needs.
   d. All of the above.

5. The best interest of the minor:
   a. is the legal standard used by judges to decide if children should be removed from home for their own protection.
   b. is a standard judges use in making decisions about children's welfare in abuse, neglect, and dependency cases.
   c. governs the majority of court actions concerning children and their families.
   d. is a standard used by professionals who take temporary custody.

6. "Safety" differs from "risk" in that:
   a. safety concerns are now or in the near future, while risk is longer term.
   b. safety concerns should be addressed with interventions, while risk is only documented and observed.
   c. only safety can be controlled by family strengths or mitigating circumstances.
   d. risk situations typically change more rapidly than safety concerns.

7. People who are in the chronic stage of chemical dependency will often display the following symptoms:
   a. decreased tolerance of drugs; long periods of intoxication; physical, mental, and moral deterioration; vague spiritual desires; exhaustion of excuses.
   b. increase in tolerance of drugs; blackouts; guilt; preoccupation with using drugs.
   c. admission of defeat; seeking treatment; investment in treatment; rebuilding family.
   d. aggressive, grandiose behaviors; repeated failures to control drug use; protection of drug supply; avoidance of family, friends; self-pity.

8. The four major steps in the assessment process are information gathering, _____, drawing conclusions, and decision-making.
   a. information analysis
   b. relationships with the media
   c. outreach programs
   d. preparing reports

9. Which of the following are necessary components of interview preparation for the child welfare professional?
   a. provision of comfortable and confidential settings
   b. an evaluation of personal prejudices, attitudes, and emotions
   c. determination of tentative interview goals, time available, and strategies to accomplish the goals.
   d. All of the above.

10. Which type of questions allows the client a variety of responses, expressions of fact, and feelings and concerns?
   a. leading questions
   b. closed-ended questions
   c. multiple questions
   d. open-ended questions

11. Among reasons why child welfare professionals may consider filing for expedited termination of parental rights is:
    a. child neglect
    b. abandonment of newborns in a hospital where evidence suggests parents intended to relinquish parental rights
    c. abandonment of children to the care of relatives for a period of six months or more
    d. the custodial parent has been charged with aggravated sexual assault

12. A family circumstance that is indicative of a "poor prognosis" case is:
    a. single severe incident of abuse/neglect
    b. a history of failing to correct conditions which resulted in maltreatment of children.
    c. parents have other children for whom parental rights were involuntarily terminated, and there has not been significant change in behavior or conditions in the interim.
    d. all of the above.

13. Family systems theory is based on all of the following, except:
    a. regular interaction over time
    b. repetitive patterns of behavior
    c. disconnectiveness to others
    d. maintaining routines

14. Research indicates that the single most significant factor in achieving family reunification is the:
    a. amount of contact the child welfare professional has with the child and family.
    b. proximity of the foster home to the child's family home
    c. frequency, consistency and quality of parent-child visitation
    d. successful completion of parenting classes

15. Documentation is one of the cornerstones of permanency planning. Ongoing case notes should not reflect:
    a. progress towards permanency goals.
    b. important facts, discussions, case events, and observations that affect important decisions.
    c. work with other staff and providers on behalf of families.
    d. bias and opinions of the child welfare professional.

Answers:

1. b
2. d
3. a
4. d
5. b
6. a
7. a
8. a
9. d
10. d
11. b
12. d
13. c
14. c
15. d