



**Office of Children  
and Family Services**

# **Preventive Services Practice Guidance Manual**

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**Office of Children  
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## Chapter 1

# What are Preventive Services?

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Preventive services strengthen families: they help parents and caregivers provide an environment where children can thrive. Like preventive health care, these services address early symptoms of family problems that, if left untreated, may result in a breakdown of the family unit.

According to New York State Social Services Law ([SSL §409](#)), preventive services are supportive and rehabilitative services that are provided to children and their families for the purpose of:

- Averting an impairment or disruption of a family which will or could result in the placement of a child in foster care;
- Enabling a child who has been placed in foster care to return to his family at an earlier time than would otherwise be possible; or
- Reducing the likelihood that a child who has been discharged from foster care would return to such care.

Generally, preventive services are provided to families with children under the age of 18, because only children under 18 may be at risk of placement into foster care. There are two significant exceptions:

- Preventive housing services may be provided to a youth with the goal of discharge to another planned living arrangement with a permanency resource, who is to be discharged from foster care prior to his/her 18<sup>th</sup> birthday, or who will be placed in trial discharge status after his/her 18<sup>th</sup> birthday. In these cases, services end when the youth reaches age 21.
- Preventive services must be provided to a youth who requests to re-enter foster care when such services may prevent the youth returning to care. Former foster care youth may be returned to foster care if they file a motion in court within 24 months of the date of their first final discharge. Preventive service providers should evaluate youth before they reach the 24-month mark to determine the effectiveness of Preventive Services in meeting their needs [[11-OCFS-ADM-02](#)].

Preventive services may be provided directly by the local social services district (LDSS) or by another agency that is authorized and approved to provide a program of preventive services [[NYCRR 423.2\(a\)](#)].

## Preventive services and child welfare

As child welfare professionals, we believe that every child deserves to be protected from harm in a stable, nurturing environment. Our goals for all children are safety, permanency, and well-being. Preventive services play a crucial role in achieving these goals, as they are designed to improve the well-being of the family as a whole and the safety and security of the children in those families.

In New York State, families usually come into the child welfare system because a report of child abuse or maltreatment has been made. According to national statistics, about one third of the cases investigated by CPS are substantiated. Of these cases, more than half will be eligible for preventive services because the children are at risk for placement into foster care. Even when abuse or maltreatment is *not* substantiated,

30% of cases will involve children who are at risk for placement into foster care.<sup>1</sup> Clearly, culturally and linguistically competent preventive services can have a significant impact on stopping a downward spiral.

A child or family may be eligible for either **mandated** or **non-mandated** preventive services, depending on the level of risk for a child's placement into foster care. A child or family is eligible for mandated preventive services when the risk of placement is immediate or imminent.

Non-mandated preventive services are provided at the discretion of the local social services department when children are at risk of placement into foster care but that risk is not immediate or imminent. The case manager must determine that the risk will be reduced if the family receives one or more of the preventive services available to them.

When children live in particular communities or have circumstances that put them at elevated risk of placement into foster care, they and their families can be referred for Community Optional Preventive Services.

## Mandated Preventive Services

New York State Social Services Law [SSL 409-a(1)] addresses when preventive services are mandated. As set forth in OCFS regulation [18 NYCRR 423.3](#), the eligibility criteria for mandated preventive services are defined in OCFS regulation [18 NYCRR 430.9](#). To be eligible for mandated preventive services, the case must satisfy these eligibility criteria. These standards are detailed in **Chapter 2** of this manual.

When a child and his/her family meet the eligibility requirements for mandated preventive services, the LDSS or voluntary agency determines which service is available, appropriate and necessary to meet the needs of the child or family. OCFS regulation [18 NYCRR 423.4\(d\)\(1\)](#) requires that each LDSS have specified core services available. Core services include:

- Day care
- Homemaker services
- Parent training or parent aide
- Clinical services
- Transportation
- Respite Care and Services for Families when a parent, legal guardian, caretaker, or child has HIV/AIDS or an HIV-related illness
- Emergency services (24-hour access)
- Preventive housing services

Preventive services must be provided to eligible families, as determined by LDSS or voluntary agency, regardless of income, but only when a family agrees to accept them. Families may refuse to accept services, but if there is a risk to children's health or safety, further action by Child Protective Services may be needed.

Preventive services can be provided directly by LDSS staff or by a contracted preventive services agency. The agency does not need to be located within the district: the key is the availability and

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<sup>1</sup> U.S. Department of Health and Human Services (2008), *Child Maltreatment 2006*, Washington: U.S. Government Printing Office

accessibility of the service, should it be needed. The local district may improve accessibility by providing transportation for family members.

Preventive services funds also can be used for outreach activities designed to publicize the existence and availability of preventive services for parents, caretakers, and children who meet the criteria for the provision of preventive services and to advise such parents, caretakers and children of the availability of such services to meet their needs, alleviate the cause or condition that creates the risk of foster care placement, and to assist the family to stay together. These outreach activities are for the purpose of identifying parent service needs and child services needs [18 NYCRR 432.2(b)(18)].

## **Mandated-only preventive services**

Three services may be provided only in cases that are eligible for mandated preventive services:

- Intensive, Home-Based Family Preservation Services
- Preventive Housing Services
- Respite Care and Services for Families

Each of these services has requirements and specifications **in addition to** the eligibility standards set for mandated preventive services. They cannot be provided as non-mandated preventive services.

### ***Intensive, Home-Based Family Preservation Services***

As defined in OCFS regulation [18 NYCRR 423.2(17)(i)], these services are part of a direct intervention designed to restore or stabilize family functioning, primarily through teaching and role modeling, to give parents the skills to resolve conflict and seek out help.

Intensive family preservation services are provided over a brief period of time. The initial period is up to 30 days, with the possibility of a 30-day extension when necessary to maintain the progress already achieved or to avoid the foster care placement of children. The caseworker must be available to the family on a 24/7 basis in order to establish a relationship between the caseworker and the family. At least half of these services must be provided in the family's home. While state law [SSL 409-a(5)(e)(ii)] requires that a caseworker be assigned no more than four families at a time, the optimum caseload for intensive family preservation services is two or three families.

On behalf of the family, the caseworker providing intensive services also may arrange for:

- Housing assistance
- Child care
- Job training
- Education
- Emergency cash grants
- Basic support

### ***Preventive Housing Services***

A child or family may be eligible for preventive housing services when the LDSS determines that:

- Inadequate housing makes it difficult or impossible for parents or caretakers to meet the basic needs of the family, which, along with a service need other than adequate housing, places the child at imminent risk for placement in foster care
- Inadequate housing is the primary factor preventing the discharge of a child from foster care and returning home
- Inadequate housing is preventing a child from being discharged to a planned living arrangement with a permanency resource
- Inadequate housing is preventing a youth from being discharged to independent living

Preventive housing services are provided when a family needs financial assistance to afford or retain appropriate housing in order to care for a child. This may include providing more space to accommodate the child or upgrading the condition of a house or apartment so the child can live there safely.

According to Social Services Law [\[SSL 409-a\]](#), preventive housing services include cash grants in the form of rent subsidies, including payment of rent arrears, or any other assistance necessary to obtain adequate housing. In addition to rent subsidies, preventive housing services may also include:

- Rental or mortgage arrears when they place the family at risk of losing its home
- Security deposits necessary to obtain or retain a house or apartment
- Finder's or broker's fees incidental to locating adequate housing
- Household moving expenses to allow a move from inadequate to adequate housing
- Exterminator fees, as necessary to obtain or retain adequate housing
- Essential repairs of conditions that create a substantial health or safety risk

The preventive housing services rent subsidy is to be paid in addition to any other payments or benefits received by the family. Payments for preventive housing services are made directly to the landlord, mortgage holder, exterminator, or contractor responsible for repairs.

The amount paid for a rent subsidy is based on the Fair Market Rent for that geographic area, which is published annually in the *Federal Register* [\[96-LCM-071\]](#). Other factors also influence the subsidy amount, such as financial need and other types of assistance being received by the family.

When housing services are the only preventive service received by the family, reduced casework contact requirements apply. In such cases, there must be at least one in-home casework contact within the first six months, at least one contact at the time of each Reassessment and Service Plan Review, and one contact within the last 60 days before preventive housing services are terminated.

### ***Respite Care and Services for Families***

Respite Care and Services for Families are provided as brief and temporary care and supervision of children [\[18 NYCRR 435.4\]](#). They are provided in order to relieve parents of the care of children during a time when it has become difficult for them to maintain an adequate level of care. The need for respite care may result from an unexpected demand on the family or a sudden deterioration in family relationships. For the purposes of these services, "parents" include biological or adoptive parents, stepparents, legal guardians, or caretakers with the authority and responsibility to care for a child.

Respite care and services may be provided as needed which may include periods of less than 24 hours [\[18 NYCRR 435.5\(a\)\]](#). Respite care and services for families may be provided for families for up to a

maximum of 21 consecutive days at a time, except when a parent is participating in a substance abuse detoxification treatment program, respite care and services for families may be provided for up to a maximum of 30 consecutive days at a time.

A period of seven consecutive days must elapse before respite care and services may be provided to a family which has previously received such care and services. Respite care and services may be provided to each family or foster family for a maximum of seven weeks in any calendar year.

Some examples of situations in which respite care and services may be provided:

- Sudden hospitalization of a parent
- Accumulation of stress on the parent/caregiver from caring for a severely handicapped, emotionally disturbed, or terminally ill child
- Referral of a child to the Probation Service or a designated assessment service for Person in Need of Supervision (PINS) Adjustment Services
- A parent's participation in a substance abuse detoxification program

Parents or caretakers must agree to the provision of respite care and services. They have the right to reject the services or the proposed provider of services.

## Community Optional Preventive Services (COPS)

Community Optional Preventive Services (COPS) are a subset of the broader category of Preventive Services. COPS are intended to help families where placement is not immediate or imminent, but where youth and/or families are living in particular communities or have other conditions or circumstances that put them at an elevated risk of foster care. COPS cases do not require individual eligibility determinations or the establishment of uniform case records for the child and family, as required for mandated and non-mandated preventive services cases.

COPS programs are used more frequently in some counties and localities than others, and are identified and used at the discretion of the local social services department. COPS programs must be approved by OCFS. For a COPS proposal to be approved, the LDSS must submit a plan to OCFS that describes the program, specifies the target population in need, and demonstrates that the population is at an elevated risk of foster care but not at immediate or imminent risk of out-of-home placement.

Although individual eligibility determinations are unnecessary, there must be an acceptable method for determining whether a case is below or over 200 percent of the federal poverty level, consistent with criteria outlined in Chapter 3 of the OCFS *Eligibility Manual for Child Welfare Programs*.

COPS includes a wide range of services, such as home visiting programs, mental health services, respite, day treatment programs, after-school and summer programs, PINS/JD diversion, family engagement, mediation services, relative/kinship assistance, mentoring programs, alternatives for youth, parenting education, transitional support, and youth court. Caseworkers should know about any COPS programs available in their districts and the types of services provided.<sup>2</sup>

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<sup>2</sup> Note: COPS funding is available only to programs that were approved as of Oct. 1, 2008.

## Nondiscrimination

As described in NYS regulation, “staff and volunteers of agencies providing preventive services are prohibited from engaging in discrimination or harassment of families receiving preventive services on the basis of race, creed, color, national origin, age, sex, sexual orientation, gender identity or expression, marital status, religion, or disability. Such agencies must promote and maintain a safe environment, take reasonable steps to prevent discrimination by staff and volunteers, promptly investigate incidents of discrimination and harassment, and take reasonable and appropriate corrective or disciplinary action when such incidents occur.

“Gender identity or expression means having or being perceived as having a gender identity, self-image, appearance, behavior or expression whether or not that gender identity, self-image, appearance, behavior or expression is different from that traditionally associated with the sex assigned to that person at birth. Gender identity refers to a person's internal sense of self as male, female, no gender, or another gender, and gender expression refers to the manner in which a person expresses his or her gender through clothing, appearance, behavior, speech, or other means.”

[\[18 NYCRR 423.4\(m\)\(7\)\]](#)

## Reasonable efforts

Laws at both the federal and state levels contain provisions that require local social services districts and child welfare agencies to make “reasonable efforts” to avoid placement of children into foster care.

Where the permanency goal is reunification, local social services districts and child welfare agencies must also make reasonable efforts to eliminate the need for placement of the child and to enable the child to safely return home. Where reunification is not the permanency goal, districts and agencies must make reasonable efforts to finalize the alternative permanency placement plan.

## Legal requirements

New York State Social Services Law [\[SSL §358-A\(2\)\]](#) specifically requires any agency seeking court approval for a voluntary foster care placement to describe what was done to prevent or eliminate the need for removal of the child from the home. This includes outreach to all maternal and paternal family resources that could promote safety, permanency, and well-being for children. The court must make a finding that reasonable efforts were made before it approves the voluntary placement agreement.

Similar requirements apply to children whose removal from the home is sought in order to protect them [\[FCA §§1022 and 1052\(b\)\]](#) and to a child's removal from his/her home as a juvenile delinquent [\[FCA §§307.4 and 352.2\(2\)\(b\)\]](#) or a Person in Need of Supervision [\[FCA §§728 and 754\(2\)\]](#). The requirement that the court make a reasonable efforts determination also applies where the child was removed without a court order based on imminent danger [\[FCA §1028\]](#).

While what constitutes “reasonable efforts” is not defined in law, the intent of the requirement is clear. It is designed to see that, where appropriate, families are provided culturally and linguistically competent services to prevent their disruption or to repair a disruption when placement has already occurred. Where reunification is not the child's permanency goal, reasonable efforts must be made toward the alternative permanency goal. Compliance also requires that efforts are made to provide services that will effectively meet the child's and family's needs, rather than the services that are most readily available. Each family must be assessed to determine appropriate services and a reasonable effort must be made to obtain those services for the family.

## Preventive services as reasonable efforts

Preventive services are provided in order to prevent the removal of children from their homes or to reunite a family after a child's placement in foster care. Provision of such services clearly is a "reasonable effort" required by law.

Preventive services are not the only resources available to meet the requirement, however. Depending upon the child's and family's circumstances, reasonable efforts can include public assistance, medical assistance, and services provided by other agencies such as those operated or supervised by the Office of Mental Health, the Office for People With Development Disabilities, or the Office of Alcohol and Substance Abuse Services.

There are also situations in which reasonable efforts are not required. State regulations [[18 NYCRR 430.10\(b\)\(1\)](#)] list allowable exceptions to the requirement that preventive services must be provided (or at least offered) prior to any action to place a child in foster care. These exceptions include:

- The offer of preventive services has been refused by the parent or caretaker
- The child's placement is the result of a court order
- The placement is an emergency placement to protect the health and safety of the child
- The parents or caretakers are dead
- The whereabouts of the parents or caretakers is not known
- The parents are absent and their absence is anticipated to be longer than six months
- The child has been placed in a facility operated or supervised by the Office of Mental Health or the Office for People With Developmental Disabilities

There also may be situations where additional efforts will not prevent the removal of the child from the home. For example, parents may be adamant about having the child removed from their home and refuse to cooperate in the effort to provide supportive services. Or, removal from the home may be a necessary protective measure because the child's behavior is a serious danger to the safety of him/herself or others in the home. While services must be offered even in these cases, the situations are so severe that there is little likelihood that other "reasonable efforts" can be made.





## Chapter 2

# Eligibility for Preventive Services

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To determine whether a child and/or family is eligible to receive preventive services, the family's situation must be assessed to determine whether it meets one of the requirements provided in New York State law [[SSL 409-a\(1\)](#)]. The law stipulates that services must be provided when:

- The child is at imminent risk of placement into foster care
- The child is at risk of re-placement into foster care
- The child may be returned to parent(s), relative(s), or legal guardian(s) ahead of schedule
- The child has been placed in an Emergency Foster Family Boarding Home

In addition to these requirements defined by law, there are a number of eligibility criteria set forth in OCFS regulations [[18 NYCRR 430.9](#)] that must be considered when deciding whether a family is eligible for specific, mandated preventive services.

The primary difference between mandated and non-mandated preventive services is the degree of risk of the child's placement or re-placement in foster care. In general, non-mandated services are provided when there is some level of risk, but the possibility of placement is not immediate. They are provided when the child's placement into foster care is a long-term possibility that can be averted by the provision of culturally and linguistically competent services [[18 NYRCC 423.3\(b\)](#)].



### Documentation

The specific reasons why a family is eligible for preventive services must be documented in the case record. See **Appendix A** of this manual for details on how to document for each standard.

The standards in this chapter must be applied to the circumstances of the case. For each case, these questions must be considered:

- Is the child/family eligible for mandated preventive services?
- What specific services are needed to prevent placement, avoid re-placement, or allow a child to return to his/her parents?
- Is the child/family eligible for non-mandated preventive services?

## Mandated preventive services

To be eligible for mandated preventive services, a family must meet at least one of the requirements stipulated by law and described at the beginning of this chapter. In addition, in order for a child or family to be eligible for mandated preventive services, their circumstances must meet the eligibility criteria for mandated preventive services defined in OCFS regulation [18 NYCRR 430.9](#). These circumstances must be identified and documented in the Family Assessment and Service Plan (FASP) and case record.

## Eligibility criteria

### ***Children at risk of placement in foster care***

If **one or more** of these circumstances exist, the child is considered to be at imminent risk of placement into foster care.

#### **1. Health and safety of the child** [18 NYCRR 430.9(c)(1)(i)]

This standard recognizes that a primary target group for preventive services is families in which there have been incidents of child abuse or maltreatment. Where such incidents have been indicated in a Child Protective Services (CPS) investigation, efforts must be made to preserve the family and prevent foster care placement. A case is not opened for preventive services solely on the basis of an **allegation** of child abuse or maltreatment.

If, however, in the course of a CPS investigation, another reason for providing preventive services emerges, services should begin for that reason before the investigation is complete. The investigation must show:

- a. Serious, non-accidental physical injury or the risk of such injury to the child; or
- b. Serious impairment of the child's physical, mental, or emotional condition or risk of such impairment resulting from a parent's or caretaker's failure to exercise a minimum degree of care; and
- c. These conditions have occurred within the previous 12 months; and
- d. Actions by the parent or caretaker have resulted in a CPS determination that an allegation of abuse or maltreatment is indicated.

#### **2. Parental refusal** [18 NYCRR 430.9(c)(2)(i)]

This standard applies when parents or caretakers have refused to maintain the child in the home or have expressed an intention of surrendering the child for adoption.

#### **3. Parental unavailability** [18 NYCRR 430.9(c)(3)(i)]

This standard is used when the child's parents or current caretakers have become unavailable due to:

- a. Hospitalization;
- b. Arrest, detainment, or imprisonment;
- c. Death; or
- d. Their whereabouts are unknown.

When a parent or caretaker is hospitalized or arrested, children in the home may be in imminent danger of being placed in foster care. Preventive services can allow a family to remain together during a short-term unavailability of the parent or caretaker. In the event of a death or disappearance of a parent or caretaker, preventive services may allow enough time for a relative or family friend to be located who is willing to care for the child on a permanent basis.

#### **4. Parent service need** [18 NYCRR 430.9(c)(4)(i)]

This standard applies when a parent or caretaker has a condition that impairs his/her ability to care for the child. This may include alcoholism, drug abuse, mental illness, or any other impairment that hinders the person's ability to parent. It also may include a financial condition that makes it difficult

or impossible for the parent or caretaker to provide adequate housing or meet other basic family needs.

Lack of adequate housing, including homelessness, may be an indicator of risk of placement into foster care, but does not in itself constitute a basis for placing a child in care. In addition, inadequate housing alone does not establish eligibility for mandated preventive services. It must also be shown that this condition has impaired the parent's or caretaker's ability to care for the child and results in a risk of serious physical or emotional harm to the child.

#### **5. Child services needs [18 NYCRR 430.9(c)(5)(i)]**

This standard is used when a child has special needs for supervision or services that cannot be adequately met by parents or caretakers without intensive services, resulting in the child being at risk of foster care placement without such services. Unlike the Parent Service Need standard, this standard is based on the **child's** behavior or condition and not on the parent's or caretaker's inadequacy or difficulty in dealing with the behavior or condition. This need for services is the result of **one** of the following:

- a. The child has a diagnosed or diagnosable physical, mental, or emotional condition which severely impairs the child's ability to carry out daily, age-appropriate activities
- b. The child's behavior, although not dangerous, results in severe management problems in the home, the school, or the community
- c. The child's behavior presents a serious danger to other people or to the child him/herself
- d. The child is the subject of a petition under Article 7 (proceedings concerning Persons in Need of Supervision, or PINS) of the Family Court Act, or has been determined by an assessment service or by the probation service to be at risk of being the subject of such a petition, and one of the following conditions applies:
  - i. The family would have been eligible for preventive services at some time in the past, if application had been made;
  - ii. A child in the family has been placed in foster care at some time in the past;
  - iii. The child's behavior leading to the filing of the petition or to the risk of such filing is similar to the behavior described in (b.) but is less severe and this behavior has been exhibited over a period exceeding six months; or
  - iv. The family, or some member of the family has in the past or is currently receiving services from the social services district, the local mental health or developmental disabilities agency, the probation service, or the youth board for at least six months. The services which are or have been provided by the social services district must be those services which are set forth in the district's consolidated services plan.
- e. The child has been diagnosed as having AIDS, HIV-related illness, or HIV infection. The condition which results in such diagnosis must impair the child's ability to carry out daily, age-appropriate activities or result in a need or supportive services, other than medical or health-related services, to allow the parents or caretakers to maintain the child in their home.

#### **6. Pregnancy [18 NYCRR 430.9(c)(6)(i)]**

This standard applies when a mother is pregnant or has given birth and has shown an inability to provide adequate care for her unborn or infant child. This is the **only** situation when preventive services may be provided where there is no child in the family.

### ***Children at risk of re-placement in foster care***

Preventive services are mandated when these services are essential to avoid the re-placement of the child into foster care. **The standards include all of those that apply to children at risk of placement.** In addition, three other circumstances may establish eligibility for mandated preventive services. These conditions apply only to children at risk of re-placement:

#### **1. Family court contact** [18 NYCRR 430.9(d)(1)(i)]

The child is the subject of a juvenile delinquency or PINS petition, or has been determined by the Family Court Intake or Family Court Probation Service to be at risk of being the subject of such a petition. Unlike the Child Services Needs standard, Family Court contact alone is sufficient for a child to be at risk of re-placement.

#### **2. Unplanned discharge** [18 NYCRR 430.9(d)(2)(i)]

The child has been discharged from foster care within the two years immediately prior to the date of application for services **and** that discharge took place at least three months prior to the anticipated discharge date and without the achievement of all the goals set forth in the Service Plan. Both the conditions must be met – the time limit *and* the unplanned nature of the discharge.

#### **3. Recurrence of reason for placement** [18 NYCRR 430.9(d)(3)(i)]

The child, parents, or caretakers have exhibited a pattern of behavior or a condition which is substantially similar to one or more of the behaviors or conditions which contributed to the child's previous placement in foster care and which is likely to lead to the necessity of re-placement of the child. The behaviors and conditions referred to in this standard include all of the standards for risk of placement. Because of the previous placement history, however, this standard allows for the provision of mandated preventive services **before** problems reach the severity required for placement into foster care.

### ***Children who may be returned to their parents from foster care***

Preventive services, other than preventive housing services, are mandated when they will allow a child to be returned to his/her parents from foster care sooner than would otherwise be possible [18 NYCRR 430.9(e)]. **All** of the following conditions must be met for the family to be eligible.

#### **1. Service appropriateness**

Preventive services must be directly related to one or more of the reasons the child is currently in foster care. The most recent Family Assessment and Service Plan must show how specific preventive services relate to one or more documented reasons for the child's placement into foster care.

#### **2. Discharge plan**

Discharge of the child from foster care must be anticipated within six months. The case record must show the anticipated discharge date with the appropriate services and include a plan for discharge that meets the goals set forth in the most recent Service Plan.

#### **3. Safety and appropriateness**

Returning the child to parents or caretakers may only occur when placement will be safe and appropriate. The most recent Family Assessment and Service Plan must include a written

consideration and determination that the child's return to his/her parents or caretakers will be safe and appropriate.

### ***Child placed in emergency foster family boarding home care***

Preventive services must be provided to the family when a child is placed in a designated emergency foster family boarding home and is expected at the time of placement to return home **within 60 days** [18 NYCRR 430.9(i)]. If the child does not return home within 60 days, preventive services are no longer considered to be mandatory, unless the child meets another eligibility requirement.

Preventive services are also mandated as a **follow-up** for children discharged from emergency foster family boarding home care [18 NYCRR 430.9(j)]. These are provided for six months (including the time the child was in the emergency foster family boarding home) if the child returns home within 60 days.

### ***Preventive services ordered by the Family Court***

The provision of preventive services as the result of a court order arises from two possible circumstances [18 NYCRR 430.9(g)]. The court may specifically direct the provision of preventive services, or a court order for placement in foster care has been stayed or reversed upon an appeal or a request for a rehearing. In abuse or neglect proceedings, the court may order LDSS to provide preventive services in accordance with [FCA §1015-a](#) to the extent that such services are reflected in the LDSS's comprehensive annual services program plan.

An example: the court may find that the LDSS has failed to show that reasonable efforts were made to provide preventive services to a family and avoid the placement of a child in foster care. This finding may result from a proceeding involving a voluntary placement, protective placement, or PINS petition. After such a finding is made, the court may order that preventive services be provided in an effort to avoid placement and restore family functioning.

A court also may order the provision of preventive services in response to a petition to terminate parental rights. If the court finds that the agency has not made diligent efforts to preserve the family, it may order preventive services in an effort to restore family functioning. The court does not have to specify the types of preventive services to be provided.

## **Mandated-only preventive services**

Three services are limited to provision as mandated preventive services only. Each of these services has requirements and specifications for their provision that are in addition to the eligibility standards for mandated preventive services.

### **Preventive housing services**

Preventive housing services can be provided only as mandated preventive services and only to families who meet the eligibility criteria. They may not be provided as non-mandated preventive services or COPS.

#### ***To prevent placement in foster care***

Preventive housing services can be provided to families under the "Parent Service Need" standard when necessary **to prevent the placement of a child in foster care** [18 NYCRR 430.9(c)(4)], along with the standards set forth in [SSL §409-a\(7\)](#), which require that the family have at least one service need other than lack of adequate housing.

### ***To expedite discharge from foster care***

Preventive housing services are also considered to be mandatory preventive services when subsidies are needed to **expedite a child's discharge from foster care** and when the following conditions are met [[18 NYCRR 430.9\(e\)\(2\)](#)]:

#### **1. Service appropriateness**

At the time housing services are authorized, the case manager must determine that the **primary factor** preventing the discharge of the child from foster care is the family's lack of adequate housing.

Such determination requires documentation that the child is expected to be discharged from care within two months. The child must have been in foster care for at least 30 days and can be safely returned to his/her parents or caregivers if housing services are provided. Or, it can be documented that the child has been in foster care for any length of time, his/her family has moved to inadequate housing since the child's placement, and the child can be safely returned to his/her parents or caregivers if housing services and any other available preventive service are provided. Inadequate housing is indicated when a family:

- is homeless;
- is living in temporary housing such as a shelter or hotel;
- is residing in a home, room and board situation, or with friends or relatives and the return of the child would exceed the capacity of the residence according to local laws and regulations;
- has a home, but is at imminent risk of losing the home because of past due rent or mortgage payments;
- is living in a building that is subject to a vacate order; *or*
- is living in a home that poses a health and safety risk that would place the child at imminent risk of harm.

#### **2. Discharge plan**

Preventive housing services may be authorized and payments made before children are discharged, but discharge must occur no later than two months after housing subsidies are initiated or adequate housing has been made available. Return to the child's parents or caretakers may only occur where the placement will be safe and appropriate. If the child is not discharged within two months after preventive housing services have begun, it will be assumed that the child is in foster care for other reasons. At that point, preventive housing services will be terminated. For documentation, see **Chapter 11**, "Closing the Case."

### ***To allow discharge to a planned living arrangement with a permanency resource***

Preventive housing services also may be provided to a child who is being discharged from foster care to another planned living arrangement with a permanency resource [[18 NYCRR 430.9\(f\)](#)]. Housing services will be provided only when both of the following standards are met:

#### **1. Service appropriateness**

The case manager has determined that housing services are necessary and such services have been authorized; *and*

The case manager has determined that, at the time housing services are authorized, the child has been in foster care at least 90 days, is prepared for discharge to another planned living arrangement with a permanency resource, and can be discharged only if housing services are provided.

## 2. Discharge plan

Discharge of the child from foster care must occur no later than two months after housing services are authorized, unless an unforeseen circumstance, other than the family's inability to locate adequate housing, occurs and results in the case manager's determination that discharge must be postponed. In such instances, the reason for the child remaining in care will be deemed to be due to a factor other than inadequate housing and housing services must be terminated.

## Respite care and services for families

A family is eligible for Respite Care and Services when the family meets the eligibility requirements for mandated preventive services *and* one of the following conditions exists [18 NYCRR 435.3(a)]:

1. A child has special needs due to a high level of disturbed behavior, emotional disturbance, or physical or health needs, including, but not limited to, AIDS, HIV infection or HIV-related illness, which has placed excessive or unusual stress upon the parent(s) and/or family and temporary relief of this stress will prevent the placement of the child in foster care and maintain or restore family functioning; *or*
2. A parent has an acute relapse or occurrence of AIDS, HIV infection, HIV-related illness or any other physical, mental, emotional or behavioral condition, which is either causing stress in family relationships, impairing the parent's ability to manage the family or is causing or will cause the parent to be absent from the home in order to treat or otherwise resolve such condition and there is no other parent or caretaker available to care for the child(ren) and temporary care and supervision of the child(ren) by the parent will prevent the placement of the child(ren) into foster care and maintain or restore family functioning; *or*
3. A parent is suddenly hospitalized due to accident, injury or illness; *or*
4. A child has been referred to the local probation service or designated assessment service for PINS adjustment services; *or*
5. A parent is participating in a substance abuse detoxification program.

The conditions in the home must be severe enough to threaten the health and safety of the child. Respite care and services are not to be provided when a child's behavior presents a serious danger to her/himself or others or when the child's adjustment and/or developmental problems require an extended period of absence from the child's home and family in order to make an adequate diagnosis and assessment of the child's condition and of the child's and/or family's need for services and such period of absence is expected to extend for more than 21 days [18 NYCRR 435.4(e)].

As with other preventive services, the parent or caretaker must agree to receive respite care and services. The parent or caretaker also has the right to approve or reject the proposed service provider.





## Chapter 3

# Persons in Need of Supervision (PINS) and Juvenile Delinquents (JDs)

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Preventive services caseworkers may provide services to families with one or more children/youth who are *at risk* of being adjudicated (determined by a judge) to be a Person in Need of Supervision (PINS) or juvenile delinquent (JD), or have been adjudicated to be a PINS or JD. These families come to receive culturally and linguistically competent preventive services in one of two ways:

1. A family is already receiving preventive services for their child when a situation arises that results in consideration of a PINS or JD petition being filed.
2. A family that is not already receiving preventive services is referred for preventive services because their child/youth has been determined to be a PINS or JD, or is at risk of being adjudicated a PINS or JD. This may be the sole reason for the referral for preventive services, or may be just one reason for the referral.

When a child is the subject of a Person in Need of Supervision (PINS) petition, or has been determined to be at risk of being the subject of such a petition, he/she is eligible to receive mandated preventive services if the family meets the established eligibility criteria for preventive services [[18 NYCRR 430.9\(c\)](#)]. While not specifically addressed in regulation, families with a child who is adjudicated a JD, or at risk of being adjudicated a JD, are eligible for preventive services if they otherwise meet the eligibility criteria for mandated or non-mandated preventive services.

If a family is already receiving preventive services when a child is at risk of being adjudicated a PINS, the preventive services case planner/caseworker must reassess whether the services currently being provided to the family address the needs of the family, in light of the current circumstances. This process includes a reassessment of the immediate safety and future risk of serious harm to the child(ren).

Collateral contacts, including those with the Probation Department and/or other agencies involved with the family (such as law enforcement) may provide helpful information. If the case planner/caseworker determines that the change in the family's circumstances requires different or additional preventive services, those services should be arranged for or provided.

## Persons in Need of Supervision (PINS)

A person in need of supervision (PINS) is defined in the Family Court Act [[FCA §712\(a\)](#)] as a child under the age of 18 who:

- Does not attend school;
- Behaves in a way that is dangerous or out of control;
- Often disobeys his/her parents, guardians, or other authorities;
- Unlawfully possesses marijuana;
- Commits an act of prostitution; and/or

- Appears to be a sexually exploited child as defined in Social Services Law.

## PINS diversion services

Prior to a petition being filed, diversion services must be offered to the child and his/her family [FCA §735]. PINS diversion services are intended to divert the child or youth from the court system, and, in some cases, from placement in foster care. Preventive services are a key part of this effort.

Each county or city with a population of one million or more must provide PINS diversion services and must designate a lead agency to coordinate the provision of diversion services. The lead agency facilitates the collaboration of various entities in the planning process and is responsible for plan development, submission, and implementation. The lead agency must be either the local Probation Department or the LDSS (ACS in New York City). While one agency must be designated as the lead, the two agencies may work together to assess the appropriateness of diversion services, make referrals for these services, and/or provide diversion services. The two agencies may be assisted by a voluntary agency, the local Youth Bureau, or other service providers.

Many counties have created a special unit for cases involving both juvenile justice and child welfare services. This Designated Assessment Service (DAS) conducts a formal assessment of the family's situation and develops PINS Adjustment Service Plan. The DAS may make referrals for preventive services that are designed to avoid a PINS designation for the child or youth.

The local lead agency may prohibit a parent/guardian from filing a PINS petition when it determines that the parent has not consented or actively participated in diversion services. The lead agency may not bar a school district from filing a PINS petition, but must review the school district's documentation of the steps the school district took to improve school attendance and/or the youth's conduct. Further diversion must be attempted if the lead agency determines it would be beneficial for the youth.

PINS diversion services are not synonymous with preventive services, although the actual services provided, and the provider agencies, may be the same. Eligibility criteria are different: all youth and their families are eligible for diversion services, if the youth is at risk of having a PINS petition filed. However, for these families to receive preventive services as part of PINS diversion, the eligibility criteria for preventive services must be followed. PINS diversion services may be provided until the case is successfully closed or until the lead agency determines there is no substantial likelihood that the youth and family will benefit from further services. PINS diversion services may be coordinated by the local Probation Department, if it is designated the lead county agency. Preventive services for PINS diversion cases must be managed by the local social services district.

The PINS Adjustment Services Plan includes a needs assessment, which determines what services are needed by youth at risk of a PINS petition and their families. The plan also identifies available community services and resources to meet these needs and describes new services that are needed to assist the child and family. Preventive services must be provided when the DAS has determined that the



### NYC Family Assessment Program

In New York City, the Family Assessment Program (FAP) serves as the Designated Assessment Service, and is operated jointly by the Administration for Children's Services (ACS) and the NYC Department of Probation. PINS diversion services are provided by the FAP, as well as by contracted nonprofit preventive services agencies, in coordination with the FAP.

child or youth is at risk for placement into foster care. This assessment must be entered in the child's case record [[SSL 409-a\(1\)\(a\)\(ii\)](#)].

## Filing the PINS petition

If the designated lead agency for PINS diversion in the county determines there is “no substantial likelihood” that the youth and his or her family will benefit from further diversion services, that agency may file a PINS petition in Family Court. When a PINS petition is filed, it means that diversion services have been unsuccessful. The following persons are authorized to file PINS petitions:

- a peace officer or police officer
- a parent or other person legally responsible for the care of the child
- a person who has been injured by a child
- a school or other authorized agency
- an agency that is authorized to file a JD petition, but has agreed to substitute a PINS petition

The PINS petition must include documentation of diversion efforts and the basis for the determination that there is no substantial likelihood that the youth and his or her family will benefit from further diversion services. The court may order additional diversion services or order the parents or youth to cooperate where lack of cooperation was a barrier to diversion.

When a PINS petition is filed, the petition and a summons must be given to the child and his/her parent, directing them to appear in Family Court on a specific date. After the initial appearance, the court will schedule a fact-finding hearing. During this process, most youth continue to live with their families in the community. Youth may not be placed in detention or a secure facility because they're involved with the PINS process.

## Court hearings

At the fact-finding hearing before a Family Court judge, the parties may testify and present witnesses and evidence. The child is represented by an attorney for the child, whose role is to advocate for the child's stated position. As a result of the fact-finding hearing, the judge determines whether the child committed the acts described in the petition and whether to adjudicate him/her to be a PINS.

If the youth is adjudicated to be a PINS, the judge sets a date for a dispositional hearing. Before the hearing, the Probation Department prepares a report describing the child's home life, school attendance, and general behavior.

At the disposition hearing, the judge signs a written order of disposition, which includes one of the following options:

- Discharge the youth with a warning.
- Suspend judgment, with or without restitution, required community service, and/or attendance at an alcohol awareness program. A condition of a suspended judgment may last up to one year, with a one year extension if there are exceptional circumstances.
- Continue the proceeding and place the youth in the youth's own home, or in the custody of a relative, another suitable person, or the LDSS for up to 12 months.
- Send the youth home under the supervision of a probation officer.

The disposition order may include preventive services. In such a case, the LDSS must review the case to assess eligibility for mandated preventive services. It is likely that a child or youth who is the subject of a PINS petition will meet the Family Court contact eligibility standard for mandated services, but that standard still must be documented in the case record.

## Juvenile Delinquents

A juvenile delinquent is a child who is at least 7 years old but younger than 16, who has committed an act that would be a crime if he or she were an adult. Juvenile delinquency cases are heard in Family Court.

### JD proceedings

A child who has been arrested may be brought directly to Family Court by the police, or, when court is not in session, may be held overnight in a detention center until the next court day. The police must immediately notify the parent/legal guardian. A child also may be released by the police after an “appearance ticket” is given to the child and the child’s parent(s) or legal guardian(s). The appearance ticket directs the child and parent/legal guardian to appear at the Probation Department on a certain date.

After the arrest, a probation officer will conduct an intake interview to determine whether the case should be adjusted (diverted from court), or referred for formal court processing through the filing of a JD petition. [FCA §308.1; §320.6]. The officer will interview all concerned parties, including the child, the arresting officer, the complainant (victim), and the child’s family members.

The probation officer completes a screening using the Youth Assessment Screening Instrument (YASI), which is a web-based tool designed to assess the needs and strengths of youth and their families, and to develop case plans. The YASI is also used to objectively determine the youth’s risk for future negative legal outcomes. YASI scores provide guidance for the level of services for which the youth might be eligible.

Based upon this assessment, the Probation Department may offer adjustment services to the youth except when he/she has committed certain felonies, in which case the court must give permission for diversion services to be provided [FCA §308.1 (3) and (4)]. The adjustment process involves the Probation Department working with the child and his/her family for a period of 60 to 120 days in an attempt to “settle” the case without formal court intervention. If the JD complaint is resolved without the necessity for Family Court action, it often includes one or more of the following:

- Referrals for services
- Restitution
- Probation monitoring

If the Probation Department decides not to adjust the case, a JD petition is filed and the case moves forward with the Family Court process. There is an initial appearance where the child is assigned an attorney (“attorney for the child”) and enters a plea of guilty or not guilty. A Probation Officer interviews the child and conducts a risk assessment using a questionnaire called a Risk Assessment Instrument (RAI). The RAI uses a young person’s strengths and risk factors to assess the likelihood that the young person will commit a delinquent act or fail to reappear in court if released at the initial appearance. Based on that assessment, the child may be: released (“paroled”) to a parent/guardian with no conditions if the child is assessed to be low risk; released to the parent/guardian with Alternatives to

Detention (ATD) services ordered; or placed (“remanded”) in secure or non-secure detention. No bail is set in juvenile delinquency cases.

If the youth denies a charge contained in the petition and the court orders detention of the youth, the court will hold a **probable cause hearing** [FCA §325.1]. At the probable cause hearing, the court hears evidence in support and in defense of the charges. At the conclusion of the hearing, the court must determine: “whether it is reasonable to believe that a crime was committed; and whether it is reasonable to believe that the respondent committed such crime” [FCA §325.3]. If reasonable cause is not found, the case is adjourned and the youth released from detention. If reasonable cause is found, the court will also determine if continued detention is necessary.

Prior to the fact-finding hearing, except in cases where the commission of designated felonies is alleged, the court may issue an order for adjournment in contemplation of dismissal (ACD), which places the case on hold for a period of up to six months.

If probable cause is found, the case is tried at a **fact-finding hearing** (similar to a trial in adult court) to determine whether the child committed one or more acts which, if committed by an adult, would be a crime based on proof beyond a reasonable doubt. If the judge finds the allegations are invalid, the petition is dismissed and the youth is released if they were detained. If the judge makes a finding in favor of the prosecution, the child is determined to be a JD and a dispositional hearing is scheduled. The judge orders the Department of Probation to investigate the youth’s home and school behavior.

If the youth has been determined to be a JD after the fact finding hearing, a **dispositional hearing** is held to determine if the Juvenile Delinquent is in need of supervision, treatment, or confinement [FCA §352.1]. Prior to the disposition hearing, the Department of Probation will complete the Full Youth Assessment and Screening Instrument — a more thorough report than the intake interview—which includes information from the youth, guardians, school, community-based programs, and other sources. [FCA §351.1].

After reviewing all the information collected, the Probation Officer will make a recommendation to the court regarding the most appropriate disposition. The Probation Officer may recommend one or more disposition options, including:

- Conditional discharge (CD)
- Probation supervision
- Restitution
- Placement in the youth’s own home or in the custody of a relative, other suitable person, LDSS or OCFS



## Detention

If there is a high risk that the youth will flee, or will commit another crime prior to his/her next court appearance, a court order will be issued to detain the youth in a secure or non-secure detention facility [FCA §320.5(3)].

Detention facilities must meet the standards set forth in Title 9, Subtitle E, Part 180 of New York Codes, Rules and Regulations. These regulations apply to education, medical and mental health services, religious services, recreation, and case management. Case management must be provided to all youths in custody and a master’s-level social worker must supervise case managers.

## Sharing information

Preventive services caseworkers are encouraged to communicate with the Probation Service when both agencies are involved with a youth and his/her family, regardless of which agency initiated the involvement. Preventive services caseworkers are encouraged to attend PINS or JD proceedings in Family Court to provide support to children and families that are receiving preventive services. .

When a child enters the child welfare system for the first time because preventive services have been ordered by the Family Court or are mandated by law, copies of the Probation Department intake report, assessment, and disposition order are given to the LDSS or voluntary agency responsible for creating a case record.

When a child is already in the child welfare system at the time of the PINS or JD proceedings, information from LDSS records or reports may be disclosed to the Probation Department only when:

- There is an order by the Family Court
- A local Probation Department has received prior approval from OCFS to provide preventive services as part of an approved Person In Need of Supervision (PINS) Adjustment Services Plan [[NYCRR 18 423.2\(a\)](#)].
- When a child with the capacity to consent, or the parent/guardian, has voluntarily given written consent. The consent must:
  - Be dated and specify the person or entity to which disclosure is authorized, and whether or not redisclosure of the information by such person or entity is permitted. If redisclosure is permitted, any limitations on redisclosure must be specified.
  - Specify what information may be disclosed.
  - Identify the purpose of the disclosure and any limitations on the use of the information by the person or entity.
  - Specify a time period during which the consent is to be effective or a date or event certain upon which the consent will expire.
  - State that the person executing the consent may terminate his or her authorization at any time.

A copy of the consent must be given to the person who executed it [[18 NYCRR 423.7](#)].

## Case management

There is **one** case manager for each family receiving preventive services, even when the household is receiving multiple child welfare services, such as foster care, preventive services, child protective services, day care, and/or adoption services. The case manager must also coordinate preventive services that are provided according to a PINS Adjustment Services Plan developed by The Probation Department.

The case manager is responsible for making sure that reports about the provision of preventive services are given to the Family Court, if such services were ordered by the court in connection with a JD or PINS petition. A juvenile delinquent whose disposition order includes probation supervision will have an assigned probation officer who will ensure that he/she is complying with the conditions set by the judge. The probation officer is also responsible for monitoring the provision of services that promote the youth's adjustment at home and at school.

## Documentation

When a determination has been made that a child is eligible for mandated preventive services because he or she is or is at risk of becoming the subject of a PINS petition, include the following information in the case record:

- If the petition has been filed, describe the content of the petition, including the allegations made, the date of filing, and the person or persons who filed; or
- If a petition has not been filed, summarize the determination made by the Assessment Service or Probation Department that the child is a risk of becoming the subject of a PINS petition.

Also include **at least one** of the following:

- A description of the circumstances in which the family would have been eligible for preventive services in the past, including the standard under which it would have qualified
- A description of circumstances that led to any child in the family being placed in foster care, including the name of the child, the date of placement, and the reason for placement
- A description of instances of behavior over the previous six months that present the potential for severe management problems in the home, school, or community
- A description of services received by the family in the present or the past, including the time period during which services were provided, family member(s) receiving services, the agency providing the services, and why the services were provided

If a child has previously been in foster care and is now eligible for mandated preventive services because of an appearance in Family Court, include this information in the case record:

- Describe the child's previous placement in foster care; *and*
- Describe the current petition or other disposition by the Family Court, including the date.

If the child is the subject of or at the risk of being the subject of a JD or PINS petition, include documentation of the Family Court or Probation Office referral and the date of the referral.





## Chapter 4

# The Preventive Services Team

A number of individuals and agencies must work together to strengthen and support children and families. The case manager is responsible for the authorization of preventive services. In districts other than New York City, the **case manager** determines whether families are eligible for preventive services and coordinates their provision. The **case planner** assesses the need for preventive services and develops a Service Plan with the family. **Caseworkers** may provide the services and provide casework contacts. There may be multiple caseworkers in multiple agencies providing preventive services to the same family.

Effective communication is necessary to see that families' Service Plans are followed without duplication of effort and things don't fall through the cracks. While completing reports and holding case reviews may not seem to be as important as time spent "in the field," these activities are necessary for the team to work effectively.

### Case manager

The case manager plays a key role in the provision of culturally and linguistically competent services. The local Department of Social Services (LDSS) assigns a case manager for each case. In New York City, although eligibility for preventive services is determined by the Administration for Children's Services (ACS), the case manager role is assigned by the private agency providing preventive services.

There is **one** case manager for each family receiving preventive services, even when the household is receiving multiple child welfare services, such as foster care, preventive services, child protective services, day care, and/or adoption services. To be assigned in CONNECTIONS, the case manager must be a local district worker. Staff in New York City provider agencies that are participating in Improved Outcomes for Children (IOC) may be assigned the *functional* role of case manager, but only ACS staff can be assigned the *system* role of case manager in CONNECTIONS (see **Appendix B**)

In general, case management includes the following activities, as defined by state regulations [18 NYCRR 403.4(a) and (b)] and [18 NYCRR 423.2(b)(1)]:

- Determining or approving a determination of eligibility for services
- Approving and supervising a Service Plan
- Authorizing the scope, type, and duration of services
- Monitoring casework contacts



### Roles in CONNECTIONS

There is a difference between a system role in CONNECTIONS and a functional role in the case. A system role is the role that a worker is assigned in CONNECTIONS based on that person's need to enter information into a record or review information at certain discrete points in time. A functional role dictates the role and responsibilities that a worker has in providing services directly to a family or child. For example, the caseworker role in CONNECTIONS may be assigned to a specialized worker, such as a health services worker or a member of the agency's Quality Assurance Unit. That person may not be a functional caseworker, but has a unique role in providing services to the family and needs access to the system in order to record information that relates to the case.

*Source:* CONNECTIONS Specialized Preventive Case Management Training

- Maintaining information, including a case record for each family receiving services
- Preparing and filing reports

The case manager provides oversight of the case and approves the Family Assessment and Service Plan (FASP). The case manager assumes the duties of the case planner if no case planner is assigned. In this instance, the case manager's supervisor must approve the FASP. These duties are the same for both mandated and non-mandated preventive services. When preventive services are mandated by a court order, the case manager must follow the appropriate orders of the court in planning and authorizing services to be provided.

The case manager must also coordinate preventive services that are provided according to a Person in Need of Supervision (PINS) Adjustment Services Plan developed by Probation Services. In New York City, PINS diversion services are provided by the ACS Family Assessment Program and voluntary preventive services agencies.

In general, the case manager assigns responsibilities for case planning and makes sure that all participants in the case are actively involved in the assessment and Service Plan functions. This is especially important when services overlap or when a case is being transferred from one service area to another. The use of Service Plan Review conferences is an excellent way to facilitate communication and coordination among service providers. In New York City, this function is provided at family team conferences that are held prior to required reassessments of the FASP.

## Case planner

The case planner is the front-line observer of what is going on with a family. The LDSS staff may serve in this capacity, or the district may purchase case planning services from a preventive services agency.

State regulations [[18 NYCRR 423.2\(b\)\(2\)](#)] define case planning activities for preventive services. The case planner assesses the need for, provides or arranges for, coordinates, and evaluates the provision of preventive services needed by a child and his/her family to prevent disruption of the family or to help a child in foster care return home sooner.

The case planner assesses the need for preventive services and develops a Service Plan with the family. The Service Plan provides the family, child welfare workers, supervisors, and other service providers with a clear statement of who is going to do what and when in order to achieve the family's goal(s). Service planning should engage the family and maximize their strengths and resources. The goal in terms of engagement is for the family to feel ownership of the plan.

Case planning also includes, but is not limited to, referring the child and/or family to needed services, such as:

- Educational counseling and training
- Vocational diagnosis and training
- Employment counseling
- Therapeutic and preventive medical care and treatment
- Health counseling and health maintenance services
- Vocational rehabilitation
- Housing services

- Speech therapy
- Legal services

The case planner documents the family's progress and adherence to the FASP by entering progress notes and reassessments in the case record. The case planner is the author of the FASP and is responsible for the entirety of its contents and the timeliness of its submission for approval by the case manager. This means the case planner must coordinate all documented work done in the CONNECTIONS system by other workers who contribute to the FASP and either approve or revise it, as needed. The case planner also must require collaboration among all the case workers assigned to the case so that a single family assessment and Service Plan is developed.

There may be more than one individual performing case planning activities for a family. For example, if the family is receiving foster care services, a foster care case planner may also be working with the family. Child Protective Services will have its own case planner or CPS monitor. **However, there can be only one case planner assigned to the case in CONNECTIONS at any given time.** This is not a required role in CONNECTIONS; if no case planner is assigned, the case manager assumes the duties of the case planner.

In the CONNECTIONS system, the case planner tasks include:

- Assigning casework contact responsibility
- Referring the family for services and evaluating provision of services
- Supporting collaboration among workers
- Defining individual worker responsibilities and timeframes for recording FASP components
- Reviewing all FASP components completed by other workers and editing/revising as necessary to ensure a single, cohesive, integrated Service Plan
- Submitting the FASP for supervisory and case management approval in a timely manner<sup>3</sup>

## Caseworker

Caseworkers may be employed by the LDSS or may work for contracted preventive services agencies. Caseworkers directly provide preventive services to children and families by making the majority of casework contacts and keeping track of the family's progress toward Service Plan goals.

One or more caseworkers (who can be either local district or contracted agency workers) may be assigned to a Family Services Stage (FSS). Caseworkers work within the FASP and complete progress notes. Caseworkers may be responsible (called "associated" in the system) for one or more children in the case. If they are associated to a child, they complete specific work related to that child within the FASP (e.g., Child Strengths, Needs and Risk Assessment Scale).

Caseworkers who are employed by contracted agencies have the same responsibilities and requirements as those employed by the LDSS. The LDSS may arrange for their services through a Purchase of Services (POS) agreement that includes [18 NYCRR 423.4(f)]:

- Specification of case planning responsibilities, including responsibility for making entries in the case record and casework contacts

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<sup>3</sup> "Overview of CONNECTIONS Case Management," accessed at <http://ocfs.ny.gov/connect/imp/build18/overview%20conx%20case%20manag-final.pdf>

- Identification of the services to be provided
- Estimate of the number of children and families that will receive each service and the percentage that will be mandated and non-mandated
- Procedures for referrals between the LDSS and various public and private agencies in the district
- Methods the LDSS will use to monitor the effectiveness of the service provided
- Outreach responsibilities, where applicable
- CPS reporting requirements
- How the LDSS will authorize the service, approve the client eligibility determination, and approve the Service Plan
- Procedures for arranging case conferences and Service Plan reviews
- Payment procedures
- Procedures to support confidentiality (see **Chapter 9**)

Additional standards relating to contracts for purchase of preventive services are set forth in [18 NYCRR 405.1](#).

The case manager is responsible for monitoring (but not supervising) the work of preventive services agency staff. Supervision of agency staff is provided by supervisors employed by the agency.

## Other service program personnel

Preventive services often are provided simultaneously with other services, especially foster care and Child Protective Services (CPS). There are key points of intersection between preventive services and other service programs. For all service types, the safety of the child(ren) is paramount.

### Foster care

The primary goal of preventive services is to safely avoid placement of children into foster care. When foster care placement has been necessary, preventive services are aimed at allowing a child to safely return home as quickly as possible. For these reasons, preventive services often are interrelated with foster care issues before, during, and after discharge from placement.

#### ***Prior to placement***

In most cases, preventive services are part of the reasonable efforts that must be made to avert foster care placement. These efforts must be documented in the case record and also in petitions and court findings related to foster care placement.

#### ***During placement***

Preventive services, including preventive housing services, may be provided to a family when the child is in foster care and the goal is for him/her to be returned home or to the care of a relative. These services are mandated when they are directed at solving one or more of the issues that resulted in the child's placement and the child's planned discharge from foster care is within the next six months. Return to the child's parents or caretakers may only occur where the placement will be safe and appropriate [[18 NYCRR 430.9\(e\)\(1\)\(iii\)](#)].

Mandated preventive services may be provided to any child in foster care whose goal is to return home, but, with the exception of day services for the child, they must be provided only to the family or to the child and family together [18 NYCRR 423.4(g)(1)]. Preventive services also can be provided only if the casework contact requirements for children in foster care are fulfilled and may not duplicate services that are being provided as part of foster care services for the child. Preventive services must be directly related to one or more of the reasons the child is currently in foster care.

Mandated preventive services also may be provided to minor parents who are themselves in foster care and their own children are residing with them, either in foster care family homes or residential care facilities [18 NYCRR 423.4(g)(2)]. The child(ren) must meet the eligibility criteria for preventive services. Such services must be provided to the minor parent and his or her child or children for the purpose of keeping the minor parent and his or her child or children together, including facilitating a custody arrangement that maintains or seeks to restore custody of the child or children of the minor parent to such minor parent except when this custody arrangement would place the child or children of the minor parent at imminent risk of abuse or maltreatment.

When preventive and foster care services are provided at the same time, casework contact requirements must be met for both preventive services and foster care.

### ***After discharge***

Mandated or non-mandated preventive services may be provided to a child for the first three months following discharge from foster care [18 NYCRR 423.4(h)]. These services are provided in addition to those provided as follow-up to foster care and must include three face-to-face casework contacts (including one home visit) and one case conference with the preventive services agency.

Mandated preventive services are provided specifically to prevent the child's re-placement in foster care. For example, when lack of adequate housing is the primary factor preventing a child's discharge from foster care, preventive housing services may be an appropriate service.

## **Disrupted and dissolved adoptions**

An adoption is **disrupted** when the adoption process ends after the child is placed in a pre-adoptive home, but before the adoption is legally finalized. An adoption is **dissolved** when the legal adoption relationship is severed, either by the termination of the adoptive parent's parental rights, or by the voluntary surrender of the child by the adoptive parent(s). A child may be placed into foster care in either a disruption situation or when an adoption is being dissolved. However, these are two different situations, as the adoptive parent remains the child's parent until the adoption is legally dissolved.

Preventive services may be provided to a family formed through adoption using the same eligibility criteria described in **Chapter 2**. These criteria are the same for all families. Preventive services may be provided if an adoption is at risk of disruption, has disrupted, or is in danger of being dissolved, if the child or family meets the eligibility requirements for preventive services [18 NYCRR 423.4(j)].

Preventive services for adopted children are provided in addition to any post-adoption services that may be provided for adoptive families. Post-adoption services include interviewing, counseling, and clinical and consultant services designed to promote permanency. Preventive services offer a wider range of options and can be provided in addition to post-adoption services as long as eligibility criteria are met.

## Child Protective Services

Preventive services may be provided to families receiving CPS services, including during the investigation period. These cases must meet the primary general criterion that preventive services will assist in preventing foster care placement.

### ***During the CPS investigation***

It is important to keep in mind that a CPS investigation does *not* necessarily mean the family is eligible for preventive services. It may be an important indicator of the need for such services, but in itself is not a basis for providing mandated preventive services. For a child or family to be eligible for **mandated** preventive services under the “Health and Safety” standard [18 NYCRR 430.9(c)(1)(i)], a CPS report must be *indicated*, not just under investigation.

**Non-mandated** preventive services may be provided during a CPS investigation if the child or family meets the standards for preventive services described in law [SSL 409-a(1)]:

- The child is at imminent risk of placement into foster care
- The child is at risk of re-placement into foster care
- The child may be returned to the parent(s), other relative, or legal guardian ahead of schedule
- The child has been placed in an Emergency Foster Family Boarding Home

Preventive services can be provided as **mandated** services if and when there is an indication of abuse or maltreatment, and as long as the child or family meets all the specific requirements under the “Health and Safety” standard.

If a CPS investigation is begun for a family already receiving preventive services, this information should not be included in the family’s case record unless and until the allegation is indicated. At no time should the source of information that prompted the CPS investigation be included in the case record.

If the LDSS is notified that the CPS report is unfounded, the LDSS must update all records that refer to the report to reflect that the report was determined to be unfounded and must legally seal the CPS report. The LDSS must inform any agency or person to which it has provided information concerning the report to update its record for the same purpose [18 NYCRR 432.9].

### ***After indication of abuse or maltreatment***

When a CPS report is indicated and a case opened for services, the local CPS unit has the responsibility for directly providing or arranging for services to the family. This may include preventive services, which can be provided if the family meets the eligibility criteria for such services. In coordinating the delivery of rehabilitative services, the CPS worker must clearly define the roles, responsibilities, and tasks and activities of all service providers and verify that the established plan of service is being implemented.

As long as the case remains open with CPS, the CPS unit will be involved through either a CPS worker or a CPS monitor. The CPS worker/monitor (who *must* be local district staff) is responsible for overseeing safety and risk assessments when:

- The case was opened from a CPS Investigation stage; *and*
- The CPS worker is not the primary service provider for the case; *and*
- Ongoing protective concerns have been identified (the program choice is or includes “protective”).

These activities include reviewing safety-related and risk-reduction actions and activities, determining that appropriate services are being provided, and modifying the Service Plan when the child or family's progress is not sufficient to meet the desired outcomes identified in the plan.

When the CONNECTIONS system role of CPS Worker/Monitor is not assigned and the case includes a program choice of "protective," the Case Planner must complete the Safety Assessment and Risk Assessment Profile in the FASP.

### ***CPS rehabilitative services***

For CPS purposes, rehabilitative services are provided to safeguard the well-being and development of a child who has been named in a report of either alleged or indicated abuse or maltreatment and to preserve and stabilize family life [18 NYCRR 432.1(i) and 432.2(b)(4)]. These services may include the provision of preventive services when they are targeted at preventing foster care placement or returning a child to his/her home quickly. Preventive services may meet the aim of CPS in these cases. However, the receiving of reports of child abuse or maltreatment, the investigation of such reports, and the determination as to whether such reports are indicated or unfounded are reserved exclusively to CPS.

### ***Reporting suspected child abuse or maltreatment***

It is possible that, in the course of providing preventive services, a caseworker may have reasonable cause to suspect that child abuse or maltreatment has occurred [SSL §413]. When this happens, the caseworker must report these suspicions and allegations to the Statewide Central Register of Child Abuse and Maltreatment. Caseworkers are mandated reporters under state law, and may be prosecuted or fined if they fail to report.



### **SCR Hotline**

The Statewide Central Register operates a 24/7, toll-free hotline for mandated reporters:

**1-800-635-1522**

If a child is in group or residential/congregate care and is receiving preventive services, the report must be made to the Vulnerable Persons Central Register administered by the New York State Justice Center for the Protection of People with Special Needs (**1-855-373-2122**).

## **Family Court**

In New York State, the Family Courts hear matters involving children and families, including whether children have been abused or neglected, as defined by state law. It also has responsibility for ordering services and monitoring cases to see that the interventions and services provided to the family are as beneficial and effective as possible.

There is at least one judge in each county of the state who hears such matters. In general, the more populated a county, the more Family Court judges there are, including more than a dozen Family Court judges in each of the five boroughs of New York City. Family Court judges may be elected or appointed, depending upon the county government structure.

Family Court has the authority to make legal decisions over the following types of cases:<sup>4</sup>

- Abused or Maltreated Children (Child Protective Proceeding)
- Adoption
- Custody & Visitation

<sup>4</sup> <https://www.childwelfare.gov/pubs/usermanuals/courts/chaptertwo.cfm>

- Domestic Violence (Family Offense)
- Foster Care Approval & Review
- Guardianship
- Juvenile Delinquency
- Paternity
- Persons in Need of Supervision (PINS)
- Child and/or Spousal Support

In addition to the inherent power of the position, Family Court judges have the power and authority to:

- Issue a subpoena for the production of witnesses
- Issue a subpoena for the production of documents and records
- Issue an order directing the production of the child involved in a CPS investigation
- Make “reasonable efforts” determinations
- Hold individuals in contempt
- Order treatment

## Court orders for preventive services

Preventive services may be provided to the family voluntarily, or as a result of an order of the Family Court. If the preventive services being provided to the family are a result of an order of the Family Court, most often that order resulted from a proceeding in Family Court in which abuse or maltreatment of a child was alleged in a petition filed by the LDSS. These child protective proceedings are Article 10 proceedings, referring to the Article number in the Family Court Law regarding child abuse and neglect proceedings.

When it appears that a child less than 18 years of age has been abused or maltreated or is in danger of being abused or maltreated, a petition may be filed by the LDSS/ACS asking the Family Court to assist in protecting the child. The court then holds hearings to decide if the allegations are true and if so, what action the court should take to protect the child.

Preventive services may be ordered by the court when a child is released to the parent or guardian, when the child is residing with the parent or guardian, or when the child is in foster care while the parents receive services. The court has continuing jurisdiction and the child remains legally placed until each permanency hearing is complete and permanency is achieved [[FCA §1088](#)].

## Opening a preventive services case in CONNECTIONS

The Family Service Intake (FSI) is the first step on the path to opening a services case. It must be completed before a Family Services Stage (FSS) can be opened and services can be delivered. Any LDSS/ACS or voluntary agency worker (with the proper security rights) can record Family Service Intakes.

For Child Protective Services cases, the FSI is created during the investigation of a CPS report. If a child or family is receiving other services, such as foster care, a case record will already exist. For this reason, it is recommended, and required by some local districts including ACS, that a Person Search be conducted in CONNECTIONS before an FSI is begun in order to avoid creating duplicate records.



The LDSS or voluntary agency will open cases for court-ordered preventive services (usually JD/PINS placement) or when a family has applied for services. If the case was opened as the result of an order by the Family Court, copies of Safety Plans and other documents may be provided to the court as requested.

For Advocates Preventive Only (ADVPO) cases in New York City, only some portions of the FSI are completed in CONNECTIONS. The full FSI is documented on the template for ADVPO cases.

Once all the information is recorded in the FSI, it is submitted to the LDSS/ACS case manager, who will approve or deny the provision of services. If services are approved, the case progresses to the Family Services Stage (FSS). If services are not to be provided, the FSI stage will be closed. Information captured in the FSI includes:

- Source of the intake
- People in need of services (including demographic information)
- Type(s) of services being requested
- Presenting concerns
- Issues requiring emergency or crisis services
- Actions necessary to deal with emergency or crisis situations
- A decision concerning the provision or denial of services
- Programmatic eligibility for mandated preventive services (see **Chapter 2** and **Appendix A**)
- Behavioral Concerns and Family Issues (BCFI) for non-protective child welfare services



### Pre-Placement Services (NYC)

In New York City, Pre-Placement Services (PPS) will open all cases involving youth being placed in an ACS planning or non-planning foster care agency if the court order is received during non-business hours. PPS completes the FSI and progresses to the FSS, assigning the role of CONNECTIONS Case Manager to the local office's Division of Child Protection (DCP) Applications Unit and the Caseworker role to the foster care agency.

If the court orders a youth to be placed in an OCFS contract agency, that agency completes the FSI and forwards it to ACS for approval and assignment of a case number.

The Behavioral Concerns and/or Family Issues (BCFI) is a non-CPS intake screening tool used to document behavioral concerns and/or issues requiring *emergency* services, interventions, or referrals. It provides a single, consistent structure for local district/ACS and voluntary agency workers to document important information about the service needs of children, youth, and families at the point of intake. The BCFI consists of Child Issues, Caretaker Issues and Family Issues. It is not available for ADVPO cases in New York City; a similar section is provided on the template for these cases.

Cases are named for the person on Line 1 in Person Demographics section in CONNECTIONS. When opening a non-CPS case, this person is the individual requesting services. Local districts and ACS may have specific policies on naming cases.

ACS requires workers to complete the Family Relationship Matrix (FRM), which is part of the Person Demographics information, at the time of intake. This shows how the individuals in a case are related to one another and helps every worker with a role in the case keep track of people who affect the permanency, safety, and risk of harm to the child. The FRM can also be created in the FSS after services have been approved.<sup>5</sup>

<sup>5</sup> CONNECTIONS Preventive Services Training Manual



## Chapter 5

# Culturally Competent Services

Initial meetings with families, and all interactions with them throughout the case, are more effective when caseworkers are culturally competent. Simply stated, cultural competence is the ability to effectively provide services across cultures.<sup>6</sup> This definition of “culture” means far more than a person’s national origin or race. It also extends to cultures that have shared lifestyles and experiences, such as religious beliefs, gender identity, and economic class. Cultural competence is:

- A continuous process of learning about the cultural strengths of others and integrating their unique abilities and perspectives into our lives.
- A vehicle used to broaden our knowledge and understanding of individuals and communities.
- Having the knowledge, ability, and skill necessary to identify and address the issues facing organizations and staff that have cultural implications, and the ability to operationalize this knowledge into the routine functioning of an agency.<sup>7</sup>

Cultural competence is an ongoing process that requires individuals to gain knowledge about various cultures, develop skills that will be useful in helping families from other cultures, and conduct an ongoing self-evaluation of their own cultural biases.



### More than national origin

“We embrace the need to be culturally competent to meet the challenges of our mission and demonstrate the behaviors that define our values. For our purposes, cultural competence is defined as the ability of all agency staff to provide the highest quality of services to children, youth, families and vulnerable adults, by responding respectfully and effectively to people of all **cultures, classes, races, ethnic backgrounds, genders, sexual orientations, ability status, and faiths or religions**, and in a manner that recognizes, affirms, and values the worth of individuals, families, tribes, and communities, and protects and preserves the dignity of each.”

– OCFS Committee on Racial Equity and Cultural Competence

## Importance of cultural competence in child welfare

Cultural competence is an essential skill for agencies and professionals providing services to children and families. A culturally competent care system is based on three unifying values: being different is positive, services must be responsive to specific cultural needs, and services must be delivered in a way that empowers family members.<sup>8</sup>

Cultural competence builds on the social work profession’s support for self-determination and individual dignity and worth, with an approach of inclusion, tolerance, and respect for diversity in all its forms.<sup>9</sup> It

<sup>6</sup> Diller J.V. (2007). *Cultural Diversity: A Primer for the Human Services, 3<sup>rd</sup> Edition*, Belmont, CA: Thomson Brooks/Cole.

<sup>7</sup> Child Welfare League of America need more detail

<sup>8</sup> Diller, *op cit*.

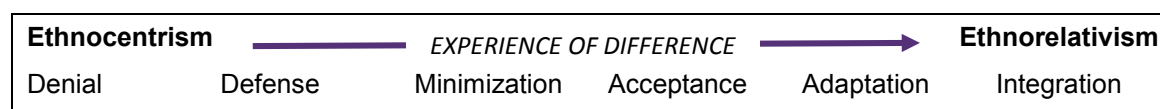
<sup>9</sup> National Association of Social Workers (2001). “NASW standards for cultural competence in social work practice,” Washington, DC: NASW.

makes it possible for caseworkers to serve all communities, bridge across differences, and ultimately improve outcomes of children, youth, and families.

## Becoming culturally competent

Increasing cultural competence requires a belief that it is important to become more culturally competent; an acknowledgement that you don't – and can't – know everything about every culture, including your own; and a recognition that becoming more culturally competent is a perpetual journey, not a destination to be reached.<sup>10</sup> See **Appendix J** for key considerations to explore.

The range of cultural competency can be described by the “Developmental Model of Intercultural Sensitivity” developed by Dr. Milton J. Bennett, Director of Intercultural Development Research Institute in Portland, Oregon. According to this model, an individual's experience of cultural differences ranges across six stages:



**Ethnocentrism** is the perception that one's own culture as the center of reality, which is the experience of most people as they grow up. **Ethnorelativism** is the understanding that one's own culture is just one way to view the world among many equally viable possibilities. Some individuals progress along this continuum and some do not. The six stages of how a person responds to cultural differences progress through:

**Denial of Difference:** People at this stage do not recognize cultures other than their own. They may not even see “culture” as a term that applies to them, because they do not see outside of their own patterns of beliefs, behaviors, and values. A person with the Denial experience has little knowledge of other cultures and shows little interest in learning more.

**Defense Against Difference:** People at this stage recognize cultural differences, but consider their own culture to be the only viable way to live. They feel threatened by other cultures and see others as stereotypes (“They're all lazy” or “They hate freedom.”) This attitude can occur in both dominant and non-dominant cultural groups.

**Minimization of Difference:** People at this stage recognize and accept cultural differences, but see them as superficial because “basically, we're all alike.” If they are part of a dominant culture, they assume that their own values, beliefs, and lifestyle can and should be adopted by people of other cultures. People of non-dominant cultures may accept this assumption and assimilate to the dominant culture.

**Acceptance of Difference:** People at this stage experience cultural difference in context. They accept that all behaviors and values, including their own, exist in distinctive cultural contexts. They see cultures as offering alternative, viable world views, but do not necessarily agree with them. A major issue to be resolved at this point is maintaining one's personal values while accepting the viewpoints of other cultures.

**Adaptation to Difference:** People at this stage apply their Acceptance of Difference to their own behavior. This stage is common among people who need to interact effectively with people of other

<sup>10</sup> National Resource Center for Diligent Recruitment. (n.d.). “Moving toward cultural competence: Key considerations to explore,” Linthicum, MD: AdoptUsKids

cultures. They are committed to their own ethical values, but are able to empathize with other world views and alter their behavior to accommodate them.

**Integration of Difference:** People at this stage are not defined by any one culture. They typically are bicultural or multicultural, due to family structure or having lived in other cultures for extended periods of time. They also may be individuals who have adapted to a dominant culture in some contexts (such as their careers), but maintain another cultural identity in other settings.<sup>11</sup>

## Cultural competency skills for caseworkers

The skills needed for cultural competence are closely aligned with family-centered, strengths-based practices that are used across the spectrum of the child welfare system. Five specific skill areas are necessary for effective cross-cultural service delivery:

1. **Awareness and Acceptance of Differences:** Caseworkers develop an awareness of the ways in which cultures differ and realize that these differences affect the helping process. Equally important, workers broaden their perspectives to acknowledge and accept that different cultures view reality in different ways.
2. **Self-Awareness:** Caseworkers recognize that their own behaviors and values have been shaped by their cultures and reinforced by families, peers, and social institutions.
3. **Dynamics of Difference:** Caseworkers understand that when families and providers come from different cultures, it is likely that sooner or later they will misinterpret or misjudge one another. An awareness of the “dynamics of difference” involves knowing what can go wrong in cross-cultural communication, recognizing it when it occurs, and correcting it immediately.
4. **Knowledge of the Family’s Culture:** Caseworkers actively educate themselves about a family’s culture in order to understand behavior in its cultural context. This can be done by referring to resource materials or consulting with a member of that culture.
5. **Adaptation of Skills:** Caseworkers adapt and adjust helping practices to accommodate cultural differences. Cultural values may affect treatment plans, treatment topics, service referrals, and even who is considered to be a family member.<sup>12</sup>

The National Association of Social Workers (NASW) has promulgated a detailed list of culturally competent skills for caseworkers. Through training and experience, caseworkers should develop the skills to:

- Work with a wide range of people who are culturally different or similar to themselves, and establish avenues for learning about the cultures of these clients.
- Assess the meaning of culture for individual clients and client groups, encourage open discussion of differences, and respond to culturally biased cues.
- Master interviewing techniques that reflect an understanding of the role of language in the client’s culture.
- Conduct a comprehensive assessment of client systems in which cultural norms and behaviors are evaluated as strengths and differentiated from problematic or symptomatic behaviors.

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<sup>11</sup> Bennett, M.J. (2004). *Becoming culturally competent*. In Wurzel, J. (ed.) *Toward multiculturalism: A reader in multicultural education*. Newton, MA: Intercultural Resource Corporation.

<sup>12</sup> Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs, M.R. (1989). *Towards a culturally competent system of care*. Washington, DC: Georgetown University Child Development Center.

- Integrate the information gained from a culturally competent assessment into culturally appropriate intervention plans and involve clients and respect their choices in developing goals for service.
- Select and develop appropriate methods, skills, and techniques that are attuned to their clients' cultural, bicultural, or marginal experiences in their environments.
- Generate a wide variety of verbal and nonverbal communication skills in response to direct and indirect communication styles of diverse clients.
- Understand the interaction of the cultural systems of the caseworker, the client, the particular agency setting, and the broader immediate community.
- Effectively use the clients' natural support system in resolving problems—for example, folk healers, storefronts, religious and spiritual leaders, families of creation, and other community resources.
- Demonstrate advocacy and empowerment skills in work with clients, recognizing and combating the “isms”, stereotypes, and myths held by individuals and institutions.
- Identify service delivery systems or models that are appropriate to the targeted client population and make appropriate referrals when indicated.
- Consult with supervisors and colleagues for feedback and monitoring of performance and identify features of their own professional style that impede or enhance their culturally competent practice.
- Evaluate the validity and applicability of new techniques, research, and knowledge for work with diverse client groups.<sup>13</sup>

Diversity exists *within* cultural groups as well. Extensive differences can exist among households in the same ethnic group based on class, age, gender, ableness, language, etc. For example, a low-income family from South America that has been in the United States for two months and is unable to speak English faces different challenges than a family that originated in the same South American country but has been in the U.S. for two generations, is middle-class, and for whom English is their first language. It is culturally insensitive to believe that all members of a particular group share all characteristics and circumstances. It is essential to know each person individually, within his/her larger cultural context.<sup>14</sup>

## A more diverse child welfare workforce

As part of its work in Racial Equity and Cultural Competence (RECC), OCFS is considering issues related to the under-representation of blacks, Native Americans, and Latinos in various forms of service delivery to identify how best to enhance outreach and preventive measures that support the safe reduction in out-of-home placements for children and adults, and focus on the well-being of children, youth, and families. Current OCFS statewide data indicates that black and Latino children and families continue to comprise 75% of the state's children in foster care and about 85% of the juvenile justice placements.

OCFS has asked service providers to consider certain elements in the design of their programs to reduce disproportionality in the delivery of services:

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<sup>13</sup> NASW (2001). *Op cit.*

<sup>14</sup> Diller, *op cit.*

- Providing service strategies, approaches, and linguistic capacities that promote the delivery of services that are culturally competent and reflective of the population and community to be served;
- Collecting and analyzing data relevant to disproportionality and service provision;
- Strategically locating services within communities, to promote better access to service delivery in high-need areas; and
- Promoting cross-agency dialogue and partnership regarding service planning to address disproportionality (including but not limited to: social services, mental health, health, education, housing, substance abuse, probation agencies, and community-based providers).

## Cultural and ethnic background

Child welfare caseworkers can expect to work increasingly with children, families, supervisors and peers from backgrounds different than their own. New York is culturally diverse, especially in the New York City metropolitan area. As many as 800 languages are spoken in that part of the state, making it the most linguistically diverse area in the world. In some parts of the city, “minority” populations are actually the majority.

Within each of these broad categories are many smaller ethnic groups. The Hispanic population includes people who have immigrated from Puerto Rico, the Dominican Republic, Mexico, Ecuador, Colombia, and El Salvador. The black population includes recent immigrants from Caribbean nations such as Jamaica, Trinidad, Barbados, and Guyana. The Asian population includes families with traditions from China, the Philippines, Korea, India, Pakistan, and Bangladesh.

What is behaviorally appropriate in one culture may be considered inappropriate in another. Accepted practice in one culture may be prohibited in another. Cultural backgrounds may affect families’ willingness to ask for help and their behaviors with helping professionals and agencies. To fully understand and appreciate these differences, caseworkers must be familiar with varying cultural traditions and norms. The ways in which social services are planned and implemented need to be culturally sensitive in order to be culturally effective.<sup>15</sup>

The following information will be important in determining any family’s situation: place of birth, number of generations in the United States, family roles and structure, language spoken at home, English fluency, economic situation and status, amount and type of education, amount of acculturation, traditions practiced in the home, familiarity and comfort with a Northern European lifestyle, religious affiliation, and community and friendship patterns.<sup>16</sup>

## Tips for cross-cultural communication

There are specific actions and behaviors that caseworkers can practice that support the delivery of culturally appropriate interactions and rapport-building, such as:

- Do not assume you know the ethnic identity of a person. Ask the client/family members how they identify themselves culturally or ethnically. People from the same ethnic group may identify themselves differently. For example, the terms Hispanic, Latino/Latina,

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<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

Chicano/Chicana, Mexican, Mexican National, and Mexican-American have individual meaning and importance for people of similar cultural and ethnic backgrounds.

- Do not assume which family member should be spoken to first. This varies from culture to culture and an incorrect assumption may interfere with the information you receive. Identify which family member(s) should be addressed first. For some cultures, it is important to identify and address the family member from whom approval needs to be obtained. Ignoring this could result in alienation and could possibly communicate unintended arrogance on your part. One approach for handling this is to request direction from the family.
- Ask individuals how they wish to be addressed. It may be perceived as disrespectful and impolite to use first names only. You may introduce yourself as follows: “Hello, Mr. \_\_\_\_\_; I am [first name] [last name].”
- Caseworkers should be aware that “personal space” may be perceived differently in other cultures. Some cultures do not allow any physical contact between strangers, including handshakes. While some cultures recognize a firm and strong handshake as a sign of respect, others perceive a firm handshake as a sign of aggression or rudeness.
- In some cultures, eye contact is an indication that a connection has been made and that a relationship has been formed. In such cultures, lack of eye contact is sometimes perceived as a lack of trust or an indication of dishonesty. In other cultures, direct eye contact indicates a lack of respect or arrogance and should be avoided.
- In some cultures, it is customary to offer food and refreshments to visitors, often before any formal conversation. If you decide that you do not want to accept the offer of food, decline it in a respectful manner. If the food or refreshment looks unappetizing to you, refrain from any facial expression that may suggest disapproval.<sup>17</sup>

In all cases, the caseworker must determine the extent to which the guidelines are true for each family. Caseworkers must avoid stereotyping and not assume that these conditions are true simply because the family is a member of a specific ethnic group.

## Race and racism

New York State is working to identify and implement strategies to address, reduce and ultimately eliminate racial and ethnic disparities and to seek equity. OCFS supports services, approaches and linguistic capacities that promote the delivery of services that are culturally competent and reflective of the population and community to be served.

**Cultural racism** is more subtle than overt, individual racism. It comes from deeply ingrained messages that affirm the assumed superiority of white people and the assumed inferiority of people of color. For white people, this can result in an internalized racial superiority: a superior definition of self that is rooted in many generations of systemic empowerment and invisible



### Racism in the U.S.

“Racism is pervasive in U.S. society and remains a silent code that systematically closes the doors of opportunity to many individuals. Contextually, racism is the belief or practice through demonstrated power of perceived superiority of one group over others by reason of race, color, ethnicity, or cultural heritage. This perceived power or right is part of the cultural inheritance of the United States....”

– *National Association of Social Workers  
Delegate Assembly, 2005*

<sup>17</sup> Oregon State Department of Human Services. (2007). *Child welfare procedure manual*. Salem, OR: OSDHS



advantages based on race. For people of color, cultural racism can give rise to an inferior definition of self, based on a history of disempowerment that expresses itself in self-defeating behaviors.

**Institutional racism** is the manifestation of cultural bias in social systems and institutions. It is a combination of policies, practices, or procedures that are embedded in an organization and lead to unequal outcomes for different racial or ethnic groups. In social work, institutional racism contributes to the problem of disparity, or unequal treatment among racial or ethnic groups. Research shows that children of color in foster care and their families are treated differently from white children and their families. For example, fewer African American children receive mental health services, even though their need for such services may be as great as other racial or ethnic groups.

Most white caseworkers would not describe themselves as racist. But, as part of the dominant American culture with a history of racism, they may have attitudes that are inherently racist. These attitudes may come out in brief verbal, behavioral, or environmental indignities that have been termed **racial microaggressions**. Whether intentional or unintentional, these words or actions communicate hostile, derogatory, or negative racial slights and insults toward people of color.

Some examples:

- A white therapist tells an American-born Latino woman that she should seek a Spanish-speaking therapist.
- A school counselor reacts with surprise when an Asian American student has trouble on the math portion of a standardized test.
- When a person of color wants to discuss racial issues with her white therapist, he replies, “When I see you, I don’t see color.”
- When a client describes his experience with racism at work; his white female therapist replies, “I understand. As a woman, I face discrimination also.”
- A black client is loud, emotional, and confrontational in a counseling session. The therapist diagnoses her with borderline personality disorder.
- Persons of color are not welcomed or acknowledged by receptionists.<sup>18</sup>

Caseworkers can judge their own attitudes and behaviors by asking themselves questions such as:

- Am I comfortable and willing to talk about race?
- Do I belittle the experience of racism by saying, “I know how you feel” or drawing parallels between racism and other types of oppression?
- Am I using protective devices, such as defensiveness, silence, or minimization of problems?
- Do I show signs of countertransference related to race? This could include strong or inappropriate reactions, forcing solutions, boundary violations, lack of objectivity, etc.<sup>19</sup>

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<sup>18</sup> Sue, D.W., Capodilupo, C.M., Torino, G.C., Bucceri, J.M., Holder, A.M.B., Nadal, K.L., Esquilin, M. (2007). Racial microaggressions in everyday life, *American Psychologist*, (62)4, 282-283.

<sup>19</sup> Holmberg, B., & Malcome, M. (2013). “Becoming an anti-racist social worker,” presentation to the NASW Illinois chapter, retrieved from [http://naswilmeets.org/wp-content/uploads/2013/10/NASW\\_Anti-Racist\\_FINAL.pdf](http://naswilmeets.org/wp-content/uploads/2013/10/NASW_Anti-Racist_FINAL.pdf)

Racial factors may play a role in the challenges facing families, regardless of their socio-economic status, and workers can adapt their practice approach in consideration of these factors.<sup>20</sup>

## Gender identity and sexual orientation

Approximately 5-10% of the general population is lesbian, gay, bisexual or transgender. LGBTQ adolescents are estimated to make up a higher, disproportionate share of the foster care and delinquency pools. Because many LGBTQ young people face disapproval and overt rejection from their families, they are more likely to be forced from their homes into the foster care and homeless populations. Once in foster care, bias against them may make it harder to find permanent placements for them, prolonging their stay in child welfare systems.<sup>21</sup>

The following principles provide the theoretical and philosophical underpinnings for professional practice:

1. All children deserve safety and acceptance in their homes and communities.
2. All children need support and nurturance to develop and embrace all aspects of their evolving identities, including their sexual orientation and gender identity and expression.
3. Children thrive when their caregivers affirm and respect their sexual orientation and gender identity and expression, and family acceptance both protects against health risks and promotes overall health. Conversely, children experience negative health and mental health outcomes when their caregivers reject or fail to support their sexual orientation and gender identity or expression.
4. Children *perceived by others* to be lesbian, gay, bisexual or gender nonconforming are exposed to the same risks as children who



### Terms & Definitions

**LGBTQ** is an abbreviation commonly used to refer to lesbian, gay, bisexual, transgender, and questioning individuals.

**Sexual orientation** refers to a person's emotional, romantic, and sexual attraction to persons of the same or different gender.

**Gender identity** refers to a person's internal sense of self as male, female, no gender, or another gender.

**Gender expression** refers to the manner in which a person expresses his or her gender through clothing, appearance, behavior, speech, etc. A person's gender expression may vary from the norms traditionally associated with his or her assigned sex at birth. Gender expression is a separate concept from sexual orientation and gender identity. For example, a male may exhibit feminine qualities, but identify as a heterosexual male.

**Lesbian** refers to a female who is emotionally, romantically, and sexually attracted to other females.

**Gay** refers to a person who is emotionally, romantically, and sexually attracted to people of the same gender identity. Sometimes, it may be used to refer to gay men and boys only. It is preferred over the term "homosexual."

**Bisexual** refers to a person who is attracted to, and may form sexual and romantic relationships with, males and females.

**Transgender** may be used as an umbrella term to include all persons whose gender identity or gender expression does not match society's expectations of how an individual of that gender should behave in relation to his or her gender. For purposes of protection from discrimination and harassment, transgender refers to both self-identified transgender individuals and individuals perceived as transgender. Transgender people may identify as heterosexual, lesbian, gay, bisexual, or questioning.

**Questioning** refers to a person, often an adolescent, who is exploring or questioning issues of sexual orientation or gender identity or expression in his or her life. Some questioning people will ultimately identify as lesbian, gay, bisexual, transgender, or heterosexual.

*Source:* OCFS Informational Letter [09-OCFS-INF-06](#), "Promoting a safe and respectful environment for lesbian, gay, bisexual, transgender, and questioning children and youth in out-of-home placement"

<sup>20</sup> National Association of Social Workers. (2007). *Institutional racism and the social work professions: A call to action*. Washington, DC: NASW.

<sup>21</sup> Child Welfare League & Lambda Legal. (2012). *Basic facts about being LGBTQ*. Washington, DC: CWLA.

openly identify as lesbian, gay, bisexual or transgender.<sup>22</sup>

Follow these guidelines when collecting family information:

**Do not ask youth if they are LGBTQ.** The only way to know another person’s sexual orientation or gender identity is for them to tell you. There are no tools or instruments to assess a person’s sexual orientation or gender identity. Youth will disclose their sexual orientation or gender identity to staff when, and if, they feel ready. This can only occur if a safe environment and trusting relationship has been created for such disclosure.

**Affirm the cultural identity of youth.** Cultural identity of youth is affirmed through supportive environments. Educational books and other reading materials should be made available for youth interested in learning more about their sexual identity. Materials should be made available in languages other than English, as needed. Youth should have access to supportive resources that provide age-appropriate LGBTQ information, including a book list, website list of community resource supports, and advocacy groups.<sup>23</sup>

## Religion and spirituality

Religion has been defined as “an organized, structured set of beliefs and practices shared by a community related to spirituality” and spirituality as “the search for meaning, purpose, and morally fulfilling relations with self, other people, the encompassing universe, and ultimate reality, however a person understands it.”<sup>24</sup>

Religion is often closely related to culture, and strongly influences a person’s view of the world. Spiritual or religious beliefs are important to many people and can be helpful to consider as a support system when developing a service plan for a family. If this dimension of a family’s life is ignored, preventive services may be less effective.<sup>25</sup>

As with other values related to culture, the worker’s own religious or spiritual beliefs could influence his/her interactions with families. Ethical concerns may arise over whether it is appropriate to pray with clients or to refer them to spiritual helpers that match their interests. Caseworkers should talk with their supervisors about any agency policies relevant to religious and spiritual discussions so they can effectively explore these topics with families.

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In summary, caseworkers must approach and interact with family members in culturally appropriate ways, and respect the cultural practices and values of the families with whom they interact. While all people share common basic needs, there are differences in how people of various cultures meet and prioritize those needs. Differences can be as important as similarities. Behaviors or interactions that are different from those familiar to a caseworker are not necessarily “less correct.”<sup>26</sup>

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<sup>22</sup> Wilber, S. (2013). *Guidelines for managing information related to the sexual orientation and gender identity and expression of children in child welfare systems*. Oakland, CA: Family Builders by Adoption.

<sup>23</sup> OCFS (2009). “Promoting a safe and respectful environment for lesbian, gay, bisexual, transgender, and questioning children and youth in out-of-home placement” 09-OCFS-INF-06.

<sup>24</sup> Canda, E.R. & Furman, L.D. (2010). *Spiritual Diversity in Social Work Practice: The Heart of Helping, 2<sup>nd</sup> Edition*. New York: Oxford University Press. p. 28.

<sup>25</sup> Dolgoff, R., Loewenberg, F.M., & Harrington, D., (2009). *Ethical Decisions for Social Work Practice, 8<sup>th</sup> Edition*. Belmont, CA: Thomson Brooks/Cole. p. 193.

<sup>26</sup> Ibid



## Chapter 6

# First Meeting and Initial Assessment

Formal assessment of the family begins when the case moves from Family Services Intake (FSI) to the Family Services Stage (FSS). At this point, the local department of social services (LDSS) or the New York City Administration for Children's Services (ACS) has opened the case for the provision of family services, including preventive services.

Preventive services may be provided directly by the LDSS, by another authorized agency, a not-for-profit corporation, or a public agency approved by OCFS [18 NYCRR 423.2(a)]. In New York City, all preventive services are provided by contracted provider agencies. Families and children who are eligible for either mandated or non-mandated preventive services generally enter the system as Child Welfare Services (CWS) cases. They may also be referred as the result of a Child Protective Services (CPS) investigation or, less frequently, by a court order.

In New York City, families may enter the system as Advocates Preventive Only (ADVPO) cases where the private preventive services agency is exempt from the responsibility of recording information in CONNECTIONS and other electronic systems. Information is entered on templates provided by ACS and stored at the private agency.



### Change: the process of making something different

We can be primed for change; that is, something in ourselves or our environment can stimulate the conditions that make us willing and able to change.

– OCFS Common Core Curriculum

## Forming a partnership

The first days of working with a family set the foundation for change. When families are referred for preventive services, they are usually at a point where their problems have become acute and stress levels are high. Some families may be at the breaking point. Case workers can use this situation to fuel a family's motivation to work toward meaningful change.

A positive, professional relationship between the caseworker and the family is essential for these efforts to succeed. This relationship is based on **partnership** rather than authority.

Before meeting a family for the first time, consider this question: If a stranger came into your home and suggested that you needed to change how you raise your children, how likely would you be to join with that person in making these changes?

Using these six principles of partnership<sup>27</sup> will increase the likelihood that you will engage and empower family members in working toward a common goal: keeping families safe and together:

1. Everyone desires respect. The most effective way to get respect is to offer it to others. As a professional, you are a model for families. If you embody respect in your interactions with families, you set a tone that will find its way into all parts of the system.

<sup>27</sup> OCFS Common Core Curriculum, Module 1, Unit A1. Adapted from Smith, C., White, P., & Comer, D. (2006) *Cornerstone III: Self study guide for family assessment*. Morgantown, NC: Appalachian Family Innovations

2. Everyone needs to be heard (and understood). Everyone's voice is important. By inviting families to freely share their ideas and concerns, we bring their strengths and resources into the open.
3. Everyone has strengths. Identify strengths with the family and use those strengths as a foundation for new learning and new ideas. Strengths-based practice sees the problems and the strengths and links them together to support the family.
4. Judgments can wait. Stay open to all information, especially that which challenges your assumptions about the family and its problems. Ask yourself, "What can I discover in this situation that would challenge my current understanding? How can I disprove my initial ideas?"
5. Partners share power. A worker walks into a family's life with a lot of power. This makes an impact on your relationship with the family and result in resistance and animosity. Sharing power among families, workers, and supervisors can open a pathway to helping families make good decisions.
6. Partnership is a process. Partnership will more successful with some families than others. You may believe you are progressing nicely and suddenly be thrown back to where you started. Involve families in evaluating your efforts and be transparent about what you are trying to achieve through partnership.

Evaluate what you think and how you feel about the families with whom you work. Do you make distinctions (consciously or unconsciously) between families that are referred by Child Protective Services and those that are not? Do you feel differently about households where allegations of child abuse or maltreatment have been substantiated? Answering these questions honestly will help you work more effectively with families, colleagues, and other service providers.

## Preparing for the initial visit

Most families referred for preventive services have a history with the child welfare system. For example, if they have been or are being investigated by CPS, they may have a negative view of preventive services.<sup>28</sup>

Careful preparation will help you know how to approach the family before you walk into the home. The following steps will help you prepare to work effectively and in a culturally and linguistically competent manner with each family referred for preventive services.

### ***Step 1: Review the intake (FSI) information.***

Review the intake information in CONNECTIONS and do a preliminary, informal analysis of the family's strengths and areas of concern. Document:

- The reasons the family was referred for services
- The problems and concerns the family faces
- The types of services being requested for the family
- The family's eligibility for mandated preventive services under the eligibility criteria described in **Chapter 2** of this manual

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<sup>28</sup> Adapted from New York City Children's Administrative Services (2011), *Conversations Around the Table: A Best-Practice Guide to Preventive Services*

Helpful information also may be available from:

- Pending or indicated Child Protective Services reports
- PINS and/or JD petitions
- Court orders
- Referral forms from individuals or agencies

***Step 2: List sources of support.***

Consider who can help support your work with the family. This network can include your supervisor, CPS worker(s), treatment providers, other case planners, juvenile justice service providers, Youth Bureau, or community agencies. If possible, contact the source who made the referral for services. Compile a list of these people, organizations, and resources and their contact information.

***Step 3: Identify the purpose of the visit.***

In your first contact with the family, you have two primary purposes, in addition to a focus on the present safety of the children and future risk of harm: 1) to introduce yourself to the family and 2) to engage family members in determining how you and they can work together to help keep children safe and strengthen the family. One mistake case planners often make is trying to do too much during the first visit. You simply want to be able to hear the family's voices and listen to the story of their lives, while maintaining a continuing focus on the present safety of the children and future risk of harm. Assessing safety and risk is discussed in detail in **Chapter 7**.

***Step 4: Plan engagement strategies.***

Your strategies for engaging the family will be aimed at creating core conditions for professional casework (helping) relationships: respect, empathy, and genuineness. Before your first meeting with the family, think about the strategies you will use to promote these conditions. Proven family engagement strategies include but are not limited to:

- Clear, honest, and respectful communication
- Sufficient frequency and length of contact with the family
- Strengths-based approach that recognizes and reinforces the family's capabilities and not just their needs and problems
- Shared decision-making and participatory planning that results in mutually agreed-upon goals and plans
- Broad-based involvement by parents, extended family members, informal networks, and community representatives
- Recognition of foster parents as resources for the entire family (if one or more children are in foster care)
- Praise and recognition of parents who are making life changes to provide safety and permanency for children<sup>29</sup>

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<sup>29</sup> U.S. Department of Health and Human Services, Administration for Children and Families (2010) "Family Engagement," available at [www.childwelfare.gov/pubs/f\\_fam\\_engagement/](http://www.childwelfare.gov/pubs/f_fam_engagement/)

For example, when you contact the parent or guardian, discuss several options for meeting times. This reflects your **respect** for the family members' time and helps to set the stage for a working relationship. Decide ahead of time how much you will disclose about your own experiences to create **empathy**, remembering that self-disclosure is used only when it is appropriate to further your professional relationship with the family. Although you may not be able to respect a person's actions or behavior, plan ways to demonstrate a **genuine** interest in the person as a human being with strengths that can lead to change.

### ***Step 5: Define assessment strategies.***

It's important to *not* begin your assessment by simply asking a series of questions. Strategize with your supervisor about how to balance the development of a relationship with the family and the need to gather information. However, basic assessment information must be gathered during the initial contact in order to create the Initial FASP. These include:

- Further examination of the issues that brought the family to your agency
- A safety assessment (see **Chapter 7**)
- A risk assessment (see **Chapter 7**)
- Strengths the family can use to begin to address the issues it faces (see **Chapter 8**)
- Current and potential team members who can help strengthen the family

## **During the initial visit**

There is no script to follow for every visit with every family. If you have gone through the five steps to prepare for the first visit, you have identified strategies for engaging the family and for gathering the information you need. Think about what you can do or say in the first 15 minutes to demonstrate both your desire to engage the family and your respect for family members.<sup>30</sup>

### **Introduce yourself.**

Keep your introduction simple: explain who you are, your role with the agency, and your commitment to working with the family.

**Confidentiality:** Clients must be informed about how their information will be collected, recorded, and shared. Explain that information from their applications and any ongoing services they receive will be maintained in the CONNECTIONS system (except in ADVPO cases), which can be accessed only by staff assigned to the case. See **Chapter 9** for details about confidentiality.

**Right to refuse services.** Also advise the family that they may refuse to accept offered services [18 NYCRR 423.4(m)(1)]. The only specific exception to this policy is when the services are to be provided as a result of a direct court order requiring either the specific provision of the services and/or the cooperation of the client. Also, if the child is the subject of a report of child abuse or maltreatment and the offered services are directed at correcting problems or behaviors that gave rise to the report, parental refusal may result in further action by CPS or the court.

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<sup>30</sup> Adapted from New York City Children's Administrative Services (2011), *Conversations Around the Table: A Best-Practice Guide to Preventive Services*



## Implement your assessment strategy.

Obtain the information needed by using the strategy you set up with your supervisor. It's OK to bring notes or an agenda with you to the interview, and if you are going to take notes during the interview, be sure to let the family know that you are taking notes. The conversation should be purposeful and focused on the reason for the visit. Be aware of the need to document the visit in future reports. For more details on family assessment, see **Chapters 7 and 8** of this manual.

**Safety Assessment.** The OCFS Safety Assessment Protocol covers 18 factors that must be considered in making a safety decision about the children in the household. This protocol is used in all child welfare cases (CPS, foster care, Family Assessment Response (FAR), preventive services) so that any worker who becomes involved in a case will have a clear understanding of the safety issues that may be present (see **Chapter 7**).

**Risk Assessment.** In non-CPS cases, preventive services workers use the Initial Non-CPS Risk Assessment tool to identify behaviors and conditions that present a future risk to children's safety and well-being (**Appendix E**). The elements in the Risk Assessment help guide workers in their observations and documentation of ongoing family dynamics (see **Chapter 7**).

**Underlying Conditions.** Underlying conditions are sets of personal characteristics and dynamics that are behind safety threats and risk of harm. They can include physical or psychological needs, beliefs, family system, values, experience, emotional state, skills and abilities, and self-concept (see **Chapter 8**).

**Contributing Factors.** Contributing factors are conditions that influence individual behavior and affect safety and risk for children in the home. They can include mental illness, substance abuse, domestic violence, developmental disabilities, physical impairment, inadequate housing, or poverty (see **Chapter 8**).

## Start to identify individual and family strengths.

Strengths are characteristics that help the individual or family meet the challenges of their lives, respond effectively to stressful situations, adapt and grow in the face of adversity, and support the goals of safety, permanency, and well-being for children and youth (see **Chapter 8**).

## Let family members tell their stories.

Part of your assessment strategy will be to interview family members. Ask open questions that encourage them to talk about their history and experiences. Listen carefully and validate what each person has to say. Validation does not mean that you accept or approve; rather, you acknowledge that you have heard how they experience their world.

Effective, open questions usually begin with "how," "what," "could," or "would." Examples include:<sup>31</sup>

- The Relationship Question ("What do you suppose your children think about this?")
- The Scaling Question ("On a scale of one to ten, how do you feel about this plan?")
- The Solution-Focused Question ("What have you done in the past when this issue came up?")
- The Exception-Finding Question ("Can you describe a time when things were different?")
- The "Miracle" Question ("What would your life be like if suddenly everything was perfect?")

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<sup>31</sup> OCFS Common Core Curriculum Module 2, Unit B2

- The Coping Question (“How have you managed to keep going?”)
- The Wide-Angle Question (“When you have a need, who can you turn to for support?”)

### **Develop a working contract.**

Discuss how you and the family will work together toward your mutual goals. It’s not necessary to tackle all of the family’s concerns in one visit; let the family know that subsequent meetings and conversations will address additional concerns. At this point, responsible family members should complete an application for services; advise them about when and where services will be provided.

### **Leave with clear “next steps.”**

At the end of the meeting, determine what you, the family, and other key team members will be working on to strengthen the family. The agreed-upon steps are included in the family’s Service Plan, which will become the family’s working document.

Decide on the number of contacts to be made within the first two months. A frequent schedule of contact is recommended during this initial period. This will give you more opportunities to build a partnership, strengthen the family, and observe underlying conditions and behaviors that need to change. It is also a good idea to set a consistent time for appointments with the family. This encourages some structure and routine for the family, and sends a message about the importance of the work you are doing together. See **Chapter 9** for more information on casework contact requirements.

## **Special Considerations**

Certain situations in the home may require special attention or action. If situations such as these arise, discuss next steps with your supervisor.

### **Possible child abuse or maltreatment**

You will need to assess family issues and behaviors on an ongoing basis to determine whether the child has been harmed or is in imminent danger and/or at risk of future harm. Observe the interactions between parents and children, among siblings, and with other adults in the home. If you have reasonable cause to suspect that abuse or maltreatment has occurred, report it immediately to the Statewide Central Register (SCR), and notify your supervisor. You do not have to inform the family that you are making a report.

### **Hygiene and cleanliness**

The issue of cleanliness – either personal hygiene or the cleanliness of the home – needs to be addressed when it influences or affects the safety or well-being of the child(ren). Parents are expected to provide a minimum level of care that includes regular bathing, hair washing, and dental care to prevent skin problems, foul odors, parasites, tooth decay, etc. In discussing this issue with family members, focus on how a lack of cleanliness can affect the children: their health, their ability to succeed in school, and relationships with friends.<sup>32</sup>

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<sup>32</sup> OCFS Core Curriculum (2012), Module 1, Unit B1, p. 179

## Domestic violence

Children’s exposure to domestic violence (DV) does not, by itself, constitute abuse or maltreatment. It is essential, however, to develop a safety plan with the cooperation of the non-offending partner and the children (depending on their ages and developmental levels). Individual or group therapy may help mitigate the effects on the children of exposure to domestic violence. Special care must be taken in scheduling family meetings when domestic violence is present. The DV offender may be included if this does not threaten the safety of the partner or the children.



### Domestic Violence

In a domestic violence situation, the non-offending parent is the expert on the situation. She is your best source of information about the behavior of the DV offender and about whether and how to engage him.

*Source: OCFS Practice Considerations for Conducting Family Meetings with Families Affected by Domestic Violence*

## Interviewing adolescents

If there are adolescents in the family, it is critical to see their perspectives on the family situation and engage them in developing the Service Plan. For some adolescents, this may be the first time they have been asked for their opinions by an adult. Listen without judgment and focus on building trust. Suggested techniques:

- Ask the youth for the words of a song or a visual image that depicts his or her life right now, and then a song, image, or phrase that describes how they would like their future to be.
- Ask the youth to imagine a better life and what would be different about it.
- Use the VERB technique: a) validate the teen’s experience; b) explore realistic options; c) respect the teen’s decisions; and d) build on the youth’s strengths, resources, assets, and coping mechanisms.<sup>33</sup>

The challenging behavior of adolescents can easily become the focus of family problems. A “problem child” is indicative of deeper family issues. The caseworker should be careful not to take sides with either the parents or the child; view the family system as a whole.

## Absent family

Prepare for the possibility that the family may not be home when you visit. Bring with you a typed note in both English and the family’s language, if necessary. Include your name, your agency’s phone number and address, and the reason for your visit. **Do not** leave any confidential case information. Ask the family to stop in or call to arrange a better time for the visit. Include the name of a person the family can ask for if you are not in when they call. This procedure may have to be repeated multiple times; enter each attempt in the case record progress notes. You must document that you have made every attempt to connect with the family before further steps are taken.

## Families that don’t follow through

If the family consistently misses meetings or fails to follow through with agreed-upon actions, it’s time for respectful confrontation, feedback, or “straight talk” with the family. Building upon the partnership

<sup>33</sup> Adapted from Richard, Michele (2006) “Engaging and Interviewing Teens,” STEPs to End Family Violence, Edwin Gould Services for Children and Families.

you have developed with the family, talk about what you have observed, hear what the family members have to say, and outline the possible consequences if they fail to follow their Service Plan.

## Indications of child trafficking

Recent federal and state laws have heightened the importance that child welfare, and other professions, must pay to possible trafficking victims. The federal Preventing Sex Trafficking and Strengthening Families Act [P.L. 113-183] was signed into law on Sept. 29, 2014. It is designed to protect and prevent at-risk children and youth from becoming victims of sex trafficking and to improve the safety, permanency, and well-being outcomes of children and youth involved with the child welfare system. The implementation of this law in New York State is in process, and is described in detail in Informational Letter [15-OCFS-INF-03](#).

## Incarcerated parents

It is important that preventive services caseworkers determine the whereabouts of any parent of a child receiving preventive services, including parents who are incarcerated. If the caseworker thinks one or more parents may be incarcerated, he or she can ask the adults in the case or check the publicly available databases of state prison inmates; many localities have similarly available lists for locally operated jails.

When completing the information about the family in the Person List in CONNECTIONS, it is recommended that workers include the status and location of parents who are not currently residing in the household, including those who are incarcerated or in residential treatment facilities. It is also important to know if and when a parent or other relative may be released from jail or prison and re-enter the household so the potential impact on the family may be assessed, including but not limited to safety of the household members.

## The Initial Family Assessment and Service Plan

The Initial FASP must be entered in CONNECTIONS (or templates for ADVPO cases) within 30 days of the case initiation date. When a case has been opened based on an indicated report from CPS, CPS will begin a case record by the day of the indication and the Service Plan will be entered within seven days. The case manager or CPS monitor must see that preventive services are included in the ongoing record maintained by CPS.

If the family is already receiving services (such as foster care for this or another child) documentation for preventive services is added as a Plan Amendment (see **Chapter 10**). It must be documented and approved by the social services district having case management responsibility for the case within 30 days of the change. If preventive services are begun within 60 days of the due date of the next FASP, the status change may be documented and approved as part of that plan. [[18 NYCRR 428.7\(d\)](#)]

A single plan is to be completed for *all* family members in the case record. If the family or child is receiving services in addition to preventive services, the case manager will identify who is responsible for timely completion of the plan and its subsequent updates.

The FASP clearly identifies what needs to change in the family and the services that are designed to achieve that change. It provides the family, child welfare workers, supervisors, and other service providers with a clear blueprint of who is going to do what in order to achieve the family's goals. The FASP is documented in CONNECTIONS (except for FAR cases, where workers use an Action Plan form).

## Family assessment

Based on source records and your assessment of the family's strengths, needs, and risks, enter the following information into the FASP:

- The presenting problem and referral source<sup>34</sup>
- The family's relevant service history, including actions taken in the past to meet the family's needs, such as a summary of casework contacts, service referrals, services provided, court involvement
- The current functioning of the family, such as family members' interaction, their ability to cope with stress, family strengths, and the caregivers' capacity to care for children
- Support currently available to the family
- The family's need for services and its ability to benefit from the provision of services
- A permanency planning goal for each child for whom services are authorized
- Program choice consistent with the assessment of the family's needs
- Placement information, including appropriateness of placement determination and visiting plan, if a child is receiving foster care

See **Chapters 7 and 8** for detailed information on the family assessment.

## Service Plan

In New York State, the collaboration between workers and families must result in a Family Assessment and Service Plan that contains statements of problems/concerns, outcomes, family strengths to be utilized, and activities. OCFs regulation [18 NYCRR 428.6](#) requires the FASP to include at least:

1. A program choice or choices for each child receiving services;
2. A goal and plan for child permanency;
3. A description of legal activities and their impact on the case;
4. A thorough and comprehensive assessment or reassessment and analysis of the family members' strengths, needs and problems;
5. Immediate actions or controlling interventions [[18 NYCRR 428.2\(j\)](#)] that must be taken or have been provided;
6. The family's view of its needs and concerns;
7. A plan of services and assistance made in consultation with the family and each child over 10 years old, whenever possible, which utilizes the family's strengths and addresses the family members' needs and concerns;
8. The status of the Service Plan, including service availability and a description of the manner of service provision;
9. The family's progress toward plan achievement;

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<sup>34</sup> For CPS cases, the referral source should be identified as the Statewide Central Register for Child Abuse and Maltreatment. The actual source must *not* be identified in any way.

10. Essential data relating to the identification and history of the child and family members and a summary which documents the involvement of the parent(s) or guardian, child(ren) and any others in the development of the Service Plan including their input into the Service Plan;
11. Safety assessments in all cases [[18 NYCRR 428.2\(i\)](#) and [428.3\(g\)](#)];
12. Risk assessments in child protective services cases [[18 NYCRR 428.2\(h\)](#)]; and
13. Assessments of family functioning.

The format for Service Plans appears in CONNECTIONS as a group of text boxes. For each behavior or circumstance that needs to change, the information below is to be entered in the specified boxes. This process can be repeated when there are multiple behaviors or circumstances that need to change.

1. The statement that specifies the behavior or circumstance that needs to change
2. The statement of the desired result/outcome of that change
3. The strengths of the family that will be built upon and supported to achieve long-term change related to the desired outcome
4. A description of the activities and services that will support that change, performed by both the family and workers/service providers

The plan also must include a summary of the involvement of the parents, children, and any others in the development of the Service Plan. The Initial FASP must be reviewed and approved by the case manager, and, if appropriate, the CPS monitor. Parents/caretakers are not required to sign the Service Plan, but should be involved in the planning process and sign Service Plans whenever possible.

## Preventive services standards

You must document the eligibility standards for mandated preventive services (see **Chapter 2**) in the family's case record and Service Plans. Generally, this is done in the first case record due after the date of authorization for preventive services. When no other services are currently being provided to the child or family, the first documentation will be in the Initial Assessment and Service Plan (IASP) as part of the assessment of family functioning. See **Appendix A** for details on how to document for each standard.

## Chapter 7

# Family Assessment: Safety and Risk

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The safety of children in preventive services cases, as in all child welfare work, is of paramount importance.

It is the responsibility of all child welfare workers and supervisors to continually assess the immediate safety and the future risk of abuse or maltreatment of all children in the case throughout the period of time that the family's case is open for services. All public and private service providers must use Safety Factors and the Risk Assessment Profile (RAP). These tools are used in all child protective investigations and in foster care and preventive services cases where children need continued protection from abuse or maltreatment.

While helping a family to achieve its Service Plan goals, the worker must simultaneously focus on the immediate safety of all children in the home and the future risk of abuse and maltreatment. This occurs during every contact with the family, even when other topics are being discussed. Information gathered from the family and from other sources usually serves multiple purposes. The worker does not, of course, have one conversation with the family about safety, then return to have a separate conversation about risk, and then return a third time to discuss progress toward Service Plan goals. Most of the information related to safety, risk, indicators of abuse or maltreatment, or service planning, is collected simultaneously.

## Safety Assessment

Caseworkers must be able to identify any presenting safety issues and determine what actions are needed to protect the child, family or community in regard to safety. In order to accomplish this, caseworkers must have a working knowledge of the specific factors that indicate whether children may be in immediate or impending danger of serious harm as well as the specific policies and practice tools that aid them in this assessment and the decision-making process.

Both the safety decision and the safety planning process are informed by the individual, family, and community strengths that surround the family, and the entire process requires the application of critical thinking skills in order to reduce worker bias and errors in decision-making.

For child protective purposes, a child is considered "safe" when there is no immediate or impending danger of serious harm to a child's life or health, as a result of acts of commission or omission (actions or inactions) by the child's parent(s) or caretaker(s). There are two types of danger:

- A child is in **immediate danger** when presently exposed to serious harm.
- A child is in **impending danger** when exposure to serious harm is emerging, about to happen, or is a reasonably foreseeable consequence of current circumstances.

An example of immediate danger: The caseworker finds two children, ages 2 and 4, alone on a Friday night in a third-floor apartment. The unscreened windows are wide open and matches have been left within the children's reach. The mother is several floors away and under the influence of drugs.

An example of impending danger: When the caseworker visits on a Thursday morning, the mother is at home with her two children, ages 2 and 4. A credible neighbor reports that the mother leaves the

children alone every Friday night, all night long. The mother has been seen entering an apartment on another floor on Friday nights to use drugs with friends.<sup>35</sup>

During the CPS investigation, a safety assessment is conducted by the caseworker, in consultation with a supervisor.<sup>36</sup> The assessment:

1. Identifies any safety factors currently present in the child's living situation.
2. Applies the safety criteria to determine if the child is in immediate or impending danger of serious harm.
3. Makes a safety decision and decides what action, if any, is necessary to protect the child.
4. Develops and implements a safety plan if the child is in immediate or impending danger of serious harm.

## Non-CPS safety issues

When a family has not been referred by CPS for preventive services, the worker should still assess for protective safety factors. However, in non-CPS cases, the assessment should move beyond the parent/child relationship. The worker must determine whether one or more children, parents, caretakers, family members, or community members are likely to be in immediate or impending danger of serious harm or face a serious threat to their emotional, physical, or developmental well-being.

The main tasks of a safety assessment in a non-protective case are:

- Identify any threats of danger to children, youth, family, or community members that are not related to parental action or inaction.
- Determine if the non-CPS safety threats pose immediate or impending danger of serious harm for the children, family members, or community.
- Identify any key protecting factors that are being used to promote safety, such as a parent seeking assistance for a recognized problem.
- Take appropriate action to protect the child, youth, family, or community from danger.

Examples of non-CPS safety issues:

- A child is suicidal or violent
- A youth is involved in gangs or abusing drugs
- A family crisis, such as a fire or other catastrophe
- Sudden loss of a primary caretaker
- Dangerous community conditions, such as substandard housing or threats against the family<sup>37</sup>

## Safety factors

Safety factors are behaviors, conditions, or circumstances that have the potential to place a child in immediate or impending danger of serious harm. These include specific parent/caretaker behaviors,

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<sup>35</sup> OCFS Common Core Curriculum, Module 1, Unit C, pp. 324-325

<sup>36</sup> See CPS Investigation Safety Assessment, OCFS-IT-BCPCPS002, for elements required for recording the Safety Assessment in CONNECTIONS or template forms.

<sup>37</sup>OCFS Common Core Curriculum, Module 1, Unit C, pp. 324-325



conditions in the home, family dynamics, history and other circumstances. The caseworker uses all available information to assess whether any of the safety factors are currently present in the child's living situation. Sources of information include, but are not limited to, direct observation of the family and the home environment, interviews with family members [including the child(ren)], and information gathered from credible collateral sources of information.

New York State has defined 18 safety factors to be used by caseworkers during safety assessments. Each of the safety factors is listed below, along with an expanded definition of each. The caseworker also has the option for "No safety factors present at this time." The following descriptions are included in the OCFS/ACS publication, *Expanded Safety Factors*.

**1. Based on your present assessment and review of prior history of abuse or maltreatment, the Parent(s)/Caretaker(s) is unable or unwilling to protect the child(ren).**

- Prior abuse or maltreatment (may include non-reported accounts of abuse or maltreatment) was serious enough to have caused or could have caused serious injury or harm to the child(ren).
- Parent(s)/Caretaker(s) current behavior demonstrates an inability to protect the child(ren) because they lack the capacity to understand the need for protection and/or they lack the ability to follow through with protective actions.
- Parent(s)/Caretaker(s) current behavior demonstrates an unwillingness to protect children because they minimize the child(ren)'s need for protection and/or are hostile to, passive about, or opposed to keeping the child(ren) safe.
- Parent(s)/Caretaker(s) has retaliated or threatened retribution against child(ren) for involving the family in a CPS investigation or child welfare services, either in regard to past incident(s) of abuse or maltreatment or a current situation.
- Escalating pattern of harmful behavior or abuse or maltreatment.
- Parent(s)/Caretaker(s) does not acknowledge or take responsibility for prior inflicted harm to the child(ren) or explains incident(s) as not deliberate, or minimizes the seriousness of the actual or potential harm to the child(ren).

**2. Parent(s)/Caretaker(s) currently uses alcohol to the extent that it negatively impacts his/her ability to supervise, protect and/or care for the child(ren).**

- Parent(s) Caretaker(s) has a recent incident of or a current pattern of alcohol use that negatively impacts their decisions and behaviors and their ability to supervise, protect and care for the child. As a result, the caretaker(s) is:
  - unable to care for the child;
  - likely to become unable to care for the child;
  - has harmed the child;
  - has allowed harm to come to the child; or
  - is likely to harm the child.
- Newborn child with positive toxicology for alcohol in its bloodstream or urine and/or was born with fetal alcohol effect or fetal alcohol syndrome.

**3. Parent(s)/Caretaker(s) currently uses illicit drugs or misuses prescription medication to the extent that it negatively impacts his/her ability to supervise, protect and/or care for the child(ren).**

- Parent(s)/Caretaker(s) has recently used, or has a pattern of using illegal and/or prescription drugs that negatively impacts their decisions and behaviors and their ability to supervise, protect and care for the child. As a result, the parent(s)/caretaker(s) is:
    - unable to care for the child;
    - likely to become unable to care for the child;
    - has harmed the child;
    - has allowed harm to come to the child; or
    - is likely to harm the child.
  - Newborn child with positive toxicology for illegal drugs in its bloodstream or urine and/or was born dependent on drugs or with drug withdrawal symptoms.
- 4. Child(ren) has experienced or is likely to experience physical or psychological harm as a result of domestic violence in the household. Examples of direct threats to child(ren):**
- Observed or alleged batterer is confronting and/or stalking the caretaker/victim and child(ren) and has threatened to kill, injure, or abduct either or both.
  - Observed or alleged batterer has had recent violent outbursts that have resulted in injury or threat of injury to the child(ren) or the other caretaker/victim.
  - Parent/Caretaker/victim is forced, under threat of serious harm, to participate in or witness serious abuse or maltreatment of the child(ren).
  - Child(ren) is forced, under threat of serious harm, to participate in or witness abuse of the caretaker/victim.
  - Other examples of domestic violence: Caretaker/victim appears unable to provide basic care and/or supervision for the child because of fear, intimidation, injury, incapacitation, forced isolation, fear or other controlling behavior of the observed or alleged batterer.
- 5. Parent(s)/Caretaker(s)'s apparent or diagnosed medical or mental health status or developmental disability negatively impacts his/her ability to supervise, protect, and/or care for the child(ren).**
- Parent(s)/Caretaker(s) exhibits behavior that seems out of touch with reality, fanatical, bizarre, and/or extremely irrational.
  - Parent(s)/Caretaker(s) diagnosed mental illness does not appear to be controlled by prescribed medication or they have discontinued prescribed medication without medical oversight and the parent/caretaker's reasoning, ability to supervise and protect the child appear to be seriously impaired.
  - The parent(s)/caretaker(s) lacks or fails to utilize the necessary supports related to his/her developmental disability, which has resulted in serious harm to the child or is likely to seriously harm the child in the very near future.
- 6. Parent(s)/Caretaker(s) has a recent history of violence and/or is currently violent and out of control.**
- Extreme physical and/or verbal abuse, angry or hostile outbursts of anger or hostility aimed at the child(ren) that are recent and/or show a pattern of violent behavior.

- A recent history of excessive, brutal or bizarre punishment of child(ren), i.e., scalding with hot water, burning with cigarettes, forced feeding.
  - Threatens, brandishes or uses guns, knives or other weapons against or in the presence of other household members.
  - Violently shakes or chokes baby or young child(ren) to stop a particular behavior.
  - Currently exhibiting, or has a recent history or pattern of behavior that is reckless, unstable, raving, or explosive.
- 7. Parent(s)/Caretaker(s) is unable and/or unwilling to meet the child(ren)'s needs for food, clothing, shelter, medical or mental health care and/or control child's behavior.**
- No food provided or available to child, or child starved or deprived of food or drink for prolonged periods.
  - Child appears malnourished.
  - Child without minimally warm clothing in cold months; clothing extremely dirty.
  - No housing or emergency shelter; child must or is forced to sleep in street, car, etc.
  - Housing is unsafe, without heat, sanitation, windows, etc., or presence of vermin, uncontrolled/excessive number of animals and animal waste.
  - Parent/Caretaker does not seek treatment for child's immediate and dangerous medical condition(s) or does not follow prescribed treatment for such condition(s).
  - Child(ren)'s behavior is dangerous and may put them in immediate or impending danger of serious harm, and the parent/caretaker is not taking sufficient steps to control that behavior and/or protect the child(ren) from the dangerous consequences of that behavior.
- 8. Parent(s)/Caretaker(s) is unable and/or unwilling to provide adequate supervision of the child(ren).**
- Parent/Caretaker does not attend to child to the extent that need for adequate care goes unnoticed or unmet (i.e., although caretaker present, child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge or be exposed to other serious hazards).
  - Parent/Caretaker leaves child alone (time period varies with age and developmental stage).
  - Parent/Caretaker makes inadequate and/or inappropriate child care arrangements or demonstrates very poor planning for child's care.
  - Parent/Caretaker routinely fails to attempt to provide guidance and set limits, thereby permitting a child to engage in dangerous behaviors.
- 9. Child(ren) has experienced serious and/or repeated physical harm or injury and/or the parent(s)/caretaker(s) has made a plausible threat of serious harm or injury to the child(ren).**
- Child(ren) has a history of injuries, excluding common childhood cuts and scrapes.
  - Other than accidental, parent/caretaker likely caused serious abuse or physical injury, i.e. fractures, poisoning, suffocating, shooting, burns, bruises/welts, bite marks, choke marks, etc.
  - Parent/Caretaker, directly or indirectly, makes a believable threat to cause serious harm, i.e., kill, starve, lock out of home, etc.

- Parent/Caretaker plans to retaliate against child for CPS investigation or disclosure of abuse or maltreatment.
- Parent/Caretaker has used torture or physical force that bears no resemblance to reasonable discipline, or punished child beyond the duration of the child's endurance.

**10. Parent(s)/Caretaker(s) views, describes or acts toward the child(ren) in predominantly negative terms and/or has extremely unrealistic expectations of the child(ren).**

- Describes child as evil, possessed, stupid, ugly, or in some other demeaning or degrading manner.
- Curses and/or repeatedly puts child down.
- Scapegoats a particular child in the family.
- Expects a child to perform or act in a way that is impossible or improbable for the child's age (i.e., babies and young children expected not to cry, expected to be still for extended periods, be toilet trained or eat neatly).

**11. Child(ren)'s current whereabouts cannot be ascertained and/or there is reason to believe the family is about to flee or refuses access to the child(ren).**

- Family has previously fled in response to a CPS investigation.
- Family has removed child from a hospital against medical advice.
- Family has history of keeping child at home, away from peers, school, or others for extended periods.
- Family could not be located despite appropriate diligent efforts.

**12. Child(ren) has been or is suspected of being sexually abused or exploited and the parent(s)/caretaker(s) is unable or unwilling to provide adequate protection of the child(ren).**

- It appears that the parent/caretaker has committed rape, sodomy or has had other sexual contact with child(ren).
- Child(ren) may have been forced or encouraged to sexually gratify caretaker or others, or engage in sexual performances or activities.
- Access by possible or confirmed sexual abuser to child(ren) continues to exist.
- Child(ren) may be sexually exploited online and parent(s)/caretaker(s) may take no action(s) to protect the child(ren).

**13. The physical condition of the home is hazardous to the safety of the child(ren).**

- Leaking gas from stove or heating unit.
- Dangerous substances or objects accessible to children.
- Peeling lead base paint accessible to young children.
- Hot water/steam leaks from radiator or exposed electrical wiring.
- No guards or open windows/broken/missing windows.
- Health hazards such as exposed rotting garbage, food, human or animal waste throughout the living quarters.

- Home hazards are easily accessible to children and would pose a danger to them if they are in contact with the hazard(s).
- 14. Child(ren) expresses or exhibits fear of being in the home due to current behaviors of parent(s)/caretaker(s) or other persons living in, or frequenting the household.**
- Child cries, cowers, cringes, trembles or otherwise exhibits fear in the presence of certain individuals or verbalizes such fear.
  - Child exhibits severe anxiety related to situation associated with a person(s) in the home, i.e., nightmares, insomnia.
  - Child reasonably expects retribution or retaliation from caretakers.
  - Child states that he/she is fearful of individual(s) in the home.
- 15. Child(ren) has a positive toxicology for drugs and/or alcohol.**
- Child(ren) (0–6 mos.) is born with a positive toxicology for drugs and/or alcohol.
- 16. Child(ren) has significant vulnerability, is developmentally delayed, or medically fragile (e.g., on apnea monitor) and the parent(s)/caretaker(s) is unable and/or unwilling to provide adequate care and/or protection of the child(ren).**
- Child(ren) is required to be on a sleep apnea monitor, or to use other specialized medical equipment essential to their health and well-being, and the parent/caretaker is unable to unwilling to consistently and appropriately use or maintain the equipment.
  - Child(ren) has significant disabilities such as autism, Down Syndrome, hearing or visual impairment, cerebral palsy, etc., or other vulnerabilities, and the parent(s)/caretaker(s) is either unable or unwilling to provide care essential to needs of the child(ren)'s condition(s).
- 17. Weapon noted in CPS report or found in the home and parent(s)/caretaker(s) is unable and/or unwilling to protect the child(ren) from potential harm.**
- A firearm, such as a gun, rifle or pistol is in the home and may be used as a weapon.
  - A firearm and ammunition are accessible to child(ren).
  - A firearm is kept loaded and parent(s)/caretaker(s) is unwilling to separate the firearm and the ammunition.
- 18. Criminal activity in the home negatively impacts parent(s)/caretaker(s) ability to supervise, protect and/or care for the child(ren).**
- Criminal behavior (e.g., drug production, trafficking, and prostitution) occurs in the presence of the child(ren).
  - The child(ren) is forced to commit a crime(s) or engage in criminal behavior.
  - Child(ren) exposed to dangerous substances used in the production or use of illegal drugs, e.g., methamphetamines.
  - Child(ren) exposed to danger of harm from people with violent tendencies, criminal records, people under the influence of drugs.

## Applying the safety criteria

The caseworker should apply safety criteria to each identified safety factor to determine whether the child is in immediate or impending danger of serious harm by taking into account:

- The seriousness of behaviors/circumstances reflected by the safety factor;
- The number of safety factors identified;
- The degree of the child's vulnerability and need for protection; *and*
- The age of the child.

Each of these considerations is important to consider when making a decision about a child's safety. Consider the example below:

You are the preventive services caseworker for a family where the grandmother is caring for her two grandchildren who were abandoned by their parents. The grandmother has severe diabetes, which makes it very difficult to walk as the circulation in her legs is very poor. Due to this condition, she cannot go upstairs where the children's bedrooms are located and she can no longer stand long enough to prepare meals for the children.

You are assessing the identified safety factor, "Parent(s)/Caretaker(s)'s apparent or diagnosed medical or mental health status or developmental disability negatively impacts his/her ability to supervise, protect and/or care for the child(ren)."

Consider these two possible scenarios related to this example:

**Scenario 1:** The children are 14 and 16 years old and have no physical or cognitive impairments. They get themselves up and out for school on time. With some nagging and direction from the grandmother, the teens make meals for the family from the groceries that she has instructed them to buy. There are no other safety factors present.

**Scenario 2:** The children are 7 and 3 years old and the 7-year-old has to supervise the 3-year-old when the children are upstairs. Also, when the 7-year-old is at school, the 3-year-old is home alone with the grandmother. The 3-year-old has developmental delays and does not respond to the grandmother's directions.

These two scenarios demonstrate how applying safety criteria can lead to different safety decisions. While the grandmother's diagnosed medical health status is the same in both scenarios, Scenario 1 includes significantly less serious behaviors/circumstances and includes the presence of no other safety factors. The children are older, less vulnerable and have no developmental delays identified. In contrast, Scenario 2 involves much younger children, one of whom is home alone with the grandmother for extended periods of time and has developmental delays. The potential for the 3-year old child to be in immediate or impending danger appears to be relatively high.<sup>38</sup>

## Safety decision

After identifying the safety factors that are present and applying the safety criteria to determine if the child is in immediate or impending danger of serious harm, the next step is to make a safety decision. A safety decision is a statement of the current safety status of the child(ren) and the actions that are needed to protect the child(ren) from immediate or impending danger of serious harm.<sup>39</sup> The caseworker, in consultation with the supervisor, selects one of five available safety decisions:

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<sup>38</sup> OCFS Common Core Curriculum, Module 1, Unit C, pp. 348-350

<sup>39</sup> OCFS CPS Investigation Safety Assessment, p. 4

**Safety Decision 1:** No safety factors were identified at this time. Based on currently available information, there is no child(ren) likely to be in immediate or impending danger of serious harm. No Safety Plan/Controlling Interventions are necessary at this time.

**Safety Decision 2:** Safety Factors do exist, but do not rise to the level of immediate or impending danger of serious harm. No Safety Plan/Controlling Interventions are necessary at this time. However, identified Safety Factors have been/will be addressed with the Parent(s)/Caretaker(s) and reassessed.

**Safety Decision 3:** One or more safety factors are present that place the child in immediate or impending danger of serious harm. A Safety Plan is necessary and has been implemented/maintained through the actions of the Parent(s)/Caretaker(s) and/or either CPS or child welfare staff. The child(ren) will remain in the care of the Parent(s)/Caretaker(s).

**Safety Decision 4:** One or more Safety Factors are present that place the child(ren) in immediate or impending danger of serious harm. Removal to, or continued placement in, foster care or an alternative placement setting is necessary as a Controlling Intervention to protect the child(ren).

*Note:* If safety decision #4 is chosen, it is necessary to document which children were placed or remain in foster care or an alternative placement. Also, if applicable, caseworkers must identify the protecting factors that allow each child(ren), if any, to remain in the home.

**Safety Decision 5:** One or more Safety Factors are present that place or may place the child(ren) in immediate or impending danger of serious harm, but Parent(s)/Caretaker(s) has refused access to the child(ren) or fled, or the child(ren)'s whereabouts are unknown.

## Safety Plan

If a child is determined to be in immediate or impending danger of serious harm, the caseworker must develop a safety plan<sup>40</sup>. This safety plan must control for the danger and protect the child from what is placing him or her in immediate or impending danger of serious harm for as long as the danger exists. This is known as managing safety.

There are several elements of the Safety Plan. The plan:

- Provides a clearly defined set of actions, including controlling interventions when necessary, that have been or will be taken without delay to protect the child(ren) from immediate or impending danger of serious harm.
- Addresses all of the behaviors, conditions, or circumstances that create the immediate or impending danger of serious harm to the child(ren).
- Specifies the tasks and responsibilities of all persons (parent/caretaker, household/family members, caseworker, or other service providers) who have a role in protecting the child(ren).
- Gives time frames associated for each action or task in the plan that must be implemented.
- Identifies how the necessary actions and tasks in the plan will be managed, and by whom.

The plan must be modified in response to changes in the family's circumstances, as necessary, to continually protect the child(ren) throughout the life of the case. The plan must stay in place until the

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<sup>40</sup> OCFS CPS Investigation Safety Assessment, p. 5

protective capacity of the parent/caretaker is sufficient to eliminate immediate or impending danger of serious harm to the child(ren) in the absence of any controlling interventions.<sup>41</sup>

A wide array of controlling interventions or activities can be included in safety plans to protect a child from situation, behaviors or conditions that are associated with immediate or impending danger of serious harm. Without controlling interventions, the dangerous situations, behaviors or conditions would still be present, would emerge, or would in all likelihood immediately return. For safety/controlling interventions to be part of a viable safety plan, they must be available immediately. Additionally, people who are integral to the plan must be capable of and committed to carrying out the interventions and the plan.

## Controlling interventions

Controlling interventions are activities or arrangements that protect a child from situations, behaviors, or conditions associated with immediate or impending danger of serious harm. Without these interventions, the dangerous situations, behaviors, or conditions would still be present, would emerge, or would in likelihood immediately return. Controlling interventions that may be selected as part of a CPS investigation include:

1. Intensive Home-Based Family Preservation Services
2. Emergency Shelter
3. Domestic Violence Shelter
4. Non-offending Parent/Caretaker Has Been Moved to Safe Environment with Children
5. Authorization of Emergency Food/Cash/Goods
6. Judicial Intervention
7. Order of Protection
8. Law Enforcement Involvement
9. Emergency Medical Services
10. Crisis Mental Health Services
11. Emergency In-Patient Mental Health Services
12. Immediate Supervision/Monitoring
13. Emergency Alcohol Abuse Services
14. Emergency Drug Abuse Services
15. Correction or Removal of Hazardous/Unsafe Living Conditions
16. Placement – Foster Care
17. Placement – Alternate Caregiver
18. Supervised Visitation
19. Use of Family, Neighbors, or Other Individuals in the Community as Safety Resources
20. Alleged Perpetrator has left the Household Voluntarily and Current Caretaker will Appropriately Protect the Victims with CPS Monitoring
21. Alleged Perpetrator has left the Household in Response to Legal Action

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<sup>41</sup> OCFS Core Curriculum, Module 1, Unit C, p. 374



22. Follow-Up to Verify Child(ren)'s Whereabouts/Gain Access to the Child(ren)
23. Other (Specify)<sup>42</sup>

## Documenting the safety assessment

The Safety Assessment is included in the FASP in the CONNECTIONS system. It helps guide and support the caseworker's professional judgment. It is also the place where the safety assessment process, including the safety decision and safety plan, if needed, are documented by the caseworker and reviewed/approved by the supervisor. Non-protective safety issues are summarized in a narrative form in CONNECTIONS.

## Assessing risk of abuse/maltreatment

While a safety assessment is focused on the immediate or impending safety of the children, risk is future-oriented. OCFS regulations define risk assessment as "a process of information gathering and analysis that examines the interrelatedness of risk elements affecting family functioning and documents them in the form, manner and time prescribed by OCFS." [\[18 NYCRR 428.2\(h\)\]](#)

## Risk Assessment Profile

The Risk Assessment Profile (RAP) is a research-based assessment protocol designed to assist workers in making informed decisions regarding the level of risk of future abuse or maltreatment. While the initial RAP is often done by CPS investigative workers, the elements in the RAP are used by preventive services workers to guide and document ongoing assessments of family functioning. In addition, when a CPS investigative worker transfers responsibility for a case to a preventive services worker, the RAP will provide information about why the case was opened and what behaviors and conditions pose risk for future abuse and maltreatment.

The primary goal of risk assessment is to promote and support a structured, rational, decision-making approach to child protective services case practice, without replacing professional judgment.

Risk assessment is based on a social work or rehabilitative approach to working with families. It deliberately bolsters the focus of child protective services beyond an evidentiary, allegation-driven system.

The RAP also guides and supports professional judgment regarding:

- The decision to keep a case open for services following case determination;
- The appropriate selection of treatment services in order to reduce risk of future maltreatment;  
*and*
- The decision to close a case based on risk reduction.

In non-CPS cases, workers complete the Non-CPS Risk Assessment Profile as part of the Initial FASP (see **Appendix E**). Risk Assessment in non-protective cases is a guide to assist in identifying family characteristics and dynamics that *could* create a risk of harm to the child(ren). That information is used to assess the family's needs, identify what must change, and build a Service Plan that will meet those needs. Since this Risk Assessment is less predictive, it does not provide the worker with a risk score or Final Risk Rating.

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<sup>42</sup> OCFS CPS Investigation Safety Assessment, p. 6

The non-CPS Risk Assessment consists of a series of 11 non-CPS-based elements that may contribute to risk. Case planners are required to respond to each of these elements by selecting “Yes,” “No” or “Ins. Info.” (insufficient Information), as appropriate.<sup>43</sup>

During the risk assessment process, the caseworker, in consultation with the supervisor:

1. Gathers information on the presence or absence of a set of circumstances and behaviors in the parent/caretaker’s household(s). These circumstances or behaviors are known as “risk elements.” *Note:* in a CPS case being tracked as a Family Assessment Response (FAR) case, the circumstances and behaviors are referred to as “assessment areas” on the Family-Led Assessment Guide (FLAG).
2. Uses the CONNECTIONS system to calculate a risk score and rating. *Note:* FAR cases use FLAG to identify, with the family, any areas of risk revealed by the information the family shares.
3. Uses that risk rating and other circumstances to determine the family’s need for services aimed at reducing the likelihood of future abuse or maltreatment of the child(ren).
4. Develops a Service Plan that targets the respective behaviors or circumstances in the parent/caretaker’s household(s) that have been identified as contributing to the risk of future abuse or maltreatment (risk elements).

## The RAP family unit

For purposes of the Risk Assessment Profile (RAP), the family unit includes:

- All persons listed in the CPS case, including but not limited to all persons residing in the child(ren)’s home at the time of the report;
- Any person who has child care responsibility or frequent contact with the child(ren) and assumes a caretaker role;
- Any child(ren) who is in foster care of alternative placement with a permanency planning goal of “return home;” *and*
- Any child(ren) who has run away or is temporarily in another living situation but is expected to return home.

### **Primary Caretaker**

The Primary Caretaker (PC) is an adult who is legally responsible for the child(ren) and resides with the child(ren). When more than one person who is legally responsible for the child(ren) resides in the household, the birth mother is presumed to be the PC. If the mother does not physically reside with the child(ren), the PC is the adult who does reside in the child(ren)’s home and assumes primary responsibility for the care of the child(ren). There can be only one Primary Caretaker.

### **Secondary Caretaker**

There does not have to be a Secondary Caretaker (SC). The SC is an adult who lives in the child(ren)’s home and assumes some responsibility for the care of the child(ren), or an adult who does not reside in the child(ren)’s home but cares for the child(ren) on a regular basis.

If there are two or more potential Secondary Caretakers with child care responsibilities, it is presumed that the caretaker listed as a subject in the CPS case should be identified as SC. In all other situations,

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<sup>43</sup> OCFS Specialized Preventive Services Case Management Training, p. 19

the adult (other than the PC) who assumes the most responsibility for the care of the child(ren) – either within or outside of the home – should be selected.

Secondary caretakers are usually family members, such as the father or grandmother. When members of the extended family (e.g., the mother’s sister or other adult friends) live with the family, one of these adults may also play an SC role. Non-related, hired babysitters who do not live in the home are not considered secondary caretakers.<sup>44</sup>

## Risk elements

Risk elements are a set of circumstances and behaviors in the parent/caretaker’s household(s). When a CPS case is being tracked as a Family Assessment Response (FAR) case, the circumstances and behaviors are referred to as “assessment areas” on the Family-Led Assessment Guide (FLAG).

Risk elements have been shown to influence the likelihood of future abuse and maltreatment. Response criteria are weighted based on a statistical analysis of their influence on risk, and added together to derive an overall score. The overall score is then assigned a risk rating level ranging from Low to Very High, depending on state research findings and specifically designated policy considerations. When an elevated risk element is identified by the worker, the risk level is automatically raised to Very High.

The 15 risk elements and 8 elevated risk elements are listed below. Risk Element Definitions are provided in **Appendix D**.

1. Total prior reports for adults and children in RAP family unit.
2. Any child in the RAP family unit was in the care or custody of any substitute caregivers (informally or formally) at any time prior to the current report date.
3. Child under one year old in RAP family unit at time of the current report, and/or new infant since report.
4. Current or recent history of housing with serious health or safety hazards; extreme overcrowding; unstable housing; or no housing.
5. Financial resources are mismanaged or limited to the degree that one or more basic family needs are intermittently or chronically unmet.
6. Caretaker has, and utilizes, reliable and constructive support and assistance from extended family, friends, or neighbors.
7. Caretaker has been a victim or perpetrator of abusive or threatening incidents with partners or other adults in family/neighborhood.
8. Caretaker’s alcohol use has had negative effects on child care, family relationships, jobs, or arrests, within the past two years.
9. Caretaker’s drug use has had negative effects on child care, family relationships, jobs, or arrests, within the past two years.
10. Caretaker’s behavior suggests a mental health problem exists and/or caretaker has a diagnosed mental illness.
11. Caretaker has very limited cognitive skills.
12. Caretaker has a debilitating physical illness or physical disability.

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<sup>44</sup> OCFS Common Core Curriculum, Module 3, Unit B3, p. 368-369

13. Caretaker demonstrates developmentally appropriate expectations of all children.
14. Caretaker attends to needs of all children and prioritizes the children's needs above his/her own needs or desires.
15. Caretaker understands the seriousness of current or potential harm to the children and is willing to address any areas of concern.

### ***Elevated risk elements***

1. Death of a child as a result of abuse or maltreatment by caretaker(s)
2. Caretaker(s) has a previous Termination of Parental Rights (TPR)
3. Siblings removed from the home, prior to current report, due to abuse or neglect and remain with the substitute caregivers or foster parent
4. Repeated incidents of sexual abuse or severe physical abuse by caretaker(s)
5. Sexual abuse of a child and perpetrator is likely to have current access to child
6. Physical injury to a child under one year old as a result of abuse or maltreatment by caretaker(s)
7. Serious physical injury to a child requiring hospitalization/emergency care within the last 6 months, as a result of abuse or maltreatment by caretaker(s)
8. Newborn child has a positive toxicology for alcohol or drugs

### ***Risk scores and ratings***

For an accurate risk score and rating to be obtained, the worker completing the RAP must not make assumptions or use opinion rather than the facts of the case. If the worker doesn't have enough information to complete the RAP, she or he must gather that information from various sources. These include individuals such as family members and collaterals, as well as written documents such as police reports, school records, and medical files.

Response criteria are weighted based on a statistical analysis of their influence on risk, and added together to derive an overall score. The overall score is then assigned a risk rating level ranging from Low to Very High.

**If at least one of the 8 elevated risk elements is selected, the risk rating will automatically be Very High.** The risk scoring system is:

<b>Total Risk Score</b>	<b>Risk Rating</b>
2 or lower	Low
3 to 6	Moderate
7 to 9	High
10 or above	Very High

## **Identification of abuse and/or maltreatment**

Caseworkers, as Social Services workers, are mandated reporters under state law [\[SSL 413\]](#). If, in his/her official or professional capacity, a caseworker has reasonable cause to suspect that a child has been abused or maltreated, he/she must report these allegations to the New York Statewide Central Register of Child

Abuse and Maltreatment (SCR). Mandated reporters may be prosecuted or fined if they willfully fail to report. The toll-free hotline number for mandated reporters is **1-800-635-1522**.

If a child is in congregate care and is receiving preventive services, the report must be made to the Vulnerable Persons Central Register administered by the state Justice Center (**1-855-373-2122**).

## Child maltreatment

Maltreatment occurs when a parent or other person legally responsible for the care of a child harms a child, or places a child in imminent danger of harm by failing to exercise the minimum degree of care in providing the child with any of the following: food, clothing, shelter, education, or medical care when financially able to do so. Maltreatment can also result from abandonment of a child or from not providing adequate supervision for the child. Further, a child may be maltreated if a parent engages in excessive use of drugs or alcohol such that it interferes with their ability to adequately care for or supervise the child. Maltreatment includes the definition of neglect and adds where a child “who has had serious physical injury inflicted upon him or her by other than accidental means.”

Neglect is defined in law at [Section 1012\(f\)](#) of the Family Court Act. A maltreated child is defined in law at [Section 412\(2\)](#) of the Social Services Law. Although the definitions of the terms are not exact in the law, for the purposes of this guide, the terms neglect and maltreatment are used interchangeably.

Categories of maltreatment include:

- Inadequate food, clothing, or shelter
- Educational neglect
- Medical neglect
- Lack of supervision
- Inadequate guardianship
- Excessive corporal punishment
- Alcohol/drug misuse that affects ability to care for the child
- Abandonment
- Emotional neglect

### ***Indicators of maltreatment***

The list that follows contains some common indicators of maltreatment. This list is not all-inclusive, and some abused or maltreated children may not show any of these symptoms. Possible indicators of maltreatment can include:

- Obvious malnourishment, listlessness, or fatigue
- Stealing or begging for food
- Lack of personal care – poor personal hygiene, torn and/or dirty clothes
- Untreated need for glasses, dental care, or other medical attention
- Frequent absence from or tardiness to school
- Child inappropriately left unattended or without supervision

## Child abuse

Child abuse is defined in [SSL §412\(1\)](#) and [FCA §1012\(e\)](#). Generally, the term “abuse” encompasses the most serious harms committed against children. An abused child is a child less than 18 years of age whose parent or other person legally responsible for his/her care inflicts upon the child serious physical injury, creates a substantial risk of serious physical injury, or commits an act of sexual abuse against the child. Not only can a person be abusive to a child if they perpetrate any of these actions against a child in their care; they can be guilty of abusing a child if they allow someone else to do these things to that child.

In this context, “serious physical injury” means that the injury may lead to death or long-lasting disfigurement, long-lasting impairment of physical or emotional health, or loss of the function of an organ in the child’s body. “Substantial risk” means that the child has not been injured, but the parent/caretaker creates or allows a situation that is likely to result in serious injury. This includes children being left unsupervised where a substantial risk of injury is present or when a parent/caretaker has been abusing other children in the household.<sup>45</sup>

### ***Indicators of physical abuse***

- Injuries to the eyes or both sides of the head or body (accidental injuries typically only affect one side of the body)
- Frequently appearing injuries such as bruises, cuts and/or burns, especially if the child is unable to provide an adequate explanation of the cause. These may appear in distinctive patterns such as grab marks, human bite marks, cigarette burns or impressions of other instruments
- Destructive, aggressive or disruptive behavior
- Passive, withdrawn or emotionless behavior
- Fear of going home or fear of parent(s)

### ***Indicators of sexual abuse***

- Symptoms of sexually transmitted diseases
- Injury to genital area
- Difficulty and/or pain when sitting or walking
- Sexually suggestive, inappropriate or promiscuous behavior or verbalization
- Expressing age-inappropriate knowledge of sexual relations
- Sexual victimization of other children<sup>46</sup>

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<sup>45</sup> OCFS Core Curriculum, Module 1, Unit B2, pp. 233-234

<sup>46</sup> OCFS “Signs of Abuse or Maltreatment,” accessed at <http://ocfs.ny.gov/main/cps/signs.asp>

## Chapter 8

# Family Assessment: Strengths and Needs

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Abuse and maltreatment of children are usually symptoms of more complex conditions or factors that must be addressed to allow the family to leave the child welfare system stronger than when it entered, and to prevent a reentry in the future.

For these reasons, caseworkers must look beyond factors that create safety threats or risk when assessing the current family situation. They need to gain a deeper understanding of the family, “where they are coming from,” and what is **behind** the behaviors that are harmful to the children. They must consider other factors that shape the functioning of the family, the family’s ability to benefit from child welfare services, and family strengths that can be built upon to reach Service Plan goals.

- Assessment of family strengths and needs
- Assessment of the underlying conditions: perceptions, beliefs, and circumstances that affect behaviors and family functioning
- Assessment of contributing factors: physical or mental conditions that influence individual behavior and affect safety and risk for children in the home

It is essential that workers be aware of the cultural backgrounds and trauma experiences of all family members in order to determine what services are likely to be appropriate and effective. There are evidence-supported and promising practices that share core principles related to children and their caregivers from diverse cultural groups. These core principles include:

- Engagement with the child, the family and the community
- Sensitivity to the family’s cultural background when building a strong therapeutic relationship
- Consideration of the impact of culture on system expression
- Careful use of interpreters, when necessary
- Understanding that differences in emotional expression exist among cultures
- Assessment of the impact of cultural views on cognitive process or reframing
- Construction of a coherent trauma narrative using culturally congruent methods
- Highlighting ways in which culture may be a source of resiliency and strength<sup>47</sup>

The areas of family functioning to be explored during casework contacts are summarized in the Strengths, Needs, and Risks (SNR) component in the Comprehensive FASP. It is an assessment protocol designed to focus the case planner or caseworker on the identification and documentation of individual and family strengths, needs, and risks. This assessment helps the worker and the family to:

- Identify and understand the factors that are putting the children at risk
- Identify strengths that may mitigate risks and may be used to meet needs
- Inform decision making about what needs to change

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<sup>47</sup> OCFS, “[Promoting the Well-Being of Children, Youth and Families in Child Welfare](#),” (2013)

The SNR Assessment Scales are divided into three subcategories: Family, Child, and Parent/Caretaker. In CONNECTIONS, some of the categories will map to the Risk Assessment Profile when a Protective Program has been chosen for the case and responses to these categories are required. The local LDSS has the option of whether to require completion of all scale categories. All scales will be displayed in CONNECTIONS, and the worker may complete any of the optional scales that are deemed relevant to the assessment of the family and any of its members.

Remember that if caretakers change, the SNR scales must be updated to reflect the current family situation. The categories for each scale are listed on the next page. See **Appendix F** for the detailed list and rating options. See **Appendix G** for suggested family assessment questions.

## Family Scales

- |  |                             |
|--|-----------------------------|
| 1. Support system                                | 4. Neighborhood Environment |
| 2. Financial Resource Management/<br>Basic Needs | 5. Living Conditions        |
| 3. Stability of Housing                          |                             |

## Child Scales

- |   |  |
|---|--|
| 1. Physical Health                        | 8. Child Behavior                          |
| 2. Physical Health Care                   | 9. Alcohol Use                             |
| 3. Mental Health                          | 10. Drug Use                               |
| 4. Mental Health Care                     | 11. Child/Family Relationships             |
| 5. Bonding & Attachment (under age 2)     | 12. Interpersonal Skills (age 6 and older) |
| 6. Child Development/Cognitive Skills     | 13. Nutrition, Clothing & Personal Hygiene |
| 7. Academic Performance (age 6 and older) |  |

## Parent/Caretaker Scales

- |   |  |
|---|--|
| 1. Caretaker Abused/Neglected as a Child                          | 10. Drug Use Within the Past 2 Years                   |
| 2. Physical Health  | 11. Criminal History                                   |
| 3. Physical Health Care   | 12. Motivation/Readiness to Change                     |
| 4. Mental Health  | 13. Parent/Caretaker Expectations of Children          |
| 5. Mental Health Care   | 14. Parent/Caretaker Acceptance of Children            |
| 6. Ability to Cope With Stress                                    | 15. Parent/Caretaker Discipline of Children            |
| 7. Cognitive Skills   | 16. Parent/Caretaker Supervision                       |
| 8. Relationships Among Caretakers and Other<br>Significant Adults | 17. Problem Solving Skills                             |
| 9. Alcohol Use Within the Past 2 Years                            | 18. Recognizes and Attends to Needs of All<br>Children |



## Underlying conditions: Community and culture

The community beyond the nuclear family has an impact on children. One of the goals in creating a Family Team (see **Chapter 9**) is to provide a support system for a family under stress and more opportunities for children to interact with adults and peers. Keep in mind, however, that the community's attitude about the desired attributes of children and preferred child-rearing methods may differ from your own (see **Chapter 5**).

Cultural strengths that foster and promote early development can include:

- Opportunities for play with peers and older children, enhancing the development of self-reliance, self-control, cooperation, empathy, and a sense of belonging
- Exposure to multiple teaching styles, with emphasis on modeling, observation, and imitation
- Presence of a rich cultural tradition of games, toys, songs, and stories that provide a culture-specific context for language acquisition<sup>48</sup>

Parents everywhere strive to bring up their children to be happy, healthy, and successful. Parents in different cultures and circumstances, however, may ask themselves different questions related to this universal goal: How can I make sure that my child will stay connected to the family? How can I teach my child to be a responsible member of the community? How can I help maximize my child's potential for great personal achievement?<sup>49</sup>

For example, a culture that values physical prowess might encourage large motor activities for children more than language stimulation. Communities that support order and obedience will reinforce child training that promotes these traits, rather than those that foster independence. Factors such as these can influence a child's rate of progress through the various developmental stages, but are not necessarily harmful to overall development.

## Underlying conditions: Heredity and toxins

Child can be born with disorders that affect the growth and development of the brain. For example, children with low levels of growth hormone (GH) or thyroid-stimulating hormone (TSH) will be delayed in body growth and brain development. Such disorders, especially when undiagnosed, can put significant stress on the family.



### Rights for SNR Scales in CONNECTIONS

**Case Manager:** View rights to all categories of scales

**Case Planner:** View, Create, and Modify rights to all categories of scales

**Caseworker:** View rights to all categories of scales; Create and Modify rights to the Family and Parent/Caretaker scales; Create and Modify rights to the Child Scales, if associated to the child

**CPS Worker/Monitor:** View rights to all categories of scales; Create and Modify rights to the Family and Parent/Caretaker scales; No rights to Create or Modify Child Scales unless associated to that child

Source: CONNECTIONS Specialized Preventive Case Management Training (2014)

<sup>48</sup> Landers, C. (2006) Consultative Group on Early Childhood Care and Development, UNICEF House, New York accessed at <http://www.ecdgroup.com>

<sup>49</sup> Harkness, S., & Super, C.M. (2006) Themes and variations: Parental ethnotheories in cultures. In K. Rubin & O. Chung (Eds.), *Parental beliefs, parenting, and child development in cross-cultural perspective*, pp 61-81

Disease or exposure to harmful substances can also affect a child's development. Researchers have found, for example, that repeated middle ear infections can cause mild to moderate hearing loss that can then reduce a child's ability to acquire language.<sup>50</sup> Children who are delayed in their communication skills should be checked for both hearing and vision impairment.

Toxic chemicals in the environment can damage the nervous system and affect brain development. Some of these are lead, mercury, various solvents, arsenic, and pesticides.<sup>51</sup> If children are experiencing developmental problems, the home should be screened for these substances.

## Underlying conditions: Poverty

Poverty and maltreatment are not the same; but they are interrelated. Children living in families with incomes below the poverty line are 22 times more likely to be abused or maltreated than those living in families with moderate incomes. When assessing the impact of poverty on the children, consider whether the parents are able to meet the children's basic needs with their own resources. If not, determine whether they are willing to accept community assistance available to them. If the parents need assistance and refuse it, they are not providing a minimum level of care to their children.<sup>52</sup>

## Contributing factors: Mental illness

A significant percentage of families in the child welfare system are affected by mental health problems and/or developmental disabilities. This can diminish a family's ability to cope with stress and increase the probability that children will be removed from the home.

### ***Parents and caretakers***

The mental health or developmental status of parents or caretakers is one of the factors used to assess the safety of children in the home. A parent/caretaker's diagnosis of mental health problems or a developmental disability does not in itself put the child at risk for harm. The assessment concerns the effect of these issues on the parent/caretaker's ability to supervise, protect, and care for the child. Considerations include whether:

- The parent/caretaker exhibits behavior that seems out of touch with reality, fanatical, bizarre, and/or extremely irrational.
- The parent/caretaker's mental illness does not appear to be controlled by prescribed medication or he/she has discontinued prescribed medication without medical oversight. The parent/caretaker's reasoning ability to supervise and protect the child appears to be seriously impaired.
- The parent/caretaker lacks or fails to utilize the necessary supports related to his/her developmental disability, which has resulted in serious harm to the child or is likely to seriously harm the child in the very near future.

Recent studies indicate that with the proper treatment and support, parents with a mental illness or a developmental disability can often successfully care for their children. The challenge for social workers is to determine the degree to which mental illness or the developmental disability is affecting the

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<sup>50</sup> Berk, L.E. (2008) *Infants and Children: Prenatal Through Middle Childhood*, 6<sup>th</sup> ed., Pearson Education

<sup>51</sup> Grandjean, P. & Landrigan, P., (2014) Neurobehavioral effects of developmental toxicity, *The Lancet Neurology*, accessed at <http://www.thelancet.com/journals/lanneur/article/PIIS1474-4422%2813%2970278-3/abstract>

<sup>52</sup> OCFS Common Core Curriculum, Module 1, Unit B1, p. 126

parent's ability to care for his/her children. In addition, the risk of harm to children staying in the home must be weighed against the harm that would be caused by removing them from the parent/caretaker.

### **Children**

Significant mental health problems can and do occur in young children. The National Survey of Child and Adolescent Well-Being found that nearly half (47.9%) of children aged 2 to 14 years with completed child welfare investigations had clinically significant emotional or behavioral problems. Only one fourth of these children had received any specialty mental health care during the previous 12 months.

Children can show characteristics of anxiety disorders, attention-deficit/hyperactivity disorder, conduct disorder, depression, and post-traumatic stress disorder at a very early age. It is often more difficult to diagnose mental health problems in young children, however, because they respond to their environment differently than older children and adults.

Warning signs that a child might have a mental health condition include:

- *Mood changes.* Feelings of sadness or withdrawal that last at least two weeks or severe mood swings that cause problems in relationships at home or school.
- *Intense feelings.* Feelings of overwhelming fear for no reason — sometimes with a racing heart or fast breathing — or worries or fears intense enough to interfere with daily activities.
- *Behavior changes.* Drastic changes in behavior or personality, as well as dangerous or out-of-control behavior. Other warning signs include fighting frequently, using weapons, or expressing a desire to badly hurt others.
- *Difficulty concentrating.* Trouble focusing or sitting still, both of which might lead to poor performance in school.
- *Unexplained weight loss.* A sudden loss of appetite, frequent vomiting, or use of laxatives.
- *Physical harm.* Suicidal thoughts or actual attempts at self-harm or suicide.
- *Substance abuse.* Use of drugs or alcohol.<sup>53</sup>

Workers and parents can use tools such as the Pediatric Symptom Checklist (**Appendix I**) to determine whether further diagnosis and treatment are needed.

### **Adolescents**

Hormonal changes and their effects on the still-developing brain tend to encourage impulsive and often risky behavior in adolescents. However, these changes also may be connected to several classes of psychiatric illnesses, including anxiety and mood disorders, psychosis, eating disorders, personality disorders, and substance abuse, that are likely to emerge during the teens and early 20s.<sup>54</sup>

Schizophrenia, for example, seems to stem in part from an abnormal reduction in the volume of gray matter in the prefrontal cortex. When compared with normal brains, the brains of schizophrenia patients

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<sup>53</sup> Mayo Clinic (2014) Mental Illness in Children: Know the Signs, accessed at <http://www.mayoclinic.org/mental-illness-in-children/art-20046577?pg=1>

<sup>54</sup> Paus, T., Keshavan, M., & Giedd, J. (2008) Why do many psychiatric disorders emerge during adolescence? *Nature Reviews Neuroscience*, December 2008, pp 947-957.

between the ages of 18 and 29 showed 9.2% reduction on the left prefrontal lobe and 7.7% reduction on the right.<sup>55</sup>

### Contributing factors: Traumatic experiences

Emotional and physical stresses have a major impact on individuals throughout their lives. A landmark study by the Centers for Disease Control and Prevention (CDC) demonstrated a clear connection between health and “adverse childhood experiences,” which included:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Neglect
- Mentally ill, depressed, or suicidal person in the home
- Drug-addicted or alcoholic family member
- Witnessing domestic violence against a parent
- Loss of a parent to death or abandonment, including divorce
- Incarceration of any family member

When study participants were tracked over time, the number of adverse experiences in their childhoods had a strong relationship to numerous health, social, and behavioral problems throughout their lives.<sup>56</sup>

The effects of trauma continue long after abuse or maltreatment ends. When considering the appropriate preventive services for families where trauma is an issue, it may be helpful to determine whether the parent or caregiver was traumatized as a child or youth. When parents or caregivers have experienced abuse or maltreatment in the past, it will affect their ability to adequately care for their children. Preventive services can help mitigate these effects for birth parents, foster parents, and kinship caregivers.

### Contributing factors: Incarcerated parents

Risk factors for emotional and behavioral problems among children of incarcerated parents generally operate along two pathways: parental problems that existed prior to and may have contributed to the parent’s incarceration, and problems introduced as a result of the parental incarceration. Many of the risk factors experienced by children of incarcerated parents may be related to parental substance abuse, mental health, inadequate education, or other challenges. However, parental incarceration also increases the risk of children living in poverty or experiencing household instability, independent of these other problems.<sup>57</sup> The incarceration of a parent, especially the mother, is a significant contributing

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<sup>55</sup> Hirayasu, Y., Tanaka S., Shenton, M.E., Salisbury, D.F., Desantis M.A., Levitt, J.J., Wible, C., Yurgelun-Todd, D., Kikinis, R., Jolesz, F.A., McCarley, R.W. (2001) “Prefrontal gray matter volume reduction in first episode schizophrenia,” *Cerebral Cortex*, 11(4):374-81.

<sup>56</sup> Centers for Disease Control and Prevention, *Prevalence of Individual Adverse Childhood Experiences*, Accessed at <http://www.cdc.gov/ace/prevalence.htm#ACED>

<sup>57</sup> Phillips, S. D., Erkanlia, A., Keeler, G. P., Costellow, E.J. & Angold, A. (2006). Disentangling the Risks: Parent Criminal Justice Involvement and Children’s Exposure to Family Risks. *Criminology and Public Policy*. 5:677–702

factor to a child's risk for placement and should be considered in the development of the family's Service Plan.<sup>58</sup>

There is no single story that describes what it is like for a child to have a parent who is incarcerated. The experience depends on diverse factors, including the quality of the parent-child relationship prior to incarceration, the degree of household stability following the incarceration, and the child's age, developmental level, and individual personality.<sup>59</sup>

Separation due to a parent's incarceration can be as painful as other forms of parental loss and can be even more complicated because of the stigma, ambiguity, and lack of social support and compassion that accompany it. Incarceration of a household member is one of 10 "adverse childhood experiences" (ACEs) that are major risk factors for illness and poor quality of life in adulthood. One study found that people who had an incarcerated household member during childhood were more likely as adults to engage in smoking and heavy drinking; behaviors that are detrimental to health.<sup>60</sup>

Preventive services that encourage healthy and positive relationships between incarcerated parents and their children have been shown to mitigate the negative effects described above.<sup>61</sup> Mitigating the traumatic effects of a parent's incarceration may require strategies such as:

- Promoting opportunities for communication between incarcerated parents and their children, where appropriate. In-person visitation can help children cope, leading to less emotional distress and fewer problematic behaviors. Some prison and jail websites have information on visitation procedures.
- Providing preventive services to the family that focus on reducing the needs and risks that may have both preceded and resulted from a parent's incarceration.
- Providing ways for incarcerated parents to participate in family planning meetings by teleconference or phone.

## Contributing factors: Developmental disabilities

The term **child development** is used to describe the physical, psychological, and emotional changes that occur in children and youth from infancy to adulthood. It is a continuous process with a predictable sequence, yet development progresses at a different rate for each child.

Families that are involved in the child welfare system are more likely than average to have characteristics that contribute to developmental delays and disabilities. The family may be undergoing major stress related to factors such as domestic violence, lack of housing, and poverty. When assessing child development, be aware that there can be a wide range of factors involved.

The warning signs for developmental problems associated with abuse or maltreatment generally vary according to age. For example, at younger ages, maltreated children show impairments in their ability to

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<sup>58</sup> Swann, C.A., Sylvester, M.S. (2006). "The Foster Care Crisis: What Caused Caseloads to Grow?" *Demography*. 43:309–35.

<sup>59</sup> The Osborne Association (2010). "New York Initiative for Children of Incarcerated Parents Fact Sheet," Brooklyn, N.Y.

<sup>60</sup> Gjelsvik, A., Dumont, D.M., Nunn, A. (2013). Incarceration of a household member and Hispanic health disparities: Childhood exposure and adult chronic disease behaviors. *Preventing Chronic Disease*. 10:120281.

<sup>61</sup> Justice Center, Council of State Governments (2013). *Children of Incarcerated Parents Initiative Fact Sheet*, accessed at <http://csgjusticecenter.org/nrrc/federal-interagency-reentry-council/publications/children-of-incarcerated-parents-fact-sheet/>

discriminate different emotions, but these difficulties are not observed at older ages. Older adolescents and young adults who were maltreated as children are more likely to be antisocial.<sup>62</sup>

Most of the people who come in contact with a child during his/her first months of life are members of the nuclear family. Family interactions have a significant impact on development, regardless of the family's economic or social status. Cognitive and social developments seem to be most affected by:

- Caregivers' self-image, self-esteem, confidence, and emotional responsiveness;
- Restrictions and types of discipline imposed on the child;
- Language stimulation provided; and
- Opportunities for exploratory play and appropriate play materials.<sup>63</sup>

Children's relationships begin in the home and expand to include extended family members, early care and education providers, and members of the community.

Interactions with parents and other caregivers are crucial in the healthy development of a young child. The National Scientific Council on the Developing Child defines these interactions as "serve and return." Young children naturally reach out for interaction through babbling, facial expressions, gestures, and words. Adults respond with the same kind of vocalizing and gesturing back at them. These responses are essential to mental and physical well-being. When the adult does not respond, children's bodies activate a stress response. If this stress continues for long periods of time, it can impair the developing brain and nervous system.

### ***Healthy and unhealthy brain development***

Physical, mental, and emotional development is controlled by the human brain. As technology has made it possible to scan brain growth and activity, much has been learned about how a child's experiences affect the brain and, consequently, health and well-being.

Life experiences have a major impact on how a child's brain grows and develops during the first three years of life. A newborn's brain has 100 billion nerve cells (neurons). These cells are most active in the brain stem and midbrain, which control basic functions such as eating, sleeping, and crying.

As the child grows older, the majority of brain development occurs in the cerebral cortex, limbic system, and frontal lobes, which regulate emotions, language, social connections, and reasoning. As the brain grows, it creates pathways (synapses) among the neurons, connecting to different parts of the brain. Synapses develop rapidly during the first three years of life – by the time children are three years old, their brains have approximately 1,000 trillion of these crucial connections.<sup>64</sup>

Over time, the brain picks and chooses among the trillions of synapses available to it. If a nerve pathway is used frequently, it is protected and retained. If a pathway is not used, it is shut down or discarded. Each person's brain is an efficient machine that adapts to positive and negative stimuli in its environment. A brain that is responding to frequent stress overdevelops the synapses that respond to anxiety and fear, while other neural pathways and other regions of the brain are underdeveloped.

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<sup>62</sup> *The Science of Neglect*

<sup>63</sup> Landers, C. (2006) Consultative Group on Early Childhood Care and Development, UNICEF House, New York accessed at <http://www.ecdgroup.com>

<sup>64</sup> Child Welfare Information Gateway (2009) *Understanding the effects of maltreatment on brain development*, accessed at [www.childwelfare.gov](http://www.childwelfare.gov)

For example, the brains of children who experience long-term stress in the form of abuse or neglect will focus their resources on survival and responding to threats in the environment. The child may withdraw from interacting with others, have inappropriate emotional outbursts, or be unable to concentrate on learning. When early life experiences are primarily negative, children may develop emotional, behavioral, and learning problems that persist throughout their lives.

Patterns in brain activity are not necessarily permanent, however. For example, when young children who had been victims of neglect received therapeutic, supportive care, their brains adapted and redirected neural pathways so that eventually they were the same as non-neglected, healthy children.<sup>65</sup> The severity and length of the child's exposure to stress has a significant impact on the success of treatment and intervention.

### ***Brain development in teens and young adults***

While brain growth is most rapid during childhood, it continues through adolescence and young adulthood. Brain scans reveal that the high point of the volume of gray matter occurs early in adolescence. Brain volume does not begin to resemble that of an adult until the early 20s.

Teenage youth are the intellectual equals of adults, but have less impulse control and ability to anticipate the future consequences of their actions. Brain imaging studies suggest that teens have heightened responses to emotionally loaded images and situations than either younger children or adults. Teens' responses to stress are also changing; stress hormones have complex effects on the brain and behavior. Adolescents are more likely to take risks, react emotionally to situations, and make snap decisions.

The scans also suggest that different parts of the cortex mature at different rates. Areas involved in more basic functions mature first: those involved, for example, in the processing of information from the senses, and in controlling movement. The parts of the brain responsible for more "top-down" control, controlling impulses, and planning ahead—the hallmarks of adult behavior—are among the last to mature.<sup>66</sup>

### ***Assessing developmental milestones***

Children's developmental status must be assessed in order to intervene effectively with families whose children are being harmed or are at risk of harm. A working knowledge of normal child development is essential to accurately assess whether the child's minimum needs are being met, to know whether a child is developmentally able to participate in a verbal interview, and to determine the help the child needs to improve his/her well-being.

The four basic domains of child well-being [identified by OCFS](#) are closely associated with key developmental areas:

1. Cognitive functioning and growth;
2. Physical health and development;
3. Behavioral/emotional functioning; and

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<sup>65</sup> National Scientific Council on the Developing Child, *The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain*, accessed at [http://developingchild.harvard.edu/resources/reports\\_and\\_working\\_papers/working\\_papers/wp12/](http://developingchild.harvard.edu/resources/reports_and_working_papers/working_papers/wp12/)

<sup>66</sup> National Institute of Mental Health (2011) *The teen brain: Still under construction*, accessed at <http://www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/index.shtml>

#### 4. Social functioning.

Tools such as the [Child Development Guide](#)<sup>67</sup> will help to identify the ages at which most children reach certain developmental milestones. These “ages and stages” tools are not, however, precise blueprints that apply to all children. Each child moves at his/her own pace within each stage. During family visits, observe the characteristics of the children and how they compare to normal developmental milestones for their age. If the child’s characteristics don’t match that age range, look at previous age ranges until they match. That point would be the child’s developmental age in that area (physical, intellectual, social, emotional, or moral). If possible, talk to the child about his/her activities and interests.

Asking questions about child development is part of assessing underlying conditions and contributing factors that impact safety and risk. You might ask the parent/caregiver the following questions:

- Is your child growing at the same rate as other kids his/her age?
- Does your child seem to be going backward in some of his/her skills and activities?
- Is your child slow in learning certain skills (talking, crawling, walking, etc.)?
- Has your child been diagnosed with a developmental problem? If so, is he/she receiving treatment?
- Does your child have friends?
- Does your child frequently get frustrated and angry?

If you are concerned about possible developmental delays, discuss your observations with your supervisor, who will work with you to determine appropriate next steps. It may be appropriate to provide parents/caretakers with information about developmental disabilities, stressing the importance of early intervention. “Wait and see” may not be appropriate, as developmental disabilities are more likely to be corrected when identified early.



### EIP Contacts

A county-by-county list of Early Intervention Program contacts is available at the [New York State Department of Health website](http://www.health.ny.gov) ([www.health.ny.gov](http://www.health.ny.gov))

A developmental evaluation administered by a professional, such as a psychologist or a pediatrician, is necessary to confirm a developmental disability. If the evaluation indicates developmental problems, preventive services targeted at improving family function (e.g., homemaker services, clinical services, parent training) may help to correct developmental delays related to chronic stress.

In addition, younger children may qualify for services through the New York State Early Intervention Program (EIP). EIP is administered by the New York State Department of Health through the Bureau of Early Intervention. To be eligible for services, children must be less than three years of age and have a confirmed disability or established developmental delay.

### ***Developmental stages***

The tables in **Appendix H** are designed as a quick reference to assist caseworkers in recognizing the common behaviors of children and youth at various stages of development. They are meant to be general guidelines: each child develops at his/her own pace. A child or youth may lag in one area while

<sup>67</sup> *Child Development Guide* (2002), Center for Development of Human Services, State University of New York at Buffalo



being advanced in another. Slow development in a particular skill does not necessarily mean that a child is developmentally delayed.

### ***Autism Spectrum Disorder***

In March 2012, the Centers for Disease Control and Prevention issued a report that 1 in every 88 children born in the United States had autism, with a rate of almost 1 in every 54 boys.<sup>68</sup> The prevalence of autism makes it likely that caseworkers will encounter children suffering from this disorder.

Autism Spectrum Disorder (ASD) is a complex developmental disability that typically appears during the first three years of life but may be diagnosed later in childhood when social demands increase. ASD affects a person's ability to communicate and interact with others and affects individuals differently and to varying degrees. There is no known single cause for ASD, but it is generally accepted that it is caused by abnormalities in brain structure or function.<sup>69</sup>

Signs and symptoms of ASD include:

- Lack of or delay in spoken language
- Repetitive use of language and/or motor mannerisms (e.g., hand-flapping, twirling objects)
- Little or no eye contact
- Lack of interest in peer relationships
- Lack of spontaneous or make-believe play
- Persistent fixation on parts of objects

Children with one or more of these symptoms should be referred for a professional evaluation. While there is no known cure for autism, there are treatment and education approaches that may reduce some of the challenges associated with the condition.

Asperger's Disorder is currently considered to be one of the developmental disabilities associated with Autism Spectrum Disorder. Children with Asperger's have less severe symptoms than children with autism and frequently have good language and cognitive skills. They usually want to fit in and have interaction with others; they simply don't know how to do it. They may be socially awkward, not understand conventional social rules, or show a lack of empathy. They may have limited eye contact, seem unengaged in a conversation, and not understand the use of gestures.

Children with Asperger's Disorder frequently have above average intelligence and good language skills, but their speech patterns may be unusual, lack inflection, have a rhythmic nature, or be too loud or high-pitched. Children with Asperger's Disorder also frequently have motor skill delays and may appear clumsy or awkward.<sup>70</sup>

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<sup>68</sup> Autism Society (<http://www.autism-society.org/>)

<sup>69</sup> American Psychiatric Association (2013), *Autism Spectrum Disorder*, accessed at <http://www.dsm5.org/Documents/Autism%20Spectrum%20Disorder%20Fact%20Sheet.pdf>

<sup>70</sup> Autism Society, accessed at <http://www.autism-society.org/about-autism/aspergers-syndrome/>



## Chapter 9

# Casework Contacts & Family Team Meetings

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The Comprehensive Family Assessment and Service Plan must be submitted within 90 days of the case initiation date. During the 60 days following the submission of the initial FASP, you will have more opportunities to observe the family as it begins to receive culturally and linguistically competent preventive services. You will get a more in-depth view of the underlying reasons for the family's current problems and the strengths family members can use to effect long-term change.

There are several strategies and tools you can use to improve your knowledge of the family and its dynamics:

- Interviews with household members
- Casework contacts
- Information from collateral contacts
- Family team meetings

## The Family Assessment and Service Plan (FASP)

The 90-day plan brings together information that is gathered subsequent to the completion of the Initial Assessment and Services Plan. Based on additional contacts with the family, the Comprehensive FASP will include:

- Actions taken on behalf of the family, including a summary of casework contacts with the family, service referrals, services provided and the family's response to such services, and any court involvement since the completion of the Initial FASP
- A discussion of the current functioning of the child(ren) and family, using the SNR Assessment Scales described in **Chapter 8**. Address individual family members separately if their problems, assets, needs, or circumstances differ. Cover the following topics in terms of problems and assets:
  - Family interaction, ability to cope with stress, and family strengths
  - Availability of supports to the family
  - Family's capacity to care for the child(ren)
  - Parents'/caretakers' motivation and readiness to change
- A summary of the family's and child(ren)'s need for preventive services, including service priorities for the family and an evaluation of the family's ability to benefit from preventive services

The following also must be included in the Comprehensive FASP:

- A current safety assessment, safety decision, and controlling interventions, if needed
- A permanency planning goal for each child for whom services are authorized; if goals have changed, describe the reason for the change

- A program choice consistent with the assessment of the family’s needs
- An updated visiting plan if the child(ren) is receiving foster care
- The family’s goals and anticipated completion dates for each goal
- A description of the activities to be completed by family members and/or service providers to achieve each goal:
  - Services and/or activities
  - The person or agency responsible for each activity

## Goals and timelines

A significant part of the Service Plan is the setting of desired outcomes and goals. After identifying the problems or behaviors that need to change, the worker and the family decide on a “preferred future” when these problems will be resolved or reduced. For example<sup>71</sup>:

**Problem/Concern:** The father is struggling with PTSD and has withdrawn from his parenting role. He expects the mother to deal with the children on her own.

**Outcome (Definition of Achievement):** The father will engage with the children and resume a co-parenting role with the mother.

The plan will include a targeted completion date for the outcome. In this example, the goal is expected to be completed at the end of 12 months. The family and worker should then identify manageable, incremental steps toward the outcome. Each step includes a specific activity or service, the person or agency responsible for that activity/service, and a timeline for completion.

In this example, the steps could be:

Activity/Service	Person/Agency	Completed By
Father begins counseling for PTSD.	Mental Health Provider	9/1
Father takes son to preschool according to a schedule.	Father and Mother	9/5
Father begins to help out with household tasks daily.	Father and Mother	9/30
Mother and Father begin to take parenting classes.	Parenting Counselor	9/30

The plan must include a description of the family’s input into the services plan, including specific family requests for services or changes to the plan. Specify the family members who contributed, including children. Describe how family input was obtained. If there was limited or no family input, describe your efforts to involve family members.

The Service Plan must be approved by the case planner, the case planner’s supervisor, the case manager, and the Child Protective Services monitor, if appropriate. Obtaining the signature of the parent(s) is not required, but it is recommended as a way to involve the parent(s) in the assessment and planning process.

<sup>71</sup> Example only: not for use as a practice model.

## Casework contacts

The essential core of human services is the casework contact. It is where a family services plan is made real. It is the essential connection between those who provide services and those who receive them. New York State regulations [18 NYCRR 423.2(b)(3)] define casework contacts in preventive services:

1. Individual or group face-to-face counseling sessions between the case planner, assigned caseworker, as directed by the case planner, or person providing specialized rehabilitation services, supportive services or probation services and the child and/or family in receipt of preventive services for the purpose of guiding the child and/or family towards a course of action agreed to by the child and/or family as the best method for obtaining personal objectives or resolving problems or needs of a social, emotional, developmental, or economic nature.
2. Individual or group activities with the child and/or the child's parents that are planned for the purpose of achieving such course of action specified in the child and family's Service Plan.

Frequent contact between service providers with children and families is critical to the delivery of effective preventive services. A casework contact involves a working session with one or more members of the family receiving preventive services that is specifically related to the child's and/or family's service needs. The casework contact allows you to:

- Make an assessment of the safety and risk to children
- Make an assessment of the family's management skills and home conditions
- Assess the family's strengths and needs
- Engage the family in developing and implementing its individualized Service Plan
- Develop, implement, and monitor the Service Plan
- Assess the family's progress toward resolving the issues, situations, or conditions that led to the provision of services
- Gather information upon which to base key case decisions, including when it is time to close the case

A casework contact is not just a casual visit or an observation of the child or family. Visits or contacts with the family that are not related to the child's or family's Service Plan goals, and visits made by people other than those authorized to make casework contacts, are not considered to be casework contacts.

For example, a day-care center bus driver's contacts with a child are not counted as casework contacts because bus drivers are not among the service providers allowed to make casework contacts. Similarly, accompanying a family to a court hearing is not, by itself, a casework contact. Although you, as the case manager, case planner or caseworker, are among those who can make casework contacts, sitting in a courtroom does not meet the definition of a "counseling session" with the child or family.

### Who can make a casework contact?

Only contacts by certain service providers "count" as casework contacts in preventive services. This does not minimize the role that additional service providers play in supporting and strengthening families. It is essential to good practice, however, that the service providers assigned to the family by the local social services district (LDSS) have regular, face-to-face contacts with families receiving preventive services.

It is important to know that the service providers authorized to make casework contacts differ for preventive services, foster care, and child protective services. This is discussed in more detail below.

There are five types of service providers whose meetings with the child and/or family can be counted as casework contacts in preventive services cases. Local social services districts and preventive services provider agencies *may not* expand the definition of who can make a casework contact.

The service providers who can make casework contacts in preventive services cases are:

- The case planner
- A caseworker, as assigned by the case planner
- A person providing specialized rehabilitation services  
Specialized rehabilitation services are defined as assessment, diagnosis, testing, psychotherapy, and specialized therapies provided as a component of a Service Plan to a child and/or family by a person who has received a master's degree in social work, is a licensed psychologist, psychiatrist or other recognized therapist in human services or is a licensed or qualified individual including, but not limited to, a registered nurse or an alcohol or substance abuse counselor [18 NYCRR 423.2(f)]
- A person providing supportive services  
Supportive services are defined as those services provided as a component of a Service Plan to a child and/or family, including, but not limited to, parent aide services, homemaker services, home health aide services, parent training services, housekeeper/chore services, and home management services [18 NYCRR 423.2(g)]
- A person providing probation services  
Probation services are defined as services provided by a probation service that are related to the provision of adjustment services to persons in need of supervision (PINS) or are included as preventive services through a contract or agreement with a social services district [18 NYCRR 423.2(h)]

Although the LDSS, including the Administration for Children's Services (ACS) in New York City, must provide case management services and assign a case manager to every open preventive services case, the contacts a case manager has with the child and/or family, if any, cannot be counted as casework contacts unless the case manager is also the case planner.

## Frequency and location of casework contacts

State regulations specify:

- The frequency of required casework contacts
- The frequency with which casework contacts must be made in the child/family's home
- Which contacts with a family can be considered casework contacts

It is important to remember that these are the *minimum* requirements for casework contacts in preventive services cases. Additional contacts may be necessary to meet the goals and objectives of a family's Service Plan. The LDSS or preventive services provider agency may impose number and frequency of casework contacts above the minimum required by regulation.

Case managers, case planners, and assigned caseworkers should be familiar with their agency's requirements and, in addition, decide on the number and frequency of casework contacts on a case-by-

case basis. The goal is to effectively monitor the safety of children and successfully implement the family Service Plan. The expectation is that the minimum requirements will usually be exceeded.

### ***Minimum frequency of casework contacts***

There must be at least 12 casework contacts with a child and/or family receiving preventive services within each six-month period of services [18 NYCRR 423.4(c)(ii)(d)]. The first six-month period of services begins at the case initiation date (CID) or at the initiation of preventive services. Subsequent six-month service periods are calculated from the Service Plan due date.

At least six of the 12 casework contacts must be made by the case planner or by a caseworker, as assigned by the case planner.

- Four of these casework contacts must be individual, face-to-face meetings with the child and/or the family.
- Two of these contacts must take place in the family's home.

No more than two of the remaining six contacts in any six-month period may be made by supportive service providers. There are exceptions to these requirements:

When the only preventive service a family is receiving is housing services, there must be at least one in-home casework contact within the first six months of provision of the housing services, at least one casework contact at the time of each reassessment and one contact 60 days prior to termination of the housing services [18 NYCRR 423.4(c)(1)(d)(3)]. These contacts must be related to efforts to locate other sources of permanent housing for the family and/or other sources of housing assistance which would enable the family to remain in the housing unit for which housing services were obtained.

### ***Which family members must be seen?***

Casework contacts must be made face-to-face with at least one family member. It is expected that the family members will be seen individually or together as frequently as necessary to assess and monitor the children's safety and meet the goals of the Service Plan. This provides flexibility for the case planner, to decide which family members should be seen at which time.

For example, a group meeting with the entire family may be the best way at one point in the case to assess the safety of the children and the family's functioning. At another point in the case, however, you may want to interview each child individually or speak with the parent without the children in the room. Clarifying the purpose of the visit before making the visit will help guide which family members the worker will want to interview.

## **Documenting casework contacts**

You must document all casework contacts as Progress Notes in CONNECTIONS. For each contact, you must describe the location of, reason for, and outcomes of the contact. You must also document who was present during the casework contact. Such documentation must be made as soon as possible after the event [18 NYCRR 428.5(a)].

Also document attempted but unsuccessful casework contacts. An attempt that does not result in a face-to-face contact with at least one family member does not count as a casework contact. You must make repeated attempts to meet with the family to meet the casework contact requirements. If you have made several unsuccessful attempts to make a casework contact, discuss this with your

supervisor to assess whether another type of action may be needed. This may include a return to court if the preventive services were ordered by a judge.

## Families receiving other services

Families receiving preventive services may also be receiving foster care (including adoption) and/or child protective services (CPS). There are different requirements regarding the frequency and location of casework contacts for each of the three types of services. There also are differences in which service provider contacts can be counted as casework contacts.

As a general rule, casework contacts made for each of the three service areas are separate and distinct and may not be counted for the other service type. However, where foster care or preventive services are being provided as a direct service by a CPS caseworker, the CPS contacts may also be counted as the contacts for preventive services or foster care, provided that the protective services standards for face-to-face and in-home contacts are met. See **Appendix C**, “Casework Contact Requirements by Service Type.”

## Family team meetings

The Family Team Meeting is “an outward sign of a commitment to inclusive, empowering practice by professionals who work with families.”<sup>72</sup> Family meetings are a **family-driven**, shared decision-making child welfare strategy aimed at partnering with families to achieve long-term change. Although known by numerous models and types, family meetings are a process of bringing immediate and extended family members, friends, and other supports identified by the family together with professionals to make child welfare decisions.<sup>73</sup> It recognizes that these individuals have knowledge and strengths and that they need to participate in finding solutions to the problems that are putting children at risk.

Family Team Meetings, when conducted as Service Plan Reviews for children in foster care, must comply with the standards in OCFS regulation [18 NYCRR 430.12\(c\)\(2\)](#). They also are recommended whenever a family is receiving services from the LDSS. For example, a Family Team Meeting may be desirable at key points in the preventive services timeline, such as:

- Within 90 days of the case initiation date, to assist in the preparation of the Comprehensive Service Plan (CSP)
- Every six months after the submission of the CSP, to coincide with required Reassessment and Service Plan Reviews

Team meetings also may be held when the LDSS determines that there is an elevated risk of placement and there is a need to re-engage the family in services, adjust the Service Plan, and identify strategies to reduce the risk to children.

The objectives of the Family Team Meeting are:

- To improve decision-making by including family members, people important to the family’s life, key community supports, and agencies that are involved with the family
- To comprehensively assess service needs and to plan and coordinate service delivery to the family

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<sup>72</sup> Doolan, M. (2004), “The Family Group Conference: A mainstream approach in child welfare decision-making.” <http://www.americanhumane.org/assets/pdfs/children/fgdm/pc-fgdm-conf-fgc2004.pdf>

<sup>73</sup> OCFS Family Meetings Toolkit (2008), Module 1, p. 142



- To evaluate the need for ongoing placement or services, reassess the service needs of the family, and ensure that the goals of the Service Plan are being achieved

## Preparing for the meeting

The Family Team Meeting is usually arranged by the case planner. He/she will work with the family and identify individuals who should be invited to the meeting. These will include the parent(s), children or teens (if they are old enough to understand the issues), LDSS caseworkers, and representatives from all the agencies involved in the case. They also may include other people who serve as support for the family, such as clergy, a neighbor, or a work colleague. If a parent is incarcerated, work to provide ways for him/her to participate in the meeting by teleconference or phone.

The case planner also will contact a coordinator/facilitator to conduct the meeting. Some counties have contracted with third-party coordinators and some use LDSS employees who have been trained in facilitating Family Team Meetings. Professionals provide information and support, but the ultimate decisions are explored, discussed, and ultimately reached by the family, with the approval of the caseworker. The family is not told by professionals “what to do.” Rather, they are given information regarding what must change in the family situation, and are provided with the support and structure to arrive at the best course of action to meet the needs of the children and the family. Talk with the family about the purpose of the upcoming meeting and explain what is likely to happen during the meeting. Discuss what information the family would like to share with the group and what should remain confidential. Organize your notes about family members, including their strengths and resources.

During meeting preparation, family members should be asked how they would like the coordinator to record the information developed during the Family Team Meeting. While flip charts are often used, there are some drawbacks to this system. It requires some skill to ensure that the perspectives are presented accurately, draws attention to the coordinator as the meeting leader, and creates a climate of professionalism in a process that should be family-driven.<sup>74</sup>

## Format of the meeting

The format of the initial meeting generally follows the format below. As much as possible, these steps are led by family members. Participants will:

- Make introductions
- Conduct opening ritual, if requested by family
- Establish ground rules for discussion
- Identify the situation
- Assess the situation
- Develop ideas/brainstorming
- Make plans with or without professionals in the room (optional)
- Develop an action plan

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<sup>74</sup> OCFS (2008), *Family Meetings Toolkit*, “Participating in Family Meetings: Information for Parents and Family Members”

- Assign responsibilities
- Set dates for future meetings

At follow-up meetings, participants will:

- Review the Service Plan
- Make adjustments to the plan as needed
- Address any ongoing concerns regarding risk
- Reach agreement on strategies to reduce risk
- Assess progress toward achieving Service Plan goals
- Examine the need for ongoing preventive services



## Family Team Meetings

Resources for caseworkers:

American Humane Association (2010)  
[\*Guidelines for Family Group Decision Making in Child Welfare\*](#)

New York State Office of Children and Family Services (2008) *Family Meetings Toolkit*.

Family members may decide to have a private time without professionals in the room to write their own goals and plans. The plan created during the Family Team Meeting will be incorporated into the Family Assessment and Service Plan (FASP). If a child has been placed in foster care, a written statement of the conclusions and recommendations from the Family Team Meeting or a copy of the plan must be sent to all participants, including family members. The family must also be involved in planning any follow-up meetings.

## Special considerations

### Cross-cultural issues

Family team meetings provide a way to access culturally relevant services and are particularly helpful in working with immigrant families. In preparing for the meeting, learn from the family about its structure, interpersonal relationships, child-rearing practices, and other traditional or religious practices the family uses. In addition, interpreter and translator services may be needed so the family and their supporters can converse in their native tongue.<sup>75</sup>

### Domestic violence

When there is a history of domestic violence in the family, safety must be a prime concern in deciding who to invite to a family meeting. Domestic violence does not automatically rule out a family meeting, as the level of violence and its impact on children varies from family to family. In making these decisions, you must be informed by the non-offending parents' perceptions as to whether they and their children will be safe before, during, and after the meeting. It's possible that a separate meeting with the domestic violence offender and his/her support system will be helpful.<sup>76</sup>

## Confidentiality

Individuals who have applied for preventive services must receive written notification of the following, before any individual information is collected or recorded:

- The funding of preventive services through public revenue;

<sup>75</sup> American Humane Association (2008), "Using Family Group Conferencing to Assist Immigrant Children and Families in the Child Welfare System"

<sup>76</sup> OCFS (2012), "Practice Considerations for Conducting Family Meetings With Families Affected by DV"

- The applicable statutes and regulations regarding the collection and disclosure of individually identifiable preventive services records; *and*
- The service provider's procedures and practices for maintaining and allowing access to client-specific records [18 NYCRR 423.7(a)].

Individual identifiable information about social services applicants or recipients that is obtained by OCFS, the local departments of social services, and preventive services agencies is to be kept confidential [18 NYCRR 423.7]. Individual identifiable information contained in the CONNECTIONS system regarding children and families receiving preventive services also is confidential [18 NYCRR 466.4(a)(2)]. This requirement covers all client identifiable information including, but not limited to:

- Names and addresses of clients, their families, and relatives
- Information contained in applications and correspondence
- Reports of investigations
- Reports of examinations or tests
- Reports of medical examinations or treatments
- Resource information
- Financial statements or other employment or income information
- Records of agency assessments or evaluations
- Records or reports of Service Plans or services provided

OCFS preventive services regulations [18 NYCRR 423.7] state that all records relating to applications for and recipients of preventive services may be accessed by:

- The New York State Office of Children and Family Services
- The local department of social services
- Any preventive services agency or authorized agency that is providing services to the child and/or family
- Any person or entity upon the order of a court of competent jurisdiction
- Any other person or entity that is providing or agreeing to provide services to the child's family upon execution of a written consent by the child or the child's parent

Records relating to the provision of preventive services must be made available to federal, state, or local agencies conducting a fiscal audit [SSL §409-a(9); 18 NYCRR 423.7(c)]. Information pertaining to psychological, psychiatric, therapeutic, clinical or medical reports, evaluations or like materials or information pertaining to such child or family may not be released unless disclosure is absolutely essential to the specific audit activity and OCFS gives prior written approval. Preventive services records may be made available for bona fide research purposes [SSL §409-a(7)]. Client-identifiable preventive services information may not be released unless absolutely necessary to the research purpose and only with prior OCFS approval.

All individual identifiable information regarding a child or family receiving preventive services that are not provided in conjunction with or in addition to child protective, foster care, or adoption services must be expunged from the CONNECTIONS system six years after the 18<sup>th</sup> birthday of the youngest child in

the family [18 NYCRR 466.5(a)]. When preventive services are provided in conjunction or in addition to foster care, adoption, or child protective services, the applicable standards for those services apply.

## Advocates Preventive Only (ADVPO) cases

In New York City, families may enter the system as Advocates Preventive Only cases when the voluntary agency providing preventive services is exempt from the responsibility of recording information in CONNECTIONS in accordance with the terms of the *Advocates for Children* court settlement. In these cases, records are maintained on the premises of preventive services agencies.

However, preventive services agencies must follow state and federal law when disclosing or sharing client information. They also must provide on-site access to case records to the New York City Administration for Children's Services (ACS) and OCFS. The case records and documents must be forwarded to ACS if child abuse or maltreatment is reported in the household or where a child has been referred to ACS for foster care placement or a sibling of a child is in foster care.

In ADVPO cases, preventive services agencies are not required to obtain clients' citizenship status, Social Security number, or the names of individuals in the household who are not directly receiving preventive services.

## Outside agencies providing services

As indicated in the list above, disclosure of individual identifying information to agencies outside of OCFS, the LDSS, and preventive services agencies requires a court order (18 NYCRR 423.7) or informed written consent from the child or parent.

Agencies that are not preventive services agencies as defined in 18 NYCRR 423.2(a) may play a role in a family's Service Plan. For example, agencies providing alcohol/substance abuse treatment may be licensed by the Office of Alcohol and Substance Abuse Services (OASAS) and mental health services may be provided by agencies licensed by the state Office of Mental Health (OMH).

These providers need information on those who are referred to them for care and treatment. On the other hand, parents and children have a right to expect that their personal data, their needs and problems, and the services they are receiving will be treated in a manner that respects their privacy. The use of informed consent is a way to share information with agencies that need it while maintaining the necessary safeguards of confidentiality.

If a FASP includes services that will not be provided by a preventive services agency, the parent or child must sign a written consent statement [18 NYCRR 423.7(b)(5) and (e)]. A statement must be prepared for each agency and must specify the services that will be provided (see *details on the next page*).

## Probation Services

In general, information from LDSS records or reports may be disclosed to a Probation Service only upon the order of the Family Court or when a child or child's parent has given written consent. There are two exceptions to this rule:

- When a youth is the subject of a Juvenile Delinquency (JD) petition or adjudication, a written summary of services rendered to the youth must be made available upon the request of the Probation Service.
- When a local Probation Service is providing services as part of an approved Person In Need of Supervision (PINS) Adjustment Services Plan, the Probation Service is considered a preventive

services agency and must be given access to information necessary to provide these services to the child and/or family.

## Law enforcement

Law enforcement officials (police, district attorneys, etc.) may have access to individually identifiable preventive services records in the possession of a LDSS/ACS or a preventive services agency only upon issuance of an order of a court with jurisdiction to issue such an order. While some governmental agencies, including law enforcement agencies, may have the power to issue subpoenas without a court order, OCFS regulations [[18 NYCRR 423.7](#)] require that preventive services records are to be released only when there is a specific court order directing the release and identifying the information or records to be made available.

A court order is required even when a child or child's parent is willing to consent to the release of the information to law enforcement officials or agencies.

## HIV-related information

[Public Health Law §2782](#) sets standards for the maintenance and release of confidential HIV-related information. It applies to how information must be handled when a parent or child has Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) infection, or HIV-related illness. It also applies to when a person has been tested for HIV, irrespective of the outcome of the test. With certain exceptions, a person who is referred to as the protected individual must give informed, written consent before information can be shared that he/she has been the subject of an HIV test or has an HIV-related illness.

An authorized agency may have access to confidential HIV related information in connection with foster care or adoption of a child. Health or social services providers also may have access to confidential HIV-related information when disclosure of such information is reasonably necessary for the supervision, monitoring, administration, or provision of services to a parent, child, or family. Standards and policies for the disclosure and re-disclosure of confidential HIV-related information are outlined in New York [State Public Health Law §2135](#) and [91 ADM-36](#).

## Written consent

The requirements for obtaining consent, and who may give consent, are found in OCFS regulation [18 NYCRR 423.7](#). Any child with the capacity of consent or a child's parent may sign a written consent authorizing the disclosure of preventive services information to a person or entity that has agreed to provide services to the child or the child's family.

The consent must be written and given voluntarily; carefully explain the reasons for the consent and answer any questions the child or parent may have. A copy of the written consent statement must be given to the person who signed it. The statement must include:

- The date the consent was signed;
- Whether or not re-disclosure of the information is permitted (if re-disclosure is permitted, any limitations on the use of the information must be specified);
- What information may be disclosed;
- The purpose of the disclosure and any limitations on the use of the information;

- A time period during which consent is effective or a date or event when the consent will expire;  
*and*
- A statement that the client may terminate his/her authorization at any time.

### ***Capacity to consent***

A person is considered to have capacity to consent to the release of information when that person is able to understand and appreciate the nature and consequences of the proposed action, treatment, or procedure [18 NYCRR 423.7(e)(4)]. This does not depend on a person's age, but may be related to factors such as the ability to read and write, to understand what is being read, and to sign one's own name.

The key to a child's capacity to give "informed" consent is his/her ability to determine the likely result or consequences of releasing the information. Once this consent is given, it can be revoked only by the child.

If a child does not have the capacity to consent, the child's parent must sign the written consent. For these purposes, a parent includes a birth parent, adoptive parent, stepparent, guardian, or caretaker with whom the child resides.

The child may give consent to release only the information that relates to him/herself. The parent must agree to release information that relates to the family as a whole.

## Chapter 10

# Reassessment FASP

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Preventive services are provided to the child and family to meet specific needs identified in the FASP and to give family members the tools they need to improve their situation. It is essential to determine whether the services are effective in helping the family achieve its goals, so ongoing adjustments can be made to the Service Plan throughout the service period.

## The process of change

Families receiving preventive services are constantly facing the need to make changes in their lives that require a shift in attitudes or behaviors. Family members will respond differently to the process of change. Some may react with commitment and motivation while others may be angry and resistant. In fact, resistance to change is an expected and normal response.

Try to identify the reasons why a family member is resisting change. In general, a person reacts this way because he or she is afraid that the change will make things worse instead of better. Review the “Elements of Change” to identify which element needs more attention as you support a family member’s ability and willingness to change.

The family’s progress must be assessed and monitored on an ongoing basis. A formal Reassessment and Service Plan Review must be completed every six months after the approval of the Comprehensive FASP [18 NYCRR 428.3(f)(5)].

The purpose of the review is document the changes in family functioning and progress toward achievement of the goals established in the Service Plan. In addition, the review provides an opportunity to amend goals and develop a new or revised Service Plan based on the continuing service needs of family members. A single Reassessment FASP is completed for *all* family members.

## Reassessment FASP

The original assessment of the family was intended to identify safety and risk factors, underlying conditions, and contributing factors for the family’s problems. Development of the Comprehensive FASP required the worker and the family to identify desired outcomes and decide which preventive services would help the family build on its strengths to achieve these outcomes. As the case progresses, it will be necessary to determine whether the desired change is happening, especially in areas that threaten children’s safety and well-being.<sup>77</sup>

## Safety Assessment

The Reassessment FASP includes a review and update of the Safety Assessment. For CPS cases, complete the Safety Factors, make a Safety Decision, identify Controlling Interventions, and update or continue the Safety Plan. Describe how each controlling intervention currently in place is protecting the child(ren) from the identified dangers.

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<sup>77</sup> OCFS Reassessment FASP (OCFS-IT-BCP-REASS001)

For non-CPS cases, describe in narrative form any current safety issues and concerns, as well as key protecting factors that support the present safety of the child(ren), family, and community members.

## Family update

Summarize the original reason the case was opened and identify the area the family considered to be the most important to address. Describe any relevant family background and history that may affect implementing the Service Plan and providing services for the family.

## Case update

The family's Service Plan includes specific time frames for accomplishing each of the family's outcomes. As described in **Chapter 9**, the plan should include manageable steps for each identified goal. Having management steps and timelines in the plan makes it easier for the family to achieve success and makes it easier to assess progress. Compare the family's activities and services with the timelines in the plan.

Summarize key family events, services, and casework activities since the last FASP. Include a summary of casework contacts, including the frequency and quality of the contacts with parents, children, and caretakers; any barriers to such contacts; and steps planned overcome these barriers.

For cases where emergency services were recorded at Intake, the case planner will summarize the critical behavioral concerns or family issues that were identified and document specific emergency actions that were taken or services provided to address those issues and concerns. If behavioral concerns or family issues were not sufficiently resolved as a result of the emergency actions, the case planner must explain what remains unresolved.

## Legal activity

Summarize any court-related or legal activity since the last FASP, including the court type, type of legal activity, the children involved, and the court outcome. If there was legal activity, describe the effect on the family's Service Plan or the child's permanency planning goal.

## Family strengths, needs, and risks

Complete the SNR Scales, based on your experiences with and observations of the family since the last FASP. The results should indicate whether or not the family is making progress toward its goals in areas such as:

- Family interaction, ability to cope with stress, and family strengths
- Availability of supports to the family
- The family's capacity to care for the child(ren)
- The family's and children's needs for services
- Service priorities for the family
- The family's ability to benefit from the provision of services.

Observe the family to determine the extent to which they have made progress toward the desired changes in attitudes and behaviors. This is not necessarily the same as compliance with agency guidelines and services. Visible changes that indicate progress is occurring:



- Family members exhibit characteristics, attributes, or features associated with success or progress
- Family members demonstrate specific examples of personal strengths
- Family members show signs of motivation to change and continue moving toward change

## Risk Assessment Profile

Review the risk levels from the previous FASP and indicate whether caretakers understand the seriousness of current or potential harm to the child(ren) and are willing to address any areas of concern. The progress of each caretaker in carrying out the Service Plan is analyzed in one of three areas:

- Awaiting initiation of services, compliant with referrals
- Participating in services and actively pursuing case plan objectives or has successfully completed all services recommended
- Participating in services but not actively pursuing case plan objectives, or has refused or dropped out of services

## Analysis

This section of the Reassessment FASP includes a summary of the family's current situation. Three major areas are covered:

**Family View:** What is the family's view of the situation at this time? What do family members see as their most pressing needs and concerns? What do family members believe needs to happen in order for them to meet the needs of their children for safety, permanency, and well-being? What do they want from Child Welfare or other services at this time?

**Behaviors/Contributing Factors:** Based on the assessments of safety, risk, and family functioning, summarize the factors and underlying conditions that are contributing to behaviors or conditions that warrant continued Child Welfare interventions.

**Strengths:** Summarize the individual, family, and community strengths, resources, and supports that can be used to meet the family's pressing needs and support their ability to meet the child's needs for safety, permanency, and well-being.

## Service Plan Review

To effectively complete this section, the caseworker will need to review the Service Plan with the family. A formal Service Plan Review (SPR) with a panel and third-party reviewer is required only for cases involving children placed in foster care. However, a case planning conference that involves parents and children, and possibly the family support team, is encouraged for preventive services cases (see "Family Team Meetings," **Chapter 9**).

Service Plan Review information can be updated as often as necessary in CONNECTIONS, where it is recorded under a separate tab outside of the FASP. The system can be used to schedule conferences and notify assigned workers and family members. CONNECTIONS also provides support in documenting SPR conferences by storing selected meeting data (dates, invitees, attendees) that will be carried forward into the FASP report. Workers also may record comments in the SPR tab, but this information is not carried forward into the FASP.

## Programmatic eligibility

In the section for continuing preventive services, indicate the criteria that qualify the family for mandated preventive services. Document the behaviors or circumstances that support the recertification of preventive services for another six months (see next section).

## Plan Amendments

Plan Amendments describe and document significant changes in the status of a case. This makes it possible to make changes in services in response to the family's needs without conducting a complete reassessment. They are completed for a variety of status changes during the Family Services Stage, and often coincide with a change in program choice (e.g., a family with mandated preventive services has a child placed in foster care).

A Plan Amendment should be entered into the case record within 30 days of the change in services. If the Reassessment FASP is due within the next 60 days, the change in service may be recorded in the FASP rather than in a Plan Amendment. There is an exception when Child Protective Services are opened or ended: in those cases, a Plan Amendment must be entered within seven days of the conclusion of the CPS investigation. When a program choice of Protective is assigned to a previously non-CPS case, the CPS worker must complete the Plan Amendment.

Plan Amendments may be launched by anyone with a role in the case, but only the case planner can submit a Plan Amendment. When a caseworker has completed a Plan Amendment, he/she must alert the case planner that it is ready for submission. The case planner will review and submit the amendment, or return it to the caseworker for changes.

Certain status changes require documentation in a Plan Amendment if they occur outside the time frames for periodic assessment and service planning [[18 NYCRR 428.7\(b\)](#)]. These include but are not limited to when:

- Preventive services are started for a child
- Preventive services are ended for a child
- A case is opened for Child Protective Services
- Child Protective Services are ended for a case
- A child is removed from the home and enters or re-enters foster care
- A child is moved from one foster care setting to another
- A child is removed from his/her home and is placed by a court in the direct custody of a relative or other suitable person pursuant to Article 10 of the Family Court Act
- A child becomes legally free for adoption
- A child is discharged (either trial or final) from foster care (including finalization of adoption)

## Recertification of mandated preventive services

OCFS regulations for preventive services require that mandated preventive services can be recertified only if a new determination is made every six months after the initial application for services. The determination must show that it is reasonable to believe that the child will be placed or will remain in foster care unless preventive services are provided [[18 NYCRR 423.4\(b\)\(1\)](#)].

## Child in foster care

There are additional limits on the provision of mandated preventive services to children and their families while the child is in foster care [18 NYCRR 423.4(b)(2)]:

- With the exception of housing services, mandated preventive services will be provided for no more than an average of three months for all children in foster care within the local DSS district who have a permanency planning goal of returning home to parents or relatives.
- Mandated preventive services will not be provided for more than a total of 24 months to any single child in foster care whose permanency planning goal is to return home to parents or relatives.
- Non-mandated preventive services to children in foster care may be provided beyond 24 months, subject to re-authorization every six months.

## Child in designated emergency foster family boarding home

Under the standard for provision of mandated preventive services for children placed in Designated Emergency Foster Family Boarding Homes (EFBH), services may be provided as long as the child is expected to return home within 60 days. If the child does not return home within that period, preventive services are no longer considered to be mandated [18 NYCRR 430.9(i)].

When more than 60 days have elapsed since the child's placement in the EFBH, the case record must show that:

1. The mandated preventive services have been terminated;
2. Services are being provided as non-mandated preventive services; or
2. The child and/or family are eligible for mandated preventive services for a reason other than the child's placement in the EFBH.

When a child is discharged from care in an EFBH within 60 days, preventive services are mandated as a follow-up service for six months (including the time the child was in the EFBH). These services are a continuation of the services the child and/or family received while the child was in care. The case record must document the child's entry and discharge dates from the EFBH and the follow-up services that are being provided.

## Preventive Housing Services

Preventive Housing Services cannot be provided for more than three years (see **Chapter 1**). As with other mandated preventive services, the need for housing services must be reassessed every six months.

While OCFS regulations [18 NYCRR 423.2(b)(16)(v)] specify that Preventive Housing Services must be terminated when the family moves out of the housing unit being subsidized, services may be continued if the family moves to a new residence within the same LDSS and the LDSS determines that services continue to be needed in the new home [18 NYCRR 423.2(b)(16)(ii)]. If the family moves into another LDSS, it is the responsibility of the new district to determine whether Preventive Housing Services are necessary and should be continued.



## Chapter 11

# Closing the Case

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When a case closure is under consideration, the LDSS or agency caseworker must consider and include the following information in the case's most recent Progress Note in CONNECTIONS:<sup>78</sup>

- Clear analyses of safety and risk to the child(ren)
- Current living conditions
- Current family functioning
- Most recent contact with the family, including the dates each child was last seen
- Reasons for the case closure or the decision to end services

To analyze safety and risk, review the family situation against the Safety Assessment and Risk Assessment Profile parameters that were used when the case was opened. Current family function and living conditions should be analyzed using the SNR scales (**Appendix F**). In addition, discuss the current family situation with others involved in the case: service providers, supervisors, and family members themselves.

## Progress toward Service Plan goals

Throughout the case, the family has participated in setting desired goals or outcomes and the Service Plan has described what was needed to achieve those goals. Some questions to ask as you consider closing the case:

- Are all the children in the family safe?
- Has the future risk of abuse or maltreatment been sufficiently reduced?
- Do the parents/caretakers interact safely with the children?
- Are the children's basic needs being met?
- Are there physical conditions in the household that pose a risk to the children?
- Are there relationships that pose a risk to the children?

## Development of family behaviors and skills

Identify specific behaviors, skills, and knowledge that have been developed and demonstrated by family members in order to maintain safety and stability for the children. Consider these questions:

- What are the behaviors and conditions that brought the family into contact with child welfare?
- What parent/caretaker behaviors interfered with keeping children safe and meeting their needs?
- What behaviors have parents/caretakers attempted to change?

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<sup>78</sup> For New York City ADVPO cases, this information will be documented on templates.

- What skills and knowledge have parents and other family members learned and put into practice?
- What strengths were identified and developed that will benefit the family in the future?

## Access to support and resources

A family support team and network of community resources should be in place and active by the time the case reaches this point. Ask these questions to assess the family's ability to sustain this support:

- How strong is the family team?
- How strong is the informal support network?
- Are family members willing to seek and access these supports?
- Are family members active in making decisions about the amount and type of assistance they need?
- Can the family's progress be maintained without involvement by Child Welfare?

## Preparing the family

Families should be informed from the opening of their case that preventive services are designed to help them meet specific goals. The general goal is that their children will be able to remain in a home that is safe, stable, and supportive of their well-being. When a review of the Service Plan indicates that the goals have been satisfactorily met, it is time to talk about closing the case.

If the family has a support team, a Family Team Conference should be held between the time the decision is made to close the case and actual termination of services. Each team member will have an opportunity to review his/her involvement with the family to maintain the progress made while child welfare was involved.

Family members may be reluctant to end their relationship with the caseworker and may be concerned about their ability to create a positive future without supportive services. This is a good time to:

- Highlight the family's accomplishments and the progress they have made
- Remind family members of available formal and informal support networks
- Allow the family members to express their feelings about ending their relationship with the agency<sup>79</sup>

## Required case closings

As was noted in the previous chapter, there are some cases in which a family/child is no longer eligible to receive mandated preventive services and must be closed, such as:

- The family does not meet the standards for recertification of mandated preventive services
- More than 60 days have elapsed since the child's placement in an Emergency Foster Family Boarding Home

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<sup>79</sup> Adapted from New York City Children's Administrative Services (2011), *Conversations Around the Table: A Best-Practice Guide to Preventive Services*

- A child has been in foster care for more than a total of 24 months when the permanency planning goal is for the child to return home to parents or relatives

In any of these cases, the LDSS may determine that the child/family is eligible to receive non-mandated preventive services.

## Termination of Preventive Housing Services

Preventive Housing Services may not be provided for more than three years [[18 NYCRR 430.9\(h\)\(2\)](#)]. In addition, these services must be terminated when:

- The maximum allowable amount of payment or the maximum allowable time for services is completed. A child receiving a Preventive Housing Services subsidy for Independent Living is eligible only until his/her 21st birthday, even if it has been less than 36 months since services were started.
- The child for whom the subsidy was initiated has been returned to foster care (except when a child's return to care is for no longer than 30 days and is due to a parent service need emergency).
- Adequate housing has been obtained and the family no longer requires a subsidy.
- The family no longer satisfies the financial eligibility standards for Preventive Housing Services [[18 NYCRR 423.2\(b\)\(16\)\(iv\)](#)].
- The child for whom that subsidy was initiated no longer lives in the family home.
- A child who has been receiving Preventive Housing Services while on trial discharge status for Independent Living has been discharged and is no longer in the custody of the local commissioner [[93-LCM-140](#)].
- The family has moved out of the state.
- The youngest child for whom the family is receiving the Preventive Housing Services subsidy has turned 18.
- The family moves out of the original housing unit for which housing services were obtained and the local social services district in which the family currently resides determines that adequate permanent housing is available and continued housing services are not necessary to prevent the child's return to foster care.

## Conferences and fair hearings

Any client whose services have been reduced or terminated is entitled to request a conference and a fair hearing. Recipients of preventive services must be informed in writing of both this right and what they need to do to request a conference and/or fair hearing. Each preventive services agency must keep a record of the number of families applying for or referred for preventive services and a record of whether their application was denied and the reason for such denial [[18 NYCRR 423.4\(m\)](#)].

A **conference** is an informal meeting at which the case is reviewed by an LDSS employee who has the authority to change the decision under question. The LDSS must encourage the use of conferences to settle disputes and complaints [[18 NYCRR 358.4.2\(e\)](#)]. Conferences are excellent mechanisms to resolve disputes and explain rights and procedures. The proper utilization of conferences may result in avoiding unnecessary fair hearings.

The conference may not be used to discourage the applicant or client from requesting a fair hearing. Agency conferences must be scheduled before the date of the fair hearing. The social services agency must attend the conference and must bring the necessary information and documentation to any conference to explain the reason for the agency determination and to provide a meaningful opportunity to resolve the problem [18 NYCRR 358.4.2(g)].

A recipient of preventive services whose service has been reduced or terminated by a social services district is entitled to a **fair hearing** by the department, provided the request is made to the fair hearing office set forth in the notice of denial, reduction or termination within 60 days after such action [18 NYCRR 358-3.5(b)].

The recipient may have the right for services to be continued unchanged, pending the rendering of a fair hearing decision under conditions set for in [18 NYCRR 358-3.6\(a\)](#).

## Closing a case in CONNECTIONS

To begin the case closing process, the caseworker or case planner will complete an FASP Plan Amendment in CONNECTIONS and submit it for system approval. To do this, highlight the relevant case and click “Tasks.” Select a reason for case closure from the drop-down list. State regulations require that before a case can be closed, documentation must be provided that outcomes have been achieved. In the appropriate box, describe the level of achievement for outcomes essential to each child’s safety, permanency, and well-being.

The system will generate a To Do Memorandum for staff assigned to the case. In New York City, a clearance will be conducted by the Central Team to ensure that there are no open investigations or pending activities. If all requirements have been met and the family has not submitted a fair hearing notice for aid to be continued, the LDSS closes the Family Service Stage of the case.



### Reminder!

A case cannot be reopened once the Family Services Stage is closed. It must be opened as a new case if the family becomes eligible for services in the future.



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## Appendix A

# Documenting Standards for Mandated Preventive Services

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In order for a family or child to receive mandated preventive services, eligibility must be established and documented in the family's case record. Use this section as a reference to the regulatory eligibility standards for mandated preventive services and the documentation that must be included in the case record when the case record is opened, reviewed, or amended. [[18 NYCRR 423.3](#) and [430.9](#)]

Eligibility for preventive services is documented in "Programmatic Eligibility" area of the Family Assessment and Service Plan in CONNECTIONS. You are required to include a description of relevant behaviors and/or circumstances for each eligibility standard selected for the family and child(ren).

### Provision of mandated preventive services when children are at risk of placement in foster care

#### 1. Health and Safety of the Child

- a. Describe the instances within the 12 months immediately prior to the application for preventive services when the child has been harmed or put at risk of harm emotionally, mentally, or physically by the parent(s) or caretaker(s);
- b. Describe the type of harm that has resulted or a description of the conditions that existed to place the child or siblings in danger of serious emotional or physical harm, including the type of harm that would have been likely to result from these conditions; and
- c. Include date of indication of any Child Protective Services report pertaining to such instances and actions by the parent(s) or caretaker(s).

#### 2. Parental Refusal or Surrender

- a. Describe the actions taken by the parent(s) or caretaker(s) that indicate a refusal to maintain the child in the home; or
- b. Provide the date(s) and a summary of verbal statements made by the parent(s) or caretaker(s) in which he/she refuses to care for the child or expresses his/her intent to surrender the child.

#### 3. Parent Unavailability

- a. Describe the reason for the parent's or caretaker's absence from the home. If the unavailability is due to hospitalization, arrest, detainment, or imprisonment, describe the whereabouts of the parent or caretaker and the expected duration of the absence. If the whereabouts of the parent or caretaker is unknown, include a summary of the efforts made to locate the parent or caretaker.
- b. If the parent or caretaker has died, the fact of death must be documented.
- c. In all cases, describe any attempts that have been made to find a new caretaker for the child and an estimated time frame in which that might be accomplished.

#### 4. Parent Service Needs

- a. If service need is based on the emotional, physical, or mental condition of the parent or caretaker:
  - i. Describe the type of emotional, physical, or mental condition that impairs the functioning of the parent /caretaker;
  - ii. Summarize the functions that are impaired; and
  - iii. Describe instances when the impairment has seriously harmed the child emotionally or physically or has placed the child in danger of such harm.
- b. If the service need is related to the financial condition or need of the parent/caretaker:
  - i. Summarize the financial needs (e.g., lack of adequate housing) that impair the ability of the parent/caretaker to care for the child; and
  - ii. Describe the specific risk to the child if such needs are not met.
- c. If the parent/caretaker has been diagnosed as having AIDS, HIV infection, or HIV-related illness:
  - i. Include a medical report showing a diagnosis by a licensed physician that the parent/caretaker has AIDS, HIV infection, or HIV-related illness; and
  - ii. Describe how this condition seriously impairs the ability of the parent/caretaker to care for the child and how this puts the child at risk for placement into foster care.<sup>80</sup>

#### 5. Child Service Needs

- a. If the child is physically, mentally, or emotionally impaired:
  - i. Describe behaviors that illustrate a serious impairment of the child's ability to carry out everyday activities at an age-appropriate level; or
  - ii. Include a diagnosis by a licensed psychiatrist or psychologist (including a permanently certified school psychologist) or by a certified social worker (other than the case manager or case planner).
- b. If the child exhibits severe management problems:
  - i. Describe repeated instances of the child's behavior with the previous 12 months that have led to severe management problems in the home, school, or community.
- c. If the child is a danger to him/herself or others:
  - i. Describe instances within the past 12 months in which the child has intentionally harmed or attempted to harm others or him/herself; or
  - ii. Include a statement in writing from a licensed psychiatrist or psychologist, or from a certified social work (other than the case manager or case planner), that the child presents a serious danger to him/herself or others.

Of these two options, the description of instances of a child's dangerous behavior is preferred. The description is more likely to illustrate and point to the child's service needs.

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<sup>80</sup> Records that include information regarding AIDS, HIV infection, or HIV-related illness must be maintained and safeguarded according to law and OCFS regulations.

- d. If the child has been diagnosed as having AIDS, HIV infection, or HIV-related illness:
  - i. Describe how the conditions resulting from the child's illness impairs his/her ability to carry out daily, age-appropriate activities; or
  - ii. Show how the child's illness results in a need for supportive services, other than medical or health-related services, that will allow the parent(s)/caretaker(s) to maintain the child in the family home.
  - iii. Include a medical report showing the relevant diagnosis by a licensed physician.<sup>81</sup>
- e. If the child is the subject of or is at risk of becoming the subject of a PINS petition:
  - i. If the petition has been filed, describe the content of the petition, including the allegations made, the date of filing, and the person or persons who filed; or
  - ii. If a petition has not been filed, summarize the determination made by the Assessment Service or Probation Service that the child is a risk of becoming the subject of a PINS petition.
  - iii. Also include at least one of the following:
    - a. A description of the circumstances in which the family would have been eligible for preventive services in the past, including the standard under which it would have qualified;
    - b. A description of circumstances that led to any child in the family being placed in foster care, including the name of the child, the date of placement, and the reason for placement;
    - c. A description of instances of behavior over the previous six months that present the potential for severe management problems in the home, school, or community;
    - d. A description of services received by the family in the present or the past, including the time period during which services were provided, family member(s) receiving services, the agency providing the services, and why the services were provided.

## 6. Pregnancy

- a. Indicate that a woman is pregnant or has recently given birth and describe the parental functions that the woman is unable to perform.<sup>82</sup>
- b. Describe how preventive services will assist the woman in performing parental functions.

## 7. Court-Ordered Placement

- a. Document the court order to establish the reason for services.

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<sup>81</sup> Records that include information regarding AIDS, HIV infection, or HIV-related illness must be maintained and safeguarded according to law and OCFS regulations.

<sup>82</sup> Available resources such as a secondary caretaker, extended family, and the child's father may be considered.

## Provision of mandated preventive services when children are at risk of re-placement in foster care

In addition to the categories listed above, these areas may be documented for a child who is in need of mandated preventive services to prevent re-placement:

### 1. Family Court Contact

- a. Describe the child's previous placement in foster care; and
- b. Describe the current petition or other disposition by the Family Court, including the date.
- c. If the child is the subject of or at the risk of being the subject of a JD or PINS petition, include documentation of the Family Court or Probation Office referral and the date of the referral.

### 2. Unplanned Discharge

- a. Document the time period the child was in foster care, anticipated discharge date at the time of placement, and the actual discharge date.
- b. Describe the goals that could not be met due to an early discharge (at least three months prior to the anticipated discharge date).

### 3. Recurrence of the Reason for Placement

- a. Describe the child's previous placement, including the dates of and reason for placement;
- b. Describe the behavior or circumstances at the time of application for services that are similar to the factors that led to the previous placement; and
- c. Describe the reasons why this behavior or condition places the child at risk of re-placement.

## Provision of mandated preventive services to return children to their parents/caretakers

### 1. Preventive Services Other Than Housing

- a. Indicate that mandated preventive services that are to be delivered to the family relate to one or more of the documented reasons for the child's placement.
- b. Show that an anticipated discharge date has been set within the next six months and that it includes a safe and appropriate discharge plan.

### 2. Preventive Housing Services

- a. Describe the family's housing situation, showing that one or more of the following circumstances exist:
  - i. The family is homeless or is residing in a shelter, hotel, motel, or other temporary housing; or
  - ii. The family is residing in its own home, in a room and board situation, or in the home of friends or relatives; and the addition of the discharged child would exceed the capacity of such residence as specified by local laws, ordinances, rules, or regulations, resulting in unsafe overcrowding or eviction; or
  - iii. The family has a home, but past-due rent or mortgage payments put the family at imminent risk of losing the home; or
  - iv. The family is living in a building that is the subject of a vacate order; or

- v. The condition of the family's home poses a health and safety risk that would put the discharged child at imminent risk of harm.
- b. Describe how the provision of preventive housing services is in compliance with the discharge plan and discharge date requirements.

### **Provision of mandated preventive services for children placed in designated emergency foster boarding home**

These services are available only when children will be discharged within 60 days. Ensure that the most recent FASP indicates a planned discharge within that period of time.

### **Provision of preventive housing services to clients with a goal of discharge to independent living**

1. Describe why housing is the primary factor preventing the client from being discharged to independent living.
3. Indicate that the client has been appropriately prepared for discharge and that discharge is planned within the next two months.
4. Describe the home that has been located for the client – if none has been located, indicate the type of home the client will need in order to be discharged from foster care.

### **Provision of preventive housing services to children with a goal of discharge to another planned living arrangement with a permanency resource**

1. Describe the home that has been located or, if none has been located, the type of home the child will need in order to be discharged from foster care.
2. If the child is discharged within two months after housing services are authorized, document the actual date of discharge and the date housing services were authorized.
2. If the child is not discharged within two months of the authorization of housing services, document the specific circumstances that prevented the child's discharge, the reason(s) such circumstances were unforeseeable, and a termination date for the authorization of housing services.





## Appendix B

# Stages in CONNECTIONS

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Caseworkers are granted access to case information in CONNECTIONS when they have an implied role in a stage. A worker who is assigned to a stage will have an implied role in another case if there is a person in common between the stages. All workers with an implied role in a stage will have **view-only** access to the Family Service Stage (FSS) information, since the FSS information may be pertinent to their stage.

Contract Preventive Services and Voluntary Foster Care Agency staff will also have view-only access to in-process or Indicated CPS Investigation stages. Any worker with a role in the Family Services Stage will receive an alert in CONNECTIONS when a new CPS report is made that involves any family member in their FSS stage and will receive a subsequent alert when the determination on that CPS investigation is made, so that they may view certain information in the Investigation stage or contact the CPS worker assigned to discuss the status of the investigation, any relevant safety issues, and the findings. Information relevant to any previous Indicated or current CPS Investigation stages may be shared with any person who has a role in the stage.

Case managers, case planners, and caseworkers have assigned roles in the Family Services Stage. A caseworker's role determines his/her ability to view or maintain information in CONNECTIONS. We will be talking about your role in each stage that you are assigned to; this is an important part of determining which components of the Family Assessment and Service Plan (FASP) you might be responsible for completing in CONNECTIONS.

## STAGES

**INT** (CPS Intake) Documents the information gathered by the State Central Register (SCR) and decision to initiate an investigation of allegations of abuse and/or or maltreatment of children. The INT stage is progressed to the Investigation stage. Multiple intake stages can exist in one CPS case. Only SCR and LDSS workers can be assigned an INT

**INV** (CPS Investigation) Documents the investigation of suspected abuse or maltreatment of children and the resulting determination based on supporting evidence found. Multiple investigation stages can exist in a CPS case. Only an LDSS worker can be assigned an INV, although VA staff may have an implied role and be able to view it.

**ARI** (Administrative Review Investigation). Documents a State level review of the investigation and determination documented in an Investigation stage. Only SCR staff can be assigned an ARI

**FAD** (Foster/Adoptive Home Development) documents activities to create/maintain a foster or adoptive home. A FAD case contains only one stage. LDSS and VA staff can be assigned a FAD

**FSI** (Family Services Intake) documents the decision to provide or refuse to provide child welfare services. The FSI stage is progressed to the Family Services Stage if services will be provided. Only one open FSI can exist for each case. LDSS and VA staff can be assigned a FSI

**FSS** (Family Services Stage) establishes a single, electronic case record, where caseworkers document information about children and families receiving child welfare services. Only one open FSS per district can exist in a case. LDSS and VA staff can be assigned a FSS.

**Child Welfare Services (CWS)**

This is the most commonly used type of Family Services Stage. It includes adoption, foster care, preventive (mandated and optional) and ongoing (post investigation) child protective services

**Child Case Record (CCR)**

The Child Case Record is created when a child is legally freed for adoption. Every child who has been freed, including those who might not have a goal of adoption, has a separate CCR.

**Out-of-Town Inquiry/Family Assessment Response (OTI/FAM)**

There are two types of Out-of-Town Inquiry (OTI): out-of-state and county-to-county. An out-of-state OTI is a written request for assistance or follow-up on a specific matter that usually involves a family (or family members) now residing in New York State. A *county-to-county* OTI is a request made by one local district to another local district for assistance or follow-up on a specific matter that involves a family (or family members) residing outside the requesting district. The request usually requires an action that cannot be completed by the requesting district. Some districts may also record a Family Assessment Response via the FSI.

**Court Ordered Investigation (COI)**

This type is used for a case that was initiated to document a court-ordered investigation.

**Interstate Compact for the Placement of Children (ICPC)**

This type is used for cases where the local district/ACS or voluntary agency is receiving a child from another state (incoming). It is used to document services/activities with respect to the child and such information may be sent to the sending state. All children who were in foster care in New York State and are being placed via ICPC in another state already have an open FSS/CWS in CONNECTIONS and will continue to be tracked in that stage (outgoing).

**Advocates Preventive Only (ADVPO)**

The Advocates Preventive Only (ADVPO) type is used exclusively for Family Services Stages in New York City when ACS is the Case Manager in CONNECTIONS for a preventive services case and the voluntary agency directly providing only preventive services to the family is exempt from the responsibility of documenting certain case activities (primarily Progress Notes and FASPS) in CONNECTIONS, in accordance with the terms of the Advocates Settlement Agreement.

*Source:* CONNECTIONS Specialized Preventive Case Management Training, Professional Development Program, Rockefeller College, University at Albany, pp. 18-20.

## Appendix C

## Casework Contact Requirements by Service Type

	Preventive	Open, Indicated Child Protective Cases	Foster Care
<b>Who can make casework contacts?</b>			
Case Manager	Yes, if he/she is also the case planner	Only if he/she is also the case planner	Yes
Case Planner	Yes Must make, or direct caseworker to make, 6 of the 12 contacts every 6 months	Yes	Yes
Caseworker	Yes As assigned by case planner		Yes As assigned by case planner
Parent Advocate* *as defined in <a href="#">18 NYCRR 441.2(o)</a>	No	No	Yes <ul style="list-style-type: none"> <li>• Only with parents/relatives of child in foster care</li> <li>• Maximum of 2 contacts every 6 months</li> <li>• Only when arranged or coordinated by case planner</li> </ul>
Provider of: <ul style="list-style-type: none"> <li>• supportive services, including parent aide</li> <li>• rehabilitative services, and/ or</li> <li>• probation services (See <a href="#">18 NYCRR 423.2</a> for definitions)</li> </ul>	Yes <ul style="list-style-type: none"> <li>• Maximum of 2 contacts every 6 months</li> <li>• Only when arranged or coordinated by case planner</li> </ul>	Yes (For some contacts; see below)	No
<b>Minimum frequency of casework contacts</b>			
	12 in every 6-month period with the child and/or his or her family	<p><i>When CPS is the primary service provider:</i></p> <ul style="list-style-type: none"> <li>• two face-to-face per month with the subject(s) and other persons named in the report</li> </ul> <p><i>When CPS is coordinating services:</i></p> <ul style="list-style-type: none"> <li>• Up to six of the required 12 contacts in a 6-month period may be made by providers of rehabilitative, supportive, or probation services.</li> </ul>	<p><i>With the child:</i></p> <ul style="list-style-type: none"> <li>• During first 30 days of placement: as often as necessary, but at least twice</li> <li>• After first 30 days of placement: monthly</li> </ul> <p><i>With parent/relative:</i></p> <ul style="list-style-type: none"> <li>• During first 30 days of placement: as often as necessary but at least twice unless compelling reasons are documented why</li> </ul>

	Preventive	Open, Indicated Child Protective Cases	Foster Care
		<ul style="list-style-type: none"> <li>• However, only 2 of the contacts in a 6-month period may be made by a provider of supportive services.</li> </ul>	<p>such contacts are not possible.</p> <ul style="list-style-type: none"> <li>• After first 30 days of placement: at least monthly unless compelling reasons are documented why such contacts are not possible.</li> </ul> <p><i>With the child's caretakers:</i> Monthly</p>
<b>Location of casework contacts</b>			
	<p>Two contacts every 6 months by the case planner or the caseworker, as assigned by the case planner, must take place in the child's home</p>		<p><i>With the parent(s)/relatives:</i> In the home of the parent/relative to whom the child will be discharged:</p> <ul style="list-style-type: none"> <li>• At least once during first 30 days of placement</li> <li>• At least once every 90 days after first 30 days of placement while child is in foster care unless compelling reasons are documented why such contacts are not possible..</li> </ul> <p>Exceptions: Visits to the parent's home are not required:</p> <ul style="list-style-type: none"> <li>• Following termination or surrender of the parent's parental rights</li> <li>• Upon a court decision that reasonable efforts are no longer required other than to discuss alternatives to termination (e.g. surrender) and counseling the parent regarding relinquishment of the child</li> </ul> <p><i>With the child's caretakers:</i> In the child's placement location:</p> <ul style="list-style-type: none"> <li>• Once during the first 30 days of placement</li> <li>• Once every 90 days after first 30 days of placement</li> </ul>

## Appendix D

# Risk Element Definitions

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### Risk Elements 1-6

#### 1. Total prior reports for adults and children in the RAP family unit.

Count the number of prior indicated reports in which an adult in the RAP Family Unit was a confirmed subject or a child in the RAP Family Unit was a confirmed victim of abuse or maltreatment. Prior indicated reports where an adult in the RAP Family Unit was a subject should be included, regardless of whether the children who were abused or maltreated in the prior report are members of the current RAP Family Unit. Similarly, prior indicated reports where a child in the RAP Family Unit was abused or maltreated by an adult who is not part of the current RAP Family Unit should be counted. Do not consider prior reports in which the subject of the current report or another adult in the current RAP Family Unit was a victim of abuse or maltreatment as a child. Include prior reports that occurred in other states if credible information exists that an adult in the RAP Family Unit was a confirmed perpetrator of abuse or maltreatment or a child was a confirmed victim of abuse or maltreatment.

If only prior Unfounded Reports are included in the Uniform Case Record, verify if any member of the RAP family unit was an alleged subject or an alleged maltreated child. If "Yes," check "prior unfounded reports only." Do not count reports where all of the RAP family unit members had "no role."

If this is the first report, check "no prior determined reports."

#### 2. Any child in the RAP family unit was in the care or custody of any substitute caregivers (informally or formally) at any time prior to the current report date.

Indicates whether any child in the RAP family unit previously resided (or currently resides) with a foster parent or substitute caregiver, either informally or formally, for a significant period of time. The placement does not need to have been due to child protective concerns; it could have been an informal family arrangement for one of many reasons. You would not select this element if the child stayed with close friends or relatives for a school vacation, or while the parent/caregiver had a short-term health crisis. This element applies to situations where the parent/ caregiver was not willing or not able to provide parenting/caregiving responsibility.

#### 3. Child under one year old in RAP family unit at time of the current report, and/or new infant since report.

The response to this risk element is system generated based on the presence of one or more children younger than one year of age on the Person List. Therefore, it is important that the information on the Person list is up-to-date, complete, and accurate; otherwise this element may be calculated inaccurately. Remember to always update the Person List for the addition of a new infant to the family since the last risk assessment was completed. The date of Birth (DOB) recorded in CONNECTIONS for the child(ren) is used to determine the response to the Risk Element, regardless of whether the DOB is exact or approximate. If the DOB field on the Person Detail window is blank for any person whose Rel/Int field signifies that the person is a child, CONNECTIONS includes that person as a child younger than one year old in this calculation. The calculated answer may be changed. Remember to include a new infant born since the answer was calculated.

**4. Current or recent history of housing with serious health or safety hazards; extreme overcrowding; unstable housing; or no housing.**

Evidence of inadequate or hazardous housing may include, but is not limited to, the following: serious overcrowding; seriously inadequate furnishings to meet the family's needs; inadequate heat, plumbing, electricity or water; lack or inoperability of essential kitchen appliances or bathroom facilities; multiple serious health hazards, such as rodent or vermin infestation; garbage and junk piled up; perishable food found spoiled; evidence of human or animal waste; peeling lead-based paint; hot water or steam leaks from a radiator; broken or missing windows; and no guards on open windows.

In some cases, one or two isolated hazardous conditions that have been identified will be corrected (such as restoring heat or installing window bars) prior to the time when risk assessment is completed, either at determination of the report or as part of a FASP. In these cases, the response to this Risk Element would be "No." However, if the hazardous situations have been created over time and are likely the result of prolonged inattention by the caretakers and/or the caretakers appear to accept the hazardous conditions as an acceptable environment for children, the condition(s) is likely to reoccur even if it has been cleaned up by the time of the determination. In this situation, the response to the Risk Element would be "Yes." Health hazards and seriously substandard living conditions pose risk of future abuse or maltreatment regardless of how old the children are.

Homelessness or an unstable housing situation is also included in this risk element definition. Temporary shelter that requires frequent relocation is not adequate, stable housing.

**5. Financial resources are mismanaged or limited to the degree that one or more basic family needs are intermittently or chronically unmet.**

This Risk Element is present if either the family does not have enough financial resources to meet the basic needs of the family for shelter, food, clothing, and health. It is also present if the financial resources available should be sufficient to meet the family's basic needs, but are not sufficient due to mismanagement or inappropriate use of funds. Benefits such as public assistance, SSI, food stamps, public housing or housing vouchers, HEAP, etc., should be considered as financial resources that help meet the family's basic needs. Indicators of limited or mismanaged financial resources may include eviction or threats of eviction for failure to pay rent or loss of utilities due to failure to pay utility bills. "Intermittently or chronically unmet" does not necessarily mean permanently and continuously, but rather could reflect a pattern of shifting from financial crisis to relative stability to financial crisis. If this is the case, check "Yes" to this Risk Element.

**6. Caretaker has, and utilizes, reliable and constructive support and assistance from extended family, friends, or neighbors.**

Indicates whether the caretaker(s) living in the primary household with the child(ren) has reliable and useful social support from informal sources, such as extended family, friends, or neighbors. Reliable and useful social support is present when the adult caretaker(s) has a network of relatives, friends or neighbors to call upon for assistance in any area where the family may need help, such as child care, transportation, emergency financial or housing help, good parenting advice, or emotional support. In addition, the informal social support network is nearby and readily available when needed.

Informal social support does **not** include support from professional helping agencies, such as a case manager, mental health treatment team, or battered women's program. This Risk Element refers only to whether the caretaker has a supportive and reliable network of family, friends, and neighbors. If the caretaker's active participation in a faith-based community provides a network of supportive people who are providing needed assistance, this would meet the definition.

If extended family, friends, or neighbors exist, but are not able to provide constructive help for whatever reason, the answer to this Risk Element is "No." If the caretaker has responsible extended family who would like to be of assistance, but the caretaker has rebuffed their attempts to help, the answer to this question is "No."

## Risk Elements 7-15

Risk Elements 7 - 15 apply to the Primary and, if applicable, Secondary Caretakers in the stage. If no Secondary Caretaker has been identified, you only need to respond for the Primary Caretaker.

### **7. Caretaker has been a victim or perpetrator of abusive or threatening incidents with partners or other adults in family/neighborhood.**

This Risk Element includes situations commonly referred to as domestic violence between intimate partners, but it also refers to violent or threatening relationships with other non-partner adults. Domestic violence is defined as a pattern of coercive tactics that can include physical, psychological, social, economic or emotional abuse perpetrated by one adult against another adult. Examples of domestic violence include: grabbing, pushing, hitting, punching, kicking, choking, biting and restraining; attacking with weapons; threatening to harm the partner or the children; stalking and harassment; intimidation; forced sex; berating and belittling; denying access to family assets, etc. This includes: a caretaker who is a victim or perpetrator of domestic violence involving a partner, former partner or other adult; a caretaker who continues to maintain any type of relationship with an abusive adult and violence remains a threat (the presumption should be that domestic violence remains a threat); an order of protection is in effect against the abusive adult; or a caretaker who is involved in serious conflicts (e.g., volatile arguments, physical fighting, threats with weapons) with other adults in the extended family, adult children, or even neighbors or business or gang associates.

Please note that the definition of this Risk Element is much more expansive than physical violence between current intimate partners. For example, threats, harassment, and frequent fighting or volatile arguments are included in the definition, regardless of whether any physical contact has occurred. If the police have been called to the home for domestic disturbance(s) between the caretaker and another adult, the presumption would be that this Risk Element is present. If one of the caretakers has recently sought an order of protection, or one is in effect, this Risk Element should be checked "Yes."

You would check "Yes" to this element if there are abusive relationships in the recent past or if the caretaker's and/or secondary partner's relationships seem to consist of a series of abusive relationships. It is not uncommon for an abused person to "end" the relationship but the abuser continues to seek contact or otherwise harass the victim. Ex-partners with a violent past may continue to have intense arguments over child visitation, child support, or other issues, so the risk of violence still exists.

If an abusive or threatening relationship ended years ago and the couple (or neighbor) moved away emotionally and physically from each other, the answer would be "No" to this Risk Element.

### **8. Caretaker's alcohol use has had negative effects on child care, family relationships, jobs, or arrests, within the past two years.**

Alcohol use with negative effects means regular or periodic use of alcohol, which has had adverse effects on any aspect of relationships or responsibilities or (e.g., danger of job loss, financial problems, partner threatens to leave, child care suffers, criminal justice system involvement). Alcohol dependency or addiction does not need to be ascertained to check this Risk Element. If the caretaker was in treatment more than two years ago, but there is evidence that the person has resumed using alcohol,

consider this as a current alcohol problem. Select "Yes" for this Risk Element if the caretaker is currently participating in an alcohol treatment program, because until two years of abstinence following the successful completion of treatment has passed, the caretaker is considered to be at risk of relapse. Respond "No" to this Risk Element if the caretaker had an alcohol problem in the past, but has completed treatment and has remained alcohol-free for at least two years. If the caretaker is participating in a non-professional support group, such as Alcoholics Anonymous (AA), without any other evidence of continuing alcohol use within the last two years, do not consider this, by itself, as a current alcohol problem.

An indicator of a problem with alcohol may include a recent arrest for an alcohol-related offense as the abuse/misuse led directly to criminal justice system involvement.

**9. Caretaker's drug use has had negative effects on child care, family relationships, jobs, or arrests, within the past two years.**

Drug use with negative effects means regular or periodic use of one or more drugs which has had adverse effects on any aspect of relationships or responsibilities (e.g., danger of job loss, financial problems, partner threatens to leave, child care suffers, criminal justice system involvement). Drug dependency or addiction does not need to be ascertained to check this Risk Element. If the caretaker was in treatment more than two years ago, but there is evidence that the person has resumed using drugs, consider this as a current drug problem. Select "Yes" for this Risk Element if the caretaker is currently participating in a drug abuse treatment program, because until two years of abstinence following the successful completion of treatment has passed, the caretaker is considered to be at risk of relapse. Select "No" for this Risk Element if the caretaker had a drug problem in the past, but has completed treatment and has remained substance-free for at least two years. If the caretaker is participating in a non-professional support group, such as Narcotics Anonymous (NA), without any other evidence of continuing drug use during the past two years, do not consider this, by itself, as a current drug problem.

An indicator of problem with drugs may include a recent arrest for a drug-related offense as the abuse/misuse led directly to criminal justice system involvement.

**10. Caretaker's behavior suggests mental health problems exist and/or caretaker has a diagnosed mental illness.**

The caretaker should be considered as having a mental health problem if he or she: exhibits symptoms, such as bizarre behavior or delusions; has recent repeated referrals for mental health evaluation or treatment; has been prescribed medication for an ongoing or recurring serious mental health problem; is currently experiencing depression of an ongoing or recurring nature; is engaging in purposely hurting themselves or suicidal behavior; has a current diagnosed serious mental illness; or has attempted suicide in the past. If the caseworker observes an apparent serious mental health problem, a mental health evaluation does not need to have been completed to check that this is a suspected Risk Element at the time the RAP is completed. This Risk Element should be checked "Yes" even if the person is appropriately attending to his or mental health problem by attending mental health treatment sessions or taking prescribed medication. For example, the answer is "Yes" for a caretaker who is diagnosed with schizophrenia even if the caretaker is taking prescribed medication and doing well.

**11. Caretaker has very limited cognitive skills.**

Very limited cognitive skills could include developmental disability, brain injury or some type of cognitive disability that limits the caretaker's ability in major life activities, such as child care, capacity to



form positive relationships with others, self-care, self-direction, receptive and expressive language, learning, capacity for independent living and economic self-sufficiency.

**12. Caretaker has a debilitating physical illness or physical disability.**

Indicates whether or not the caretaker has a serious physical disability or debilitating illness that limits his/her ability to perform any major life activities, such as child care, capacity to form positive relationships with family members or others, self-care, self-direction, receptive and expressive language, learning, mobility, capacity for independent activities and economic self-sufficiency.

**13. Caretaker demonstrates developmentally appropriate expectations of all children.**

A caretaker who "demonstrates developmentally appropriate expectations" is one who shows awareness of what is possible for a child to do and what it is not possible for a child to do, based on his/her age and the stage of development of his/her cognitive, motor, language and social skills. Caretakers would demonstrate this by the level of physical care, supervision, and degree of autonomy they provide to the children, and by how closely they fit the expectations they have of the child to the child's ability. They would apply realistic standards and safe and reasonable limits to the child's behavior and also apply re-direction and discipline that matches the child's abilities and development. A parent with developmentally appropriate expectations adapts parenting practices to the needs of the child(ren) and circumstances. Select "Yes" for this Risk Element only if the caretaker has demonstrated developmentally appropriate expectations with all of the children.

A caretaker who sexually abuses a child does not have developmentally appropriate expectations of the child. A caretaker who uses disciplinary practices that are physically or emotionally abusive indicates that the caretaker does not demonstrate an appropriate understanding of children's needs and how children learn.

**14. Caretaker attends to needs of all children and prioritizes the children's needs above his/her own needs or desires.**

Indicates whether or not the caretaker has a history of recognizing and attending to the daily needs of all of the children. This strength would be present if the caretaker: has demonstrated competence in meeting the basic and unique needs of all of the children; is resourceful in making attempts to meet child(ren)'s needs despite adverse circumstances; and has demonstrated the ability to prioritize the children's needs above the caretaker's. This Risk Element does not require a perfect parent to score this as "Yes." While some caretakers may always meet the needs of all of their children, the perfect parent is rare in the real world. Some caretakers may recognize and strive mightily to meet the needs of their children, but may have an isolated or temporary instance of not meeting a child's needs. Unless the isolated instance was a seriously dangerous lapse, or the caretaker evidences a lack of concern about the harm done to the child, the answer would still be "Yes," the caretaker attends to the needs of the children.

**15. Caretaker understands the seriousness of current or potential harm to the children, and is willing to address any areas of concern.**

This Risk Element refers to whether the caretaker acknowledges any identified injuries or harm that a child has incurred or acknowledges that behaviors and conditions identified in the home by the caseworker pose a risk of harm to the child(ren). The caseworker must also take into account the caretaker's willingness (or ability) to address any current behavior or conditions where a direct link to current or potential harm can be made.

In the case where there has been no abuse or maltreatment and the children are well cared for, select "Yes" because the caseworker and the caretaker do agree on the status of the children's well-being and that there is no concern for harm or risk to the children.

Where there has been maltreatment of a serious nature, but the caretaker does not understand or accept that harm has occurred and it is likely to continue or recur unless something changes to prevent it from occurring again, select "No" for this Risk Element.

Often, the situation will not be so clear cut. Parents/caretakers often make statements to the effect of "I'll see to it that this never happens again." This statement, by itself, is not sufficient information for the caseworker to determine if this Risk Element is present or not. In addition to what the caretaker says about addressing the behaviors or conditions that pose a risk to children, the caseworker must consider if the caretaker has actually taken any steps to address these concerns to reduce risk and increase safety. For example, if the caretaker had a drug abuse problem 18 months ago, first check "Yes" for the drug use risk factor earlier in the RAP. Then consider if the caretaker recognizes the potential for drug use to harm the children. If the caretaker has already successfully addressed the drug problem and has ceased using drugs, or is addressing this problem by participating in substance abuse treatment now, the answer to this last RAP question would be "Yes" (in the absence of another serious unaddressed risk factor). Similarly, the answer to this question would be "Yes" in the case of a caretaker with a serious mental illness who understands that maintaining compliance with his treatment plan is necessary for the safety and well-being of his children and who has a record of complying with his treatment plan.

On the other hand, even if the caretaker verbally agrees that there are problems that place the child at risk, (i.e., caretaker agrees she has an active substance abuse problem), but the caretaker does not keep appointments for services she is referred to without a legitimate reason, or continues to make excuses for not addressing problems she says she understands, the caseworker would be right to question the caretaker's willingness or ability to address areas of concern at this time, and the answer to this question would be "No."

If there was a maltreatment incident, but the caretaker minimizes or denies it, and won't take reasonable steps to reduce the risk of it re-occurring, the answer would be "No." This is also the case when the caretaker has not committed the child abuse or neglect herself, and the caretaker doesn't see the need to keep another person who did harm or poses risk to the child away from the child. In those instances, the answer would be "No."

## Elevated Risk Element Definitions

The presence of any one of these Elevated Risk Elements automatically raises the level of risk of harm to the child(ren) to **Very High**.

### 1. **Death of a child as a result of abuse or maltreatment by caretakers(s)**

Applies to a confirmed fatality of a child as a result of abuse or maltreatment by the identified Primary Caretaker or Secondary Caretaker. The death of the child could have occurred at any time prior to the completion of the RAP and in any jurisdiction within or outside New York State.

**2. Caretaker(s) has a previous TPR**

The identified Primary Caretaker or Secondary Caretaker must have had a adjudication of termination of their parental rights at any time prior to the completion of the RAP. The termination of parental rights (TPR) indicates that a proceeding in family court has occurred and that the court has made a formal decision to grant the guardianship and custody of a child to the local district petitioner. The TPR may be based upon grounds that the child is a "permanently neglected child," "severely abused child," or a "repeatedly abused child." The filing of a TPR with no adjudication to date does not apply.

Parental surrenders are not to be considered as circumstances applying to this Elevated Risk Element. Parental surrenders are not a legal indication of a family court finding of permanent neglect and therefore do not apply in this circumstance.

**3. Siblings removed from the home prior to current report due to abuse or neglect and remain with substitute caregivers or foster parents**

Applies to situations or circumstances that result in the removal of a child (or children) from the home, due to alleged or confirmed abuse or maltreatment, and the child(ren) is placed with substitute caretakers or foster parents. This includes removals by CPS, law enforcement, or any authorized person or entity acting in the best interests of the child(ren).

**4. Repeated incidents of sexual abuse or severe physical abuse by caretaker(s)**

Applies to confirmed reports in which the Primary Caretaker and/or Secondary Caretaker has *repeatedly* sexually abused or *severely* physically abused one or more children in his/her care or has allowed repeated sexual abuse or severe physical abuse of said child(ren) to occur.

Although a single act of sexual abuse is a serious and grievous assault upon a child, the existence of *repeated* sexual abuse implies an inability on the part of the Primary Caretaker and/or Secondary Caretaker to protect the child(ren) and therefore implies an increased risk of future harm.

Severe physical abuse implies, but is not limited to, a substantial risk of serious and/or protracted physical injury. Examples of severe physical abuse that results in serious physical injury may include, but are not limited to, the infliction of internal injuries, fractures, blunt trauma, shaking, choking, burns/scalding, severe lacerations, hematoma, or extensive bruising.

**5. Sexual abuse of a child and perpetrator is likely to have current access to child**

Applies to situations in which a child (or children) has been sexually abused and the confirmed perpetrator (adult or child) continues to have current access to and/or contact with the child. This situation implies an inability on the part of the Primary Caretaker and/or Secondary Caretaker to protect the child(ren) from the risk of future sexual abuse. This also applies to situations in which the Primary Caretaker and/or the Secondary Caretaker is the perpetrator and resides with, or continues to have access to, the child.

**6. Physical injury to a child under one year old as a result of abuse or maltreatment by caretaker(s)**

Applies only to a child (or children) younger than one year old. The young age and inherent vulnerability of the child, coupled with the recent physical injury to the child due to abuse or' maltreatment, implies an increased risk of future harm.

**7. Serious physical injury to a child requiring hospitalization/emergency care within the last 6 months as a result of abuse or maltreatment by caretaker(s)**

Applies to situations in which the child(ren) sustained serious physical injury that requires hospitalization or emergency care provided by any of the following: emergency room, urgent care facility, doctor's office, or emergency medical technicians. The physical injury must have occurred within the last six months.

Examples of physical injury may include, but are not limited to, internal injuries, blunt force trauma, whiplash/Shaken Infant Syndrome, head injury, serious injury to or loss of limb(s), fractures (including spiral and compound), burns/scalding, eye injuries, and severe lacerations.

Malnutrition, Failure to Thrive (FTT), and other serious or life-threatening medical diagnoses directly related to confirmed child abuse or maltreatment may also be included under this Elevated Risk Element.

**8. Newborn child has positive toxicology for alcohol or drugs**

Applies to situations in which a newborn (younger than 6 months old) who is currently part of the RAP family unit tested positive for alcohol or drugs in his/her bloodstream or urine; and/or was born dependent on alcohol or drugs due to parent use.

The young age and inherent vulnerability of the newborn child, coupled with any of the circumstances above, implies an increased risk of future harm to the child.

*Source:* OCFS Common Core Curriculum (2013) Module 3, Unit B3, Research Foundation for SUNY/Buffalo State/CDHS

## Appendix E

## Non-CPS Risk Assessment Profile

Primary Caretaker:		Secondary Caretaker:					
	Questions 1-3:	Yes	No	Ins	Info		
1	Inadequate housing with serious health or safety hazards, or extreme overcrowding, or no housing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2	Financial resources are severely limited or mismanaged to the degree basic family needs are chronically unmet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3	Caretaker(s) in primary household has reliable and useful social support, from extended family, friends or neighbors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	Questions 4-11	Primary Yes No Ins Info			Secondary Yes No Ins Info		
4	Caretaker is a perpetrator of, or a victim of, domestic violence; or has serious conflicts with other adults.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Caretaker(s) with alcohol abuse problem within the past two years with risk of not meeting responsibilities:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Caretaker(s) with drug abuse problem within the past two years with risk of not meeting responsibilities:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Caretaker(s) has a serious mental health problem:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Caretaker(s) has very limited cognitive skills:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Caretaker(s) has debilitating physical illness or physical disability:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Caretaker(s) has and applies realistic expectations of all the children:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Caretaker(s) always or usually recognizes and attends to needs of all the children:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## Appendix F

## Strengths, Needs and Risks Scales

### Family Strengths, Needs and Risks

Scale	Ratings
1. Support System	a. Multiple sources of reliable and useful support from extended family, friends or neighbors
	b. Some reliable and useful support from extended family, friends or neighbors
	c. Some support from extended family, friend or neighbors, but unreliable or of limited usefulness
	d. Effectively isolated
2. Financial Resource Management/Basic Needs (Mapped to RAP)	a. Financial resources are sufficient and adequately managed to meet basic family needs
	b. Financial resources are limited, but are adequately managed to meet basic family needs
	c. Financial resources are limited or not adequately managed to the degree that basic family needs are occasionally unmet
	d. Financial resources are severely limited or mismanaged to the degree that basic family needs are chronically unmet
3. Stability of Housing	a. Housing is currently stable; no risk of loss of residence
	b. Housing is currently stable, but some risk of loss of residence in future
	c. Housing is unstable; imminent risk of loss of residence or multiple relocations
	d. Currently homeless or residing in a shelter
4. Living Conditions (Mapped to RAP)	a. Good to excellent; no overcrowding and sufficient furnishings, utilities and sanitation
	b. Adequate; some overcrowding or minor problems with furnishings, utilities and sanitation
	c. Inadequate; moderate overcrowding or significant problems with furniture, utilities and sanitation
	d. Severely inadequate; no housing, housing with serious health and safety hazards, or extreme overcrowding
5. Neighborhood Environment	a. Very safe; rare instances of violence or criminal gang activity
	b. Safe; relatively few occurrences of violence or criminal or gang activity
	c. Unsafe; occasional occurrences of violence or criminal or gang activity
	d. Very unsafe; frequent occurrences of violence or criminal or gang activity

## Child Strengths, Needs and Risks

Scale	Ratings
1. Physical Health	a. Good or excellent health
	b. Minor illness or physical disability
	c. Moderately serious illness or physical disability
	d. Debilitating illness or physical disability
2. Physical Health Care	a. Regular preventive health care is practiced
	b. Receives appropriate medical care for illness or condition
	c. Some unmet medical care needs
	d. Serious unmet medical care needs
3. Mental Health	a. No mental health concerns
	b. Minor mental health concerns
	c. Moderately serious mental health problems
	d. Serious mental health problems
4. Mental Health Care	a. No mental health concerns or able to self-monitor and take appropriate steps to stabilize emotional well-being
	b. Receives mental health care; fully complies with treatment recommendations
	c. Receives mental health care; partially complies with treatment recommendations
	d. receives little or no mental health care or is no-compliant with treatment recommendations
5. Bonding and Attachment of Child Under Age 2	a. Deep sense of connection, familiarity between infant/toddler and parent/caretaker
	b. Adequate bonding; infant/toddler recognizes and responds to parent/caretaker contact
	c. Distinct lack of positive connections and remoteness between infant/toddler and parent/caretaker
	d. Infant/toddler appears anxious and fearful upon parent/caretaker contact
6. Child Development/Cognitive Skills	a. Advanced development in one or more areas; above average cognitive skills
	b. Age appropriate development; average cognitive skills
	c. Minor developmental delays; developmental or learning disability
	d. Serious developmental delays; serious developmental or learning disability
7. Academic Performance (children age 6 and over)	a. Outstanding
	b. Satisfactory
	c. Below Average
	d. Poor
8. Child Behavior	a. Age appropriate behavior at home and within the community
	b. Some minor behavioral problems at home and/or within the community
	c. Moderately serious behavioral problems or criminal activity at home and/or within the community



Scale	Ratings
	d. Serious behavioral problems or criminal activity at home and/or within the community
9. Alcohol Use Within the Past Two Years	a. No alcohol use
	b. Light to moderate alcohol use
	c. Frequent alcohol use
	d. Alcohol dependence
10. Drug Use Within the Past 2 Years	a. No use of illegal drugs or misuse of prescription drugs
	b. Occasional use of illegal drugs or misuse of prescription drugs
	c. Frequent use of illegal drugs or misuse of prescription drugs
	d. Drug dependence or addiction
11. Child/Family Relationships	a. Mutual respect and tolerance among child and family members; very few conflicts
	b. Generally positive relationships among child and family members; minor conflicts
	c. Poor relationship between child and family; no request for placement
	d. Serious conflict between child and family; threat of separation/placement
12. Interpersonal Skills (children age 6 and over)	a. Strong interpersonal skills that facilitate positive interactions and supportive relationships with non-family members
	b. Appropriate interpersonal skills that allow for generally effective interactions and relationships with non-family members
	c. Inappropriate interpersonal skills that create barriers to effective interactions and relationships with non-family members
	d. Hostile, passive or destructive interpersonal skills that frequently result in problematic interactions or poor relationships with non-family members
13. Nutrition, Clothing and Personal Hygiene	a. Good or appropriate; meets or exceeds societal standards
	b. Adequate; meets but does not exceed societal standards
	c. Poor or inappropriate; does not meet societal standards
	d. Inadequate; absence of either food, clothing or personal hygiene

## Parent/Caretaker Strengths, Needs and Risks

Scale	Ratings
1. Caretaker Abused/Neglected as a Child	a. No childhood history of abuse or neglect
	b. Some childhood history of abuse or neglect
	c. Serious childhood history of neglect
	d. Serious childhood history of physical and/or sexual abuse
2. Physical Health	a. Good or excellent health
	b. Minor illness or physical disability
	c. Moderately serious illness or physical disability
	d. Debilitating illness or physical disability
3. Physical Health Care	a. Regular preventive health care is practiced
	b. Receives appropriate medical care for illness or condition
	c. Some unmet medical care needs
	d. Serious unmet medical care needs
4. Mental Health	a. No mental health concerns
	b. Minor mental health concerns
	c. Moderately serious mental health problems
	d. Serious mental health problems
5. Mental Health Care	a. No mental health concerns or able to self-monitor and take appropriate steps to stabilize emotional well-being
	b. Receives mental health care; fully complies with treatment recommendations
	c. Receives mental health care; partially complies with treatment recommendations
	d. Receives little or no mental health care or is non-compliant with treatment recommendations
6. Ability to Cope with Stress	a. Consistently uses effective coping skills to manage stress
	b. Uses adequate coping skills in most situations to manage stress
	c. Coping skills are not consistently used or effective in managing stress
	d. Coping skills are very limited or ineffective in managing stress
7. Cognitive Skills	a. Appears to have above average cognitive skills
	b. Appears to have average cognitive skills
	c. Appears to have limited cognitive skills
	d. Appears to have very limited cognitive skills
8. Relationships Among Caretakers & other Significant Adults	a. Supportive, nurturing relationships
	b. Generally positive relationships with minor conflicts; no threatening physically or emotionally abusive relationships
	c. Non-supportive, negative relationships with serious conflicts, threatening and controlling behaviors or minor physical violence or emotional abuse
	d. Repeated and/or severe physical violence or emotional abuse

Scale	Ratings
9. Alcohol Use Within the Past 2 Years	<ul style="list-style-type: none"> <li>a. No alcohol use</li> <li>b. Light to moderate alcohol use</li> <li>c. Frequent alcohol use</li> <li>d. Alcohol abuse, with risk of not meeting responsibilities</li> </ul>
10. Drug Use Within the Past Two Years	<ul style="list-style-type: none"> <li>a. No use of illegal drugs or misuse of prescription drugs</li> <li>b. Occasional use of illegal drugs or misuse of prescription drugs</li> <li>c. Frequent use of illegal drugs or misuse of prescription drugs</li> <li>d. Drug abuse, with risk of not meeting responsibilities</li> </ul>
11. Criminal History	<ul style="list-style-type: none"> <li>a. No known criminal offense</li> <li>b. Minor criminal offense; isolated incident</li> <li>c. Moderate to serious criminal offense or multiple incidence of minor criminal offenses</li> <li>d. Very serious criminal offense</li> </ul>
12. Motivation/Readiness to Change	<ul style="list-style-type: none"> <li>a. Accepts responsibility for problematic behaviors/conditions and has taken steps to initiate change</li> <li>b. Recognizes problematic behavior/ conditions and demonstrates willingness to change</li> <li>c. Limited recognition of problematic behaviors/conditions and is resistant to change</li> <li>d. Denies responsibility for problematic behavior/conditions; no willingness to change</li> </ul>
13. Parent/Caretaker Expectations of Children	<ul style="list-style-type: none"> <li>a. Has and applies realistic and developmentally appropriate expectations of all children</li> <li>b. Has, but inconsistently applies realistic and developmentally appropriate expectations of any of the children</li> <li>c. Has and applies unrealistic and developmentally inappropriate expectations of any of the children</li> <li>d. Has and applies very unrealistic and developmentally inappropriate expectations of any of the children</li> </ul>
14. Parent/Caretaker Acceptance of Children	<ul style="list-style-type: none"> <li>a. Very accepting of and affectionate to all children</li> <li>b. Fairly accepting of and affectionate to all children</li> <li>c. Indifferent and aloof to any of the children</li> <li>d. Rejecting of or hostile to any of the children</li> </ul>
15. Parent/Caretaker Discipline of Children	<ul style="list-style-type: none"> <li>a. Uses discipline appropriate to child's age, development and conduct; no physical discipline used</li> <li>b. Uses discipline appropriate to child's age, development and conduct; some physical discipline used</li> <li>c. Uses discipline inappropriate to child's age, development or conduct that causes minor physical or emotional harm to child</li> <li>d. Uses discipline inappropriate to child's age, development or conduct that causes serious physical or emotional harm to child</li> </ul>

Scale	Ratings
16. Parent/Caretaker Supervision	a. Consistently provides age appropriate care and supervision
	b. Usually provides age appropriate care and supervision
	c. Occasionally provides age appropriate care and supervision
	d. Rarely or never provides age appropriate care and supervision
17. Problem Solving Skills	a. Strong ability to anticipate and solve problems in a timely manner
	b. Adequate ability to anticipate and solve most problems before crises erupt
	c. Difficulty in anticipating and solving problems before crises erupt
	d. Inability to address problems until crises occur
18. Recognizes and Attends to Needs of All Children	a. Always recognizes and attends to the needs of all the children
	b. Usually recognizes and attends to the needs of all the children
	c. Occasionally recognizes and attends to the needs of all the children
	d. Rarely recognizes and attends to the needs of all the children

Appendix G

## **Family Assessment Questions**

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## Questions for Assessment of Strengths, Needs, and Risk

Below are a series of questions to support your assessment of risk with the families and children you serve. Expecting parents to answer such questions assumes that the following criteria have been satisfied:

- ➔ Service providers and parents have established a level of trust sufficient for the parents to disclose the information sought by the question.
- ➔ The questions are posed in a nonthreatening manner and/or are perceived as nonthreatening by the parent.
- ➔ Parent is capable—intellectually and emotionally—to answer the questions.

Generally, people answer the questions of others when they perceive benefit from so doing. Establishing the basis for the interview(s) in a way that incorporates parent needs and perspective is vital to gaining/discovering the desired information.

The questions in this handout can be used to gather information relative to the assessment elements contained in the Risk Assessment Profile (RAP), and the Assessment of Strengths, Needs, and Risk. The questions are organized by strengths, needs, and risk assessment scales and ordered (where feasible) from lesser to greater degrees of potential threat to the parent. If parents do not answer questions at the beginning of each scale, they are conveying that one or more of the above criteria is not satisfied. Also, the scales vary in level of potential threat to the parent. Structuring the interview to anticipate this is wise.

Questions contained in this handout should not be viewed as being asked to a “blank screen,” where the interviewee is seen uniformly capable and willing to objectively and openly answer any and all questions. The implications of this are that the questions must always be balanced by good listening skills and rapport-building behaviors. An area especially important to monitor is the immediate effect of the question on the parent. Reflecting feelings and needs and supporting the parent during this process is crucial.

Besides the information gained from the parent’s verbal response to these questions, the interviewer gets nonverbal information—often equally, if not more, important. This level of response reveals mood, intellectual ability, concentration, motivation, trust, and attitude, all of which should be factored into the current and future interview(s).

## Questions for Assessment of Strengths, Needs, and Risk

Since predicting exact parent response to questions is generally impossible, rephrasing or creating follow-up questions is essential. Also, when the parent reveals more information than might be expected by a particular question, continuing to introduce other questions from the handout may not be necessary.

*Note:* The items marked with an asterisk (\*) are elements which contribute to the calculation of a risk score in protective cases.

### Family Functioning

#### Support System\*

- ➔ Tell me about your relationships with people outside of your immediate family – relatives, friends, neighbors, acquaintances? Whom do you see or have regular contact with? How close or far away do they live?
- ➔ Do these people give you support (emotional, financial), help, or advice when you ask for it? How often do you ask? How often do they give it?
- ➔ Do you have a telephone? Does not having a telephone cause you problems? Please explain.
- ➔ What kind of activities or groups are you involved in outside your home? How often? How regularly? How often do you go to someone else's home or have someone else over to your home?
- ➔ How does it feel when you need to ask someone for help?
- ➔ How do you think others feel when you ask for help from them?

#### Financial Resource Management/Basic Needs\*

- ➔ Have you ever been evicted from where you were living? What led to the eviction? Have you ever been homeless? When? What did you do?
- ➔ Describe your sources of income?
- ➔ Have you ever had to rely upon a food pantry? Describe the circumstances.
- ➔ What utilities (gas, electric, water, cable, etc.) are you currently using. How are they paid?

## Questions for Assessment of Strengths, Needs, and Risk

### Stability of Housing

- ➔ How long have you lived at your current address?
- ➔ How often have you moved in the past two years?
- ➔ Is the title for the house, or the lease on the apartment in your name? If not, what is your relationship to the person who is responsible for the residence?
- ➔ Is there anything going on now that could result in you having to move in the near future?

### Living Conditions\*

- ➔ How do you feel about your home? What is your home lacking that you wish it had?
- ➔ How do others in the family view the conditions of the home?
- ➔ Do your children share their bedrooms with anyone? Please explain? Are there doors on any rooms so you and other family members can have privacy when getting dressed or using the bathroom?
- ➔ Is there anything in your home that makes it really uncomfortable, unsafe, or unsanitary (e.g., problems with water, heat, gas, electricity, plumbing, peeling paint, broken windows, food storage, dangerous substances, bugs or mice)? Is your neighborhood safe? Can your children play safely outside?
- ➔ Do you know how to make home repairs or does your landlord make repairs when you ask? Do you ask?
- ➔ Have you ever had a fire in your home? Describe.
- ➔ On a scale of 1-10 with one being “not important at all,” and 10 being “the most important thing to my family,” how would you rate your feelings about the condition of your home?

### Neighborhood Environment

- ➔ Where do you live?
- ➔ How long have you lived there?



## Questions for Assessment of Strengths, Needs, and Risk

- ➔ Is your home close to public transportation? Shopping? If not, tell me how you manage.
- ➔ What kind of community services have you used? Are they easy to use and get to? Do you know what community services are available if you need to use them?
- ➔ Do you feel safe in your neighborhood? Do you feel that your children are safe there?
- ➔ On a scale of 1-10, with one being "I need to get out of here," and 10 being "I would never leave the neighborhood," how would you rate your neighborhood?
- ➔ How do others in the family view the neighborhood?

### Parent/Caretaker Functioning

#### Current Age of Parent/Caretaker

- ➔ How old are you?
- ➔ How prepared were you to become a parent?
- ➔ What does your mother/father think about your parenting ability?
- ➔ Is being a parent easier or harder than you expected? On a scale of 1-10, with one being "impossible" and ten being "piece of cake," how would you rate your experience as a parent?
- ➔ At what age did your parents first become parents?
- ➔ Was your pregnancy planned? What led to your decision to have a child?

#### Caretaker Abused/Neglected as a Child

- ➔ How would you describe your childhood?
- ➔ Please share with me your best memories as a child? Your worst memories?
- ➔ How did you spend time with your family?
- ➔ Describe how your father treated you. Describe how your mother treated you.
- ➔ How would your parents describe you?
- ➔ Explain what your parents/caretakers did that showed they loved you.

## Questions for Assessment of Strengths, Needs, and Risk

- ➔ Did your parents approve of most of the things you said you did? How did they show their approval?
- ➔ Did your parents ever disapprove of things you said or did? How did they show their disapproval?
- ➔ Share with me the worst thing you ever did that your parents found out about. How did they react to what you did?
- ➔ What was the usual method of discipline your parents used? Was it the same for all the children?
- ➔ Did your mother/father ever hit you? How often? For doing what? What were you hit with (open hand, fist, belt, paddle, etc.)? How badly were you hurt?
- ➔ How else did your parents punish you?
- ➔ Can you give me some examples of things you do as a parent that are the same as what your parents did? Can you give me some examples of things you do differently?
- ➔ How do you think the way you were brought up affects your parenting?

### Physical Health\*

- ➔ How's your health? Please explain.
- ➔ Are you under a doctor's care?
- ➔ Does your medical condition require medication?
- ➔ Does the medication/treatment affect you negatively? Please explain.
- ➔ Describe anything that has been hard for you to do for your child since you've been ill.
- ➔ What are you still able to do for your child that he/she needs or wants from you?
- ➔ Is there anything you are unable to do for your child that he/she needs or wants from you?

## Questions for Assessment of Strengths, Needs, and Risk

### Physical Health Care

- ➔ Do you have any medical coverage?
- ➔ Do you have a primary physician?
- ➔ How often do you see a doctor?
- ➔ Describe how you feel about going to medical appointments.
- ➔ How important is your health to you? On a scale of 1-10, with one being “totally not important” and ten being “the most important thing in life,” how would you rate your feelings about your health?
- ➔ Do you have any physical conditions/ailments that are not being treated?

### Mental Health\*

- ➔ How are you feeling generally – happy, sad, scared, angry, overwhelmed, confused, disappointed, etc.? How long have you been feeling this way?
- ➔ When was the last time you felt different than you do now? What did you feel then?
- ➔ Describe something about your life that you like? Don't like?
- ➔ Tell me how you think your life will be in five years.
- ➔ How does \_\_\_\_\_ treat you?
- ➔ Describe how you are feeling toward \_\_\_\_\_?
- ➔ What does \_\_\_\_\_ need from you now? Give me an example of how you respond to these needs?
- ➔ What's easy about taking care of \_\_\_\_\_? What's hard? Tell me more.
- ➔ Are there things you need to take care of in your daily life that are hard for you to do (e.g., shopping, cooking, paying bills, taking care of your house, dealing with \_\_\_\_\_'s teachers and school)? Describe a hard day.

## Questions for Assessment of Strengths, Needs, and Risk

### Mental Health Care

- ➔ Are you currently taking medication for an emotional condition?
- ➔ Are you currently receiving counseling/mental health treatment?
- ➔ Have you received mental health services in the past? On a scale of 1-10, with one being “of no use at all” and 10 being “extremely effective,” how effective were past mental health services.
- ➔ How do others in the family view mental health services?

### Ability to Cope With Stress

- ➔ Have you had any major stress or crisis in your family in the last year or so (e.g., unemployment, death of a family member, change in marital relationships, long illness or serious injury, loss of housing)? Please explain these stresses and how often they’ve happened? Have they affected your children and/or your ability to care for them?
- ➔ Describe how you handled the major stress or crisis situations?
- ➔ What things that you do day-to-day are easiest for you? What things are the hardest? How do they affect your children?
- ➔ Whom do you ask for help when you need it? Tell me what they do.

### Cognitive Skills\*

- ➔ Do you read and write with your children?
- ➔ Do problems with reading and/or writing ever cause you problems or keep you from getting things you need? Please explain.
- ➔ Do you maintain a checking account?

### Relationships Among Caretakers & Other Significant Adults\*

- ➔ Who do you consider to be members of your family? Who lives in your house or visits you often? Who has a lot of contact with your children?

## Questions for Assessment of Strengths, Needs, and Risk

- ➔ How do you and your family get along most of the time? How do you and your family handle things when you disagree—about what to do, what you want, how to deal with your children?
- ➔ Describe your relationship with \_\_\_\_\_.
- ➔ What would you say is one of the best things about \_\_\_\_\_? What do you wish was different about \_\_\_\_\_?
- ➔ What do you do when you get angry (e.g., leaving, verbal insults, yelling, threats, throwing things, physically attacking each other)?
- ➔ What does \_\_\_\_\_ do when he/she is angry?
- ➔ Is there anyone in your family that you're afraid of? Who? What does the person do that scares you? Is there anyone in your family that your children are afraid of? Who? What does the person do that scares them?
- ➔ Has anyone in your family ever threatened to hurt another family member? What did the person say or do?
- ➔ Has anyone in your family ever physically hurt you or another family member? How seriously? How often? Was this done in front of the children?
- ➔ Have you ever had to ask someone else for help because you were afraid of, threatened by, or hurt by a family member? Who (e.g., family, friends, neighbors, police)?
- ➔ Has any member forced you or another member to do sexual thing you/they didn't want to?
- ➔ Have you ever asked the police for help in a family situation? Tell me what happened? How often has this happened? Have you ever had an order of protection against another person?

### Alcohol Use within the Past Two Years\*

- ➔ Do you currently drink alcohol? Do you recall when you first began drinking alcohol? How much do you drink now, on average? (Two drinks a day for men and one drink for women—beer, wine, or liquor—is considered “moderate drinking.”)
- ➔ Tell me about the times when you drink. With whom?

## Questions for Assessment of Strengths, Needs, and Risk

- ➔ Has anyone close to you ever commented on your drinking? How much you're drinking? Things that you do when you're drinking? Please explain. How do you feel about their comments?
- ➔ Do you think that your drinking has any effect on your children, or on your ability to care for your children? Please explain.
- ➔ Has a professional (or anyone else) ever told you that drinking was causing you health problems? Please explain.
- ➔ Have you ever had any professional help/treatment for drinking or drinking-related problems? Please explain and give specifics of the treatment.

### Drug Use within the Past Two Years\*

- ➔ Have you ever used any drugs or medications prescribed to you (e.g., painkillers, sleeping pills, tranquilizers) in any way that the doctor didn't prescribe them?
- ➔ Have you ever used any over-the-counter drugs or medications (ones you bought in a store, such as diet pills, laxatives) in a way different from the directions?
- ➔ Have you ever used marijuana, acid, cocaine, crack, or heroin? Please explain.
- ➔ Are you currently using marijuana, acid, cocaine, crack, heroin, other drugs? When was the last time that you used this drug?
- ➔ How often, on average, have you used drugs in the last six months? How much do you use?
- ➔ Do you ever use drugs/alcohol while you are caring for your child(ren)?
- ➔ Has anyone close to you ever commented on your drug use? Please explain.
- ➔ Do you think that your drug use has any effect on your children, or on your ability to care for your children? Please explain.
- ➔ Has a professional (or anyone else) ever told you that drug use was causing you health problems? Please explain.
- ➔ Have you ever had any professional help/treatment for drug abuse or drug-related problems? Please explain and give specifics of the treatment.

## Questions for Assessment of Strengths, Needs, and Risk

### Criminal History

- ➔ Describe any criminal history?
- ➔ Are you currently on probation, parole?
- ➔ Are any family members/significant friends involved in criminal activity? How does it affect your life?

### Motivation/Readiness to Change

- ➔ On a scale of 1-10, with one being "everything is terrible," and 10 being "everything is perfect," how would you rate your life right now?
- ➔ Who is most responsible for your involvement with child welfare services? How so?
- ➔ If child welfare services were to get out of your life today, how would things work out for your family?
- ➔ What would happen if you complied with all being asked of you by the child welfare system?
- ➔ What services do you find helpful?
- ➔ If there was anything you could change about your life, what would it be?
- ➔ What would a perfect day/week/month look like for your family?

### Parent/Caretaker Expectations of Children\*

- ➔ How old is (the child's name)?
- ➔ Tell me about some of the things he/she does that you like. When does he/she behave that way? How often?
- ➔ What do you say/do when \_\_\_\_\_ behaves well?
- ➔ Does \_\_\_\_\_ behave the way you want him/her to? Please tell me more about this.
- ➔ Give me some examples of when \_\_\_\_\_ doesn't behave the way you expect? How often does the child behave this way?

## Questions for Assessment of Strengths, Needs, and Risk

- ➔ What do you say/do when \_\_\_\_\_ doesn't behave the way you expect?
- ➔ How do you want him/her to behave? How can you get him/her to do this?
- ➔ How does \_\_\_\_\_'s behavior compare with other kids' his/her age?
- ➔ Share with me how you want your child to turn out as an adult.

### Parent/Caretaker Acceptance of Children

- ➔ Please describe \_\_\_\_\_ for me. What would I like about him/her? Not like?
- ➔ What does \_\_\_\_\_ do that causes you problems? How often does this happen?
- ➔ How do you feel when \_\_\_\_\_ acts in a way you like? Don't like?
- ➔ Do you ever wish \_\_\_\_\_ was different in some way? Tell me more. How would your life be better?
- ➔ Give me an example of when \_\_\_\_\_ is a good child. How often does \_\_\_\_\_ act this way?
- ➔ What do you think \_\_\_\_\_ thinks of you?

### Parent/Caretaker Discipline of Children

- ➔ How well prepared do you think your child will be to succeed as an adult?
- ➔ What function do you think you have with regards to their future success? How will you perform that function?
- ➔ When your child fails to perform/behave as you expect, how do you respond? Give examples.

### Parent/Caretaker Supervision

- ➔ When you were a child, how much time did you have without adult supervision at age \_\_\_\_\_? How did that work out? How did you feel about it?
- ➔ Describe how you make decisions about whether and how long you can leave \_\_\_\_\_ alone?



## Questions for Assessment of Strengths, Needs, and Risk

- ➔ Describe how you make decisions about selecting substitute child care, when you must be elsewhere.
- ➔ How much unsupervised time does \_\_\_\_\_ have per day? At what times does this occur?

### Problem Solving Skills

- ➔ Describe some difficulties your family has faced. How did you overcome them?
- ➔ Who do you look to for support during difficult times?
- ➔ When you, your friends, your children and/or your employer make different demands upon your time, how do you decide what to do? Describe a time when this occurred.

### Recognizes and Attends to Needs of All Children\*

- ➔ Describe how your children's needs are different?
- ➔ Describe how your children's needs are the same?
- ➔ Describe what you do to meet your child/ren's needs
- ➔ Describe what you have done to overcome obstacles to meeting your children's needs.

## Child Functioning

### Physical Health

- ➔ Do your children suffer from any ongoing physical health conditions?
- ➔ Have your children had any significant health problems in the past?
- ➔ Is your child on target developmentally? How have you determined that?
- ➔ How much school do your children miss during a school year?

## Questions for Assessment of Strengths, Needs, and Risk

### Physical Health Care

- ➔ How do you feel about taking the child for medical care?
- ➔ Where does your child receive medical care?
- ➔ Who is the child's primary care physician?
- ➔ Do you have a record of the child's immunizations?
- ➔ When was the child's last physical?

### Mental Health

- ➔ Does your child behave as you expect children should behave? Explain?
- ➔ How does your child's behavior affect others in the family?
- ➔ How do others feel about your child's behavior?

### Mental Health Care

- ➔ Does your child currently receive any mental health services? In the past?
- ➔ How do you feel about mental health service providers?
- ➔ How do others feel about your child's condition?

### Bonding and Attachment of Child Under Age 2

- ➔ How do you describe your child?
- ➔ How does your child respond to members of the family? Strangers? Describe.
- ➔ How does your child respond when you enter the room? When you leave?

### Child Development/Cognitive Skills

Use the *Child Development Guidebook* to gather information necessary to complete this element.

## Questions for Assessment of Strengths, Needs, and Risk

### Academic Performance

Check with school officials. If home-schooled, check to see how progress is being monitored.

### Child Behavior

- ➔ Describe your child's behavior.
- ➔ How do others in the family describe your child's behavior?
- ➔ How does the school describe your child's behavior?
- ➔ How do your neighbors describe your child's behavior?
- ➔ What is the child's self-view?
- ➔ Has your child ever been in trouble with the law?

### Alcohol Use within the Past Two Years

- ➔ Does your child currently drink alcohol? Do you recall when drinking behavior first occurred? How much does your child drink? Tell me about the times when your child drinks. With whom?
- ➔ Do you think that your child's drinking has any effect on your family, school, or behavior in the community? Please explain.
- ➔ Has your child ever had any professional help/treatment for drinking or drinking-related problems? Please explain and give specifics of the treatment.

### Drug Use Within the Past Two Years

- ➔ Does your child currently use drugs? Do you recall when this behavior first occurred? What drugs does your child use? How much does your child use? Tell me about the times when your child uses drugs. With whom?
- ➔ Do you think that your child's drug use has any effect on your family, school, or behavior in the community? Please explain.
- ➔ Has your child ever had any professional help/treatment for drug-related problems? Please explain and give specifics of the treatment.

## Questions for Assessment of Strengths, Needs, and Risk

### Child/Family Relationships

- ➔ What do your siblings think of \_\_\_\_?
- ➔ How does \_\_\_\_ get along with his siblings?
- ➔ What kinds of things does \_\_\_\_ do with members of the family?
- ➔ How does \_\_\_\_ get along with you?
- ➔ Describe what disagreements between \_\_\_\_ and members of the family look like.

*Note:* (A Family Map may be useful in assessing this element)

### Interpersonal Skills

- ➔ How does \_\_\_\_ express his/her needs? \_\_\_\_\_
- ➔ On a scale of 1-10 with 1=Passive and 10= Demanding, how would you rate your child's interaction with family members? Describe the behaviors that lead to your rating?
- ➔ How does your child ask for help, if needed?
- ➔ Does your child have many friends? What are they like?

### Nutrition, Clothing and Personal Hygiene

- ➔ How well does your child eat?
- ➔ Are there foods that your child rejects?
- ➔ Describe your child's diet.
- ➔ Describe your child's personal care habits and routines.
- ➔ Are you satisfied with your child's appearance? What do you approve of? What do you dislike?
- ➔ Does your child's appearance or personal care standards cause him problems in any way?

## Appendix H

# Developmental Stages

The tables on the following pages are designed as a quick reference to assist caseworkers in recognizing the common behaviors of children and youth at various stages of development. They are meant to be general guidelines: each child develops at his/her own pace. A child or youth may lag in one area while being advanced in another. Slow development in a particular skill does not necessarily mean that a child is developmentally delayed.

For a more detailed developmental guide, see the *Child Development Guide* (2002), published by the Center for Development of Human Services, State University of New York at Buffalo with funding provided by the New York State Office of Children and Family Services Bureau of Training.

### Infants and Toddlers (Birth to 3 years)

Source: Centers for Disease Control and Prevention  
(<http://www.cdc.gov/ncbddd/actearly/milestones/index.html>)

	<b>Social/Emotional</b>	<b>Communication</b>	<b>Cognitive</b>	<b>Physical</b>	<b>Problem Signs</b>
2 months	<ul style="list-style-type: none"> <li>Begins to smile at people</li> <li>Can briefly calm him/herself</li> <li>Tries to look at parents</li> </ul>	<ul style="list-style-type: none"> <li>Coos, makes gurgling sounds</li> <li>Turns head toward sounds</li> </ul>	<ul style="list-style-type: none"> <li>Pays attention to faces</li> <li>Begins to following things with eyes</li> <li>Fusses if activity doesn't change</li> </ul>	<ul style="list-style-type: none"> <li>Can hold head up and begins to push up when lying on tummy</li> <li>Smoother movements of arms and legs</li> <li>Brings hands to mouth</li> </ul>	<ul style="list-style-type: none"> <li>Doesn't respond to loud sounds</li> <li>Doesn't watch moving objects</li> <li>Doesn't smile at people</li> <li>Doesn't bring hands to mouth</li> </ul>
4 months	<ul style="list-style-type: none"> <li>Smiles spontaneously</li> <li>Likes to play with people</li> <li>Copies some movements and facial expressions</li> </ul>	<ul style="list-style-type: none"> <li>Begins to babble</li> <li>Copies sounds he/she hears</li> <li>Cries in different ways for different reasons</li> </ul>	<ul style="list-style-type: none"> <li>Responds to affection</li> <li>Uses hands and eyes together</li> <li>Recognizes familiar people and things</li> </ul>	<ul style="list-style-type: none"> <li>Holds head steady without support</li> <li>Pushes down with legs when feet are on a hard surface</li> <li>Can hold a toy</li> </ul>	<ul style="list-style-type: none"> <li>Doesn't watch moving objects</li> <li>Can't hold head steady</li> <li>Doesn't coo or make sounds</li> <li>Doesn't push with legs</li> </ul>
6 months	<ul style="list-style-type: none"> <li>Knows familiar faces</li> <li>Responds to others' emotions</li> <li>Likes to look at self in mirror</li> </ul>	<ul style="list-style-type: none"> <li>Strings vowels together when babbling</li> <li>Responds to own name</li> <li>Makes sounds to show joy or displeasure</li> </ul>	<ul style="list-style-type: none"> <li>Looks around at nearby objects</li> <li>Brings things to mouth</li> <li>Tries to get things that are out of reach</li> </ul>	<ul style="list-style-type: none"> <li>Rolls over in both directions</li> <li>Supports weight on legs</li> <li>Rocks back and forth on hands and knees</li> </ul>	<ul style="list-style-type: none"> <li>Doesn't respond to caregivers</li> <li>Doesn't respond to sounds</li> <li>Doesn't make vowel sounds</li> <li>Seems very stiff or very floppy</li> </ul>
9 months	<ul style="list-style-type: none"> <li>May be afraid of strangers</li> <li>May cling to familiar adults</li> </ul>	<ul style="list-style-type: none"> <li>Understands "no"</li> <li>Uses consonants in babbling</li> </ul>	<ul style="list-style-type: none"> <li>Plays "peek-a-boo"</li> <li>Puts things in mouth</li> </ul>	<ul style="list-style-type: none"> <li>Stands, holding on</li> <li>Sits without support</li> </ul>	<ul style="list-style-type: none"> <li>Doesn't bear weight on legs</li> <li>Doesn't babble</li> </ul>

	<b>Social/Emotional</b>	<b>Communication</b>	<b>Cognitive</b>	<b>Physical</b>	<b>Problem Signs</b>
	<ul style="list-style-type: none"> <li>• Has favorite toys</li> </ul>	<ul style="list-style-type: none"> <li>• Copies sounds and gestures</li> <li>• Points at things</li> </ul>	<ul style="list-style-type: none"> <li>• Moves things from one hand to the other</li> <li>• Picks things up between thumb and index finger</li> </ul>	<ul style="list-style-type: none"> <li>• Pulls to stand</li> <li>• Crawls</li> </ul>	<ul style="list-style-type: none"> <li>• Doesn't recognize familiar people</li> <li>• Doesn't follow objects with eyes</li> </ul>
1 year	<ul style="list-style-type: none"> <li>• Shows fear in some situations</li> <li>• Repeats sounds or actions to get attention</li> <li>• Puts out arm or leg to help with dressing</li> </ul>	<ul style="list-style-type: none"> <li>• Responds to simple requests</li> <li>• Says single words such as "mama" and "dada"</li> <li>• Tries to imitate speech</li> </ul>	<ul style="list-style-type: none"> <li>• Finds hidden things</li> <li>• Bangs things together</li> <li>• Points or looks at thing when named</li> <li>• Puts things in and out of containers</li> </ul>	<ul style="list-style-type: none"> <li>• Gets to sitting position without help</li> <li>• Walks holding onto furniture or people</li> </ul>	<ul style="list-style-type: none"> <li>• Doesn't crawl</li> <li>• Can't stand when supported</li> <li>• Doesn't say single words</li> <li>• Doesn't use gestures</li> <li>• Doesn't point to things</li> </ul>
18 months	<ul style="list-style-type: none"> <li>• Likes to hand things to others</li> <li>• May have temper tantrums</li> <li>• Plays simple pretend games</li> <li>• Explores alone but with parents nearby</li> </ul>	<ul style="list-style-type: none"> <li>• Has a vocabulary of 5-20 words, mostly nouns</li> <li>• Says and shakes head "no"</li> <li>• Points to show what he/she wants</li> <li>• Follows simple commands</li> </ul>	<ul style="list-style-type: none"> <li>• Knows what ordinary things are for</li> <li>• Points to one body part</li> <li>• Scribbles on his/her own</li> <li>• Can follow one-step commands</li> </ul>	<ul style="list-style-type: none"> <li>• Walks alone</li> <li>• May run</li> <li>• Can help undress him/herself</li> <li>• Drinks from a cup</li> <li>• Eats with a spoon</li> </ul>	<ul style="list-style-type: none"> <li>• Can't walk</li> <li>• Doesn't copy others</li> <li>• Doesn't have at least six words</li> <li>• Doesn't notice when caregiver leaves or returns</li> </ul>
2 years	<ul style="list-style-type: none"> <li>• Copies others</li> <li>• Gets excited when with other children</li> <li>• Shows more independence</li> <li>• Plays beside other children</li> </ul>	<ul style="list-style-type: none"> <li>• Knows names of familiar people and body parts</li> <li>• Uses brief sentences</li> <li>• Volume and pitch of voice not well-controlled</li> </ul>	<ul style="list-style-type: none"> <li>• Begins to sort shapes and colors</li> <li>• Builds towers of blocks</li> <li>• Follows two-step instructions</li> <li>• Names things in picture books</li> </ul>	<ul style="list-style-type: none"> <li>• Stands on tiptoe</li> <li>• Kicks a ball</li> <li>• Climbs onto and down from furniture</li> <li>• Uses stairs with help</li> </ul>	<ul style="list-style-type: none"> <li>• Doesn't use 2-word phrases</li> <li>• Doesn't copy actions and words</li> <li>• Doesn't follow simple instructions</li> <li>• Can't walk steadily</li> </ul>
3 years	<ul style="list-style-type: none"> <li>• Shows affection for friends</li> <li>• Takes turns in games</li> <li>• Understands the idea of "mine" and "his" or "hers"</li> <li>• Shows a wide range of emotions</li> <li>• Dresses and undresses self</li> </ul>	<ul style="list-style-type: none"> <li>• Follows 2-3 step instructions</li> <li>• Says first name, age, and sex</li> <li>• Uses "I" and "me" correctly</li> <li>• Uses some plurals and past tense</li> <li>• Can reason out answers to simple questions</li> </ul>	<ul style="list-style-type: none"> <li>• Can work toys with buttons, levers, and moving parts</li> <li>• Plays make-believe</li> <li>• Does simple puzzles</li> <li>• Copies a circle with pencil or crayon</li> </ul>	<ul style="list-style-type: none"> <li>• Climbs well</li> <li>• Runs easily</li> <li>• Pedals a tricycle</li> <li>• Walks up and down stairs, one foot on each step</li> </ul>	<ul style="list-style-type: none"> <li>• Unsteady on his/her feet</li> <li>• Very unclear speech</li> <li>• Can't work simple toys</li> <li>• Doesn't speak in sentences</li> <li>• Doesn't understand simple instruction</li> </ul>

## Preschool and Kindergarten (4 to 6 years)

Source: Centers for Disease Control and Prevention

<http://www.cdc.gov/ncbddd/actearly/milestones/index.html>

	<b>Social/Emotional</b>	<b>Communication</b>	<b>Cognitive</b>	<b>Physical</b>	<b>Problem Signs</b>
4 years	<p>Enjoys doing new things</p> <p>Is more and more creative with make-believe play</p> <p>Would rather play with other children than by himself</p> <p>Cooperates with other children</p> <p>Often can't tell what's real and what's make-believe</p> <p>Talks about what he/she likes</p>	<p>Knows some basic rules of grammar, such as "he" and "she"</p> <p>Sings a song or says a poem from memory</p> <p>Tells stories</p> <p>Names common objects from pictures</p> <p>Usually can repeat words of four syllables</p> <p>Tends to repeat words, phrases, and sounds</p>	<p>Names some colors and some numbers</p> <p>Understands the idea of counting</p> <p>Remembers parts of a story</p> <p>Draws a person with 2 to 4 body parts</p> <p>Uses scissors</p> <p>Plays board or card games</p> <p>Tells you what he/she thinks is going to happen next in a book</p>	<p>Hops and stands on one foot up to 2 seconds</p> <p>Catches a bounced ball most of the time</p> <p>Cuts (with supervision) and mashes own food</p>	<p>Can't jump in place</p> <p>Has trouble scribbling</p> <p>Shows no interest in interactive games or make-believe</p> <p>Doesn't respond to people outside the family</p> <p>Resists dressing, sleeping, and using the toilet</p> <p>Can't retell a favorite story</p> <p>Doesn't use "me" and "you" correctly</p> <p>Speaks unclearly</p>
5 years	<p>Wants to please friends and be like them</p> <p>More likely to agree with rules</p> <p>Likes to sing, dance, and act</p> <p>Shows concern and sympathy for others</p> <p>Is aware of gender</p> <p>Can tell what's real and what's make-believe</p> <p>Shows more independence</p> <p>Is sometimes demanding and sometimes very cooperative</p>	<p>Speaks very clearly</p> <p>Tells a simple story using full sentences</p> <p>Uses future tense; for example, "Grandma will be here."</p> <p>Can count to ten</p> <p>Uses all vowels and consonants</p> <p>Has simple time concepts: morning, night, today</p> <p>Speech on the whole should be grammatically correct</p>	<p>Can draw a person with at least 6 body parts</p> <p>Can print some letters or numbers</p> <p>Copies a triangle and other geometric shapes</p> <p>Knows about things used every day, like money and food</p>	<p>Stands on one foot for 10 seconds or longer</p> <p>Hops; may be able to skip</p> <p>Can do a somersault</p> <p>Uses a fork and spoon and sometimes a table knife</p> <p>Can use the toilet on his/her own</p> <p>Swings and climbs</p>	<p>Doesn't show a wide range of emotions</p> <p>Shows extreme behavior</p> <p>Unusually withdrawn and not active</p> <p>Easily distracted</p> <p>Doesn't respond to people</p> <p>Can't tell what's real and what's make-believe</p> <p>Doesn't play a variety of games and activities</p> <p>Can't give first and last name</p> <p>Doesn't draw pictures</p> <p>Can't get undressed without help</p>
6 years	<p>Copies adults</p> <p>Seeks praise from adults</p> <p>Understands gender differences</p> <p>Wants to be accepted by peer group</p> <p>May show fear of bodily harm</p> <p>If tired, nervous, or upset, may exhibit nail biting, thumb sucking, etc.</p> <p>Is easily embarrassed</p>	<p>May stutter if tired or nervous; may lisp</p> <p>Able to solve problems</p> <p>Speech is completely intelligible and socially useful</p> <p>Sees relationships between pictures and events</p>	<p>Follows instruction and accepts supervision</p> <p>Knows colors, numbers, etc.; may be able to read on his/her own</p>	<p>Can dress and undress self</p> <p>Can go to the toilet on his/her own</p> <p>May have a larger appetite</p>	<p>Is excessively fearful or shy</p> <p>Has toileting problems</p> <p>Has persistent speech problems</p> <p>Shows lack of interest in others</p> <p>Displays ritualistic behaviors, especially related to food</p> <p>Threatens or bullies peers</p>

## Elementary School (6 to 12 years)

### **6 to 8 years**

Most children at this age:

Speak clearly	Copy a triangle
Read well at 8	Draw a picture of a person or an animal
Show curiosity	Know the day of the week
Know left from right	

### **8 to 10 years**

Most children at this age:

Name the day, month, and year	Take responsibility for own things
Name members of their household	Practice regular hygiene (taking bath, brushing teeth)
State phone number and address	Show school supplies when asked

### **10 to 12 years**

Most children at this age:

Show concern about appearance	Have a favorite hobby, sport, or activity
Collect toys	Can talk about their feelings
Have several friends	Have passing grades
Show pride in accomplishments	Strive for independence

### **Warning signs in elementary school children**

Poor school attendance	No friends, isolating
Excessively overweight or underweight	Seeming angry, aggressive, withdrawn
Bizarre behavior: hearing or seeing things that are not real	Unrealistic fears (phobias)
Changes in eating and sleeping patterns	Destructive or self-destructive behavior: self-cutting, suicidal thoughts, substance abuse, eating disorders

## Teens (12 to 19 years)

### **12 to 15 years**

Most youth at this age:

Are well-groomed	Have passing grades
Appear calm	Are involved in sports or other activities
Report good health	Understand safe sex practices
Experiment with smoking	Strive for independence

### **15 to 19 years**

Most youth at this age:

Have plans for the future	Experiment with alcohol or other drugs
Take responsibility for some household chores	Understand safe sex



Attend school or work daily

Practice safer sex

**Warning signs for teens**

Observe or ask about:

Failing grades or cutting school	Sudden change of behavior
Withdrawn, socially isolated, or sullen	Aggressive, angry, irritable
Extremely thin or extremely overweight	Sexually active with multiple partners
Practicing unsafe sex	Abusing alcohol or other drugs
Destructive behavior	Self-destructive behavior: self-cutting, body mutilation, suicidal thoughts or actions, eating disorders

Remember: Mental, physical, and emotional development takes place in teenagers at different rates.

**Young Adults (19 to 21 years)**

Ask whether the youth:

Has realistic goals	Engages in work and/or school
Gets regular medical, dental, and gynecological checkups	Has a positive relationship with a responsible adult in the community
Uses tobacco, alcohol, or other drugs	

**Warning signs for young adults**

Failing grades or cutting school	Sudden change of behavior
Withdrawn, socially isolated, or sullen	Aggressive, angry, irritable
Extremely thin or extremely overweight	Sexually active with multiple partners
Practicing unsafe sex	Abusing alcohol or other drugs
Destructive behavior	Self-destructive behavior: self-cutting, body mutilation, suicidal thoughts or actions, eating disorders

Source: NYC Administration for Children's Services *Handbook for Healthy Development of Children and Youth* (<http://www.nyc.gov/html/acs/downloads/pdf/Handbook%20for%20Healthy%20ENG.pdf>)



Appendix I

## **Mental Health Checklists**

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## Pediatric Symptom Checklist

### INSTRUCTIONS FOR SCORING

The Pediatric Symptom Checklist is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. Included here are two versions, the parent-completed version (PSC) and the youth self-report (Y-PSC). The Y-PSC can be administered to adolescents ages 11 and up.

The PSC consists of 35 items that are rated as “Never,” “Sometimes,” or “Often” present and scored 0, 1, and 2, respectively. The total score is calculated by adding together the score for each of the 35 items. For children and adolescents ages 6 through 16, a cutoff score of 28 or higher indicates psychological impairment. For children ages 4 and 5, the PSC cutoff score is 24 or higher (Little et al., 1994; Pagano et al., 1996). The cutoff score for the Y-PSC is 30 or higher. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.

### HOW TO INTERPRET THE PSC OR Y-PSC

A positive score on the PSC or Y-PSC suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.I.C.S.W.) professional. Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC or Y-PSC score as anything other than a suggestion that further evaluation may be helpful. Data from past studies using the PSC and Y-PSC indicate that two out of three children and adolescents who screen positive on the PSC or Y-PSC will be correctly identified as having moderate to serious impairment in psychosocial functioning. The one child or adolescent “incorrectly” identified usually has at least mild impairment, although a small percentage of children and adolescents turn out to have very little or no impairment (e.g., an adequately functioning child or adolescent of an overly anxious parent). Data on PSC and Y-PSC negative screens indicate 95 percent accuracy, which, although statistically adequate, still means that 1 out of 20 children and adolescents rated as functioning adequately may actually be impaired. The inevitability of both false-positive and false-negative screens underscores the importance of experienced clinical judgment in interpreting PSC scores. Therefore, it is especially important for parents or other laypeople who administer the form to consult with a licensed professional if their child receives a PSC or Y-PSC positive score.

For more information, visit the Web site: <http://psc.partners.org>.

### REFERENCES

- Jellinek MS, Murphy JM, Little M, et al. 1999. Use of the Pediatric Symptom Checklist (PSC) to screen for psychosocial problems in pediatric primary care: A national feasibility study. *Archives of Pediatric and Adolescent Medicine* 153(3):254–260.
- Jellinek MS, Murphy JM, Robinson J, et al. 1988. Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction. *Journal of Pediatrics* 112(2):201–209. Web site: <http://psc.partners.org>.
- Little M, Murphy JM, Jellinek MS, et al. 1994. Screening 4- and 5-year-old children for psychosocial dysfunction: A preliminary study with the Pediatric Symptom Checklist. *Journal of Developmental and Behavioral Pediatrics* 15:191–197.
- Pagano M, Murphy JM, Pedersen M, et al. 1996. Screening for psychosocial problems in 4–5 year olds during routine EPSDT examinations: Validity and reliability in a Mexican-American sample. *Clinical Pediatrics* 35(3):139–146.

## Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1			
2. Spends more time alone	2			
3. Tires easily, has little energy	3			
4. Fidgety, unable to sit still	4			
5. Has trouble with teacher	5			
6. Less interested in school	6			
7. Acts as if driven by a motor	7			
8. Daydreams too much	8			
9. Distracted easily	9			
10. Is afraid of new situations	10			
11. Feels sad, unhappy	11			
12. Is irritable, angry	12			
13. Feels hopeless	13			
14. Has trouble concentrating	14			
15. Less interested in friends	15			
16. Fights with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Is down on him or herself	19			
20. Visits the doctor with doctor finding nothing wrong	20			
21. Has trouble sleeping	21			
22. Worries a lot	22			
23. Wants to be with you more than before	23			
24. Feels he or she is bad	24			
25. Takes unnecessary risks	25			
26. Gets hurt frequently	26			
27. Seems to be having less fun	27			
28. Acts younger than children his or her age	28			
29. Does not listen to rules	29			
30. Does not show feelings	30			
31. Does not understand other people's feelings	31			
32. Teases others	32			
33. Blames others for his or her troubles	33			
34. Takes things that do not belong to him or her	34			
35. Refuses to share	35			

Total score \_\_\_\_\_

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services? \_\_\_\_\_

# Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

		Never	Sometimes	Often
1. Complain of aches or pains	1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Spend more time alone	2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Tire easily, little energy	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Fidgety, unable to sit still	4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have trouble with teacher	5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Less interested in school	6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Act as if driven by motor	7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Daydream too much	8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Distract easily	9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are afraid of new situations	10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Feel sad, unhappy	11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are irritable, angry	12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Feel hopeless	13	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have trouble concentrating	14	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Less interested in friends	15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Fight with other children	16	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Absent from school	17	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. School grades dropping	18	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Down on yourself	19	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Visit doctor with doctor finding nothing wrong	20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Have trouble sleeping	21	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Worry a lot	22	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Want to be with parent more than before	23	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Feel that you are bad	24	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Take unnecessary risks	25	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Get hurt frequently	26	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Seem to be having less fun	27	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Act younger than children your age	28	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Do not listen to rules	29	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Do not show feelings	30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Do not understand other people's feelings	31	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Tease others	32	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Blame others for your troubles	33	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Take things that do not belong to you	34	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Refuse to share	35	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix J

**Moving Toward Cultural Competence**

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# Moving Toward CULTURAL COMPETENCE

## Key Considerations to Explore

### Key Attitudes and Approaches

Increasing your own cultural competence requires: a **belief** that it is important to become more culturally competent; an **acknowledgment** that you don't—and can't—know everything about every culture, including your own; and a **recognition** that becoming more culturally competent is a perpetual journey, not a destination to be reached.

As you work on moving toward cultural competence, keep in mind:

- Regardless of the various groups that someone belongs to, each person is an individual with unique preferences, strengths and perspectives and wants to be treated as such. Each of us wants to be respected and understood as an individual, not just as a member of some demographic group or category.
- Erring on the side of being more respectful and formal, rather than less, is a good starting point.
- It's okay to admit that you don't know something and to ask to be taught.
- Flexibility and adaptability are key in working effectively with diverse populations.

### Questions to Consider

As you continue on your journey toward becoming more culturally competent, there are some key areas to explore and questions to ask yourself regardless of the population with which you are working. These questions are intended to help you:

- Increase your awareness of others' worldview.
- Gain knowledge about others' practices, understandings, interpretations, culture and worldviews.
- Value the particular culture that you seek to understand better.
- Build skills to understand, communicate with, relate to, and value that culture.

The topics and questions below are by no means exhaustive, but they provide a basic framework to use as you seek to increase your competence in working cross-culturally. These questions and considerations are aimed at helping you think about ways to increase your own understanding and ability to work effectively and respectfully with other cultures. **Note: these are not questions to ask directly of the families with whom you work.**

A great first step is to reflect on these questions as they apply to your own life. By increasing your own self-awareness and understanding of how being part of certain groups and communities has shaped your experiences and attitudes, you will be better equipped to gain a richer understanding and appreciation of other cultures.



## Self-Identification

- How do members of the group refer to themselves and members of their group?
- What terms are considered most respectful? Which terms are disrespectful or inappropriate?
- How can you find out from individuals the terms that they prefer?

## Cultural Identity

- How do you think members of the group view their cultural connections?
- Might they identify themselves as members of sub-groups rather than, or in addition to, broad groups?

## Language

- Do members of the group share a language?
- Do they face any language barriers?
- How formal or informal do members of the group prefer to be with language?

## Communication Styles

- Are there common communication styles and approaches that should inform your interactions?
- How much importance does the community place on nonverbal communication, directness vs. subtlety, humor, eye contact, etc.?
- What potential conflicts or misunderstandings may arise due to differences between your communication style and that of members of the group? How can you try to avoid these misunderstandings?

## Family, Relationships, and Parenting

- Are there key patterns in relationship roles and family dynamics among members of the group?
- How do members of the group define the concept of “family” (e.g., Is family thought of as nuclear family, or is there a more expansive, inclusive concept of family?)?
- Do members of the group have common approaches to parenting and disciplining children?

## Religion and Spirituality

- What role, if any, does spirituality or religion play with the group?
- What holidays, if any, are important to members of the group, and how are those holidays celebrated?
- Do members of the group tend to view religion and spirituality as something that can be discussed publicly, or is it a private topic?

## Traditions

- What traditions and shared experiences are highly important to the group?
- What key life events and experiences are celebrated or otherwise marked by the group?
- Does the group have unique or rare traditions that may be misunderstood by others outside of the group?

## Key Strengths

- What strengths (e.g., humor, extended family networks, resilience, connections to community, tribal affiliation, relationship with elders, etc.) does the group celebrate and rely upon for success?
- Do members of the group identify key sources of resilience and empowerment, either individually or for the group as a whole?
- Are there attributes that members of the group see as strengths, but that others may view as challenges or barriers (e.g., interdependence—a shared sense of supporting and sharing resources; having a close network of trusted confidants—strong relationships that have been established by building a rapport and a commitment to share information with only those who have been proven to be trustworthy; etc.)?

## Discrimination and Barriers

- What forms of discrimination and barriers—both historical and current—does the group experience?
- Are there areas of particular sensitivity that you should be aware of related to discrimination and challenges (e.g., legal, financial, social, etc.) that members of the group experience?
- Are there ways to discuss—and provide strategies for overcoming—potential challenges that members of the group may encounter?

## Taboos

- What subjects, topics and issues are off-limits for discussion?
- Are there topics that are deemed private and only discussed within groups of trusted family or friends?
- Are there respectful ways that sensitive or taboo subjects can be approached if information is needed for family assessment, etc.?



*More free resources at:*

[www.nrcdr.org](http://www.nrcdr.org)

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