MidSOUTH Training Academy

In-Home Unit 9

Participant Manual

UA LITTLE ROCK
MidSOUTH
College of Business, Health, and Human Services
University of Arkansas at Little Rock

AGENDA

Day 1

I. **Section 1 – Prevention and In-Home Services Review**
- **A.** Pair Share

II. **Section 2 – Bridging the Gap: Collaborative Connections & Monitoring In-Home Cases**
- **A.** Choice Map
- **B.** Stages of Change
- **C.** Documentary Discussion
- **D.** FSW Word Scavenger Hunt

Day 2

I. **Section 1 – Family Advocacy and Support Tool**
- **A**. The Andrew Family
- **B**. Team Decision-Making Meeting (TDM)
- **C**. Andrews Three Column Map
- **D**. Andrews Circles of Safety and Support
- **E**. Are they ready ?
- **F**. Ideas of Involvement
- **G**. Interviewing Families using Solution Focused Questions/ Role Play
- **H**. Family Advocacy and Support Tool (FAST) Completion

Day 3

I. **Section 1- Andrews FAST Documentation in CHRIS**

II. **Section 2- Collaborative Family Case Planning**

III. **Section 3 – Clustering the FAST & Collaborative Family Case Completion**
- **A.** Anchors Away
- **B.** Writing the Collaborative Case Plan

Day 4

I. **Section 1- Andrews Collaborative Family Case Plan and Prevention Services Documentation in CHRIS**

- **A.** Risk Reassessment Introduction
- **B.** Reassessing the Andrews Family
- **C.** Guest Speaker Invitation
- **D.** Prevention Service Cases/FINS
- **E.** FINS Pair Share

II. **Section 2- Javon Parker Opening a FINS Case in CHRIS**

III. **Section 3 -Differential Response**

- **A.** Critical Time Frames

Day 5

I. **Section 1- Phone Interviews and Differential Response (Lab)**

- **A.** Preparing for the Phone Interview: Skill Practice Examples
- **B.** Differential Response Values

II. **Section 2 –Differential Response Lab**

- **A.** Henderson DR Case Documentation in CHRIS

III. **Section 3- Review and Case Closure**

- **A.** Make It Stick Review
- **B.** A note to your future self

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New Staff Training Family Service Worker
Unit 9 Section 1 Online - Handout 9.1.1

Partial Case Review

Log into the DCFS Information Management System for this assignment. The cases you review can be primary or secondary cases on your workload. This exercise steps you through some required policies and procedures. It helps you determine whether everything on your new cases has been done or whether there are tasks you need to complete. **NOTE:** This is not a comprehensive case review. (Remember, you have a case review guide from Unit 1.4 that you can use for a thorough review, or your Field Trainer may have a work aid for you.) Do not put names or identifying information on this worksheet. Make additional copies of this Handout as needed.

If you are primarily doing Protective Services, pick at most three of your cases for the part of the assignment on page 2. After you complete this assignment, file your work in your training binder. You will use this during the in-home concentration classroom training.

Number of Supportive Services Case(s) on Your Workload: _____

Case #	Length of Time Open	Opened for FINS Y/N	FAST Done Y/N	Family Case Plan Done Y/N	Services by DCFS	Other Provider Services	
						Service	DHS-3300 Y/N

Skip to Protective Services questions if you do not have any Supportive Services cases on your caseload.

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Unit 9 Section 1 Online - Handout 9.1.1

Partial Case Review

Protective Services Case Number: _____ **Date Case Opened:** _____

Open from Investigation: □ **Yes** □ **No**
If No (check one): □ FINS □ Relative or Kin/Fictive Kin Custody □ After Care □ Child Returned Home from Out-of-Home Placement □ Other

Immediate Safety Plan in Place (From Investigation) □ **Yes** □ **No**
If Yes, how long from the date the case was opened?_____
If more than 30 days, has the petition been filed? □ Yes □ No
If the petition was filed, are court screens updated? □ Yes □ No

Petition/Court Order for Any Other Reason □ **Yes** □ **No** If Yes: Explain in Notes

FAST Completed □ **Yes** □ **No** If Yes, date of last FAST: _____

Family Case Plan Completed □ **Yes** □ **No** If Yes, date of last family case plan: _____

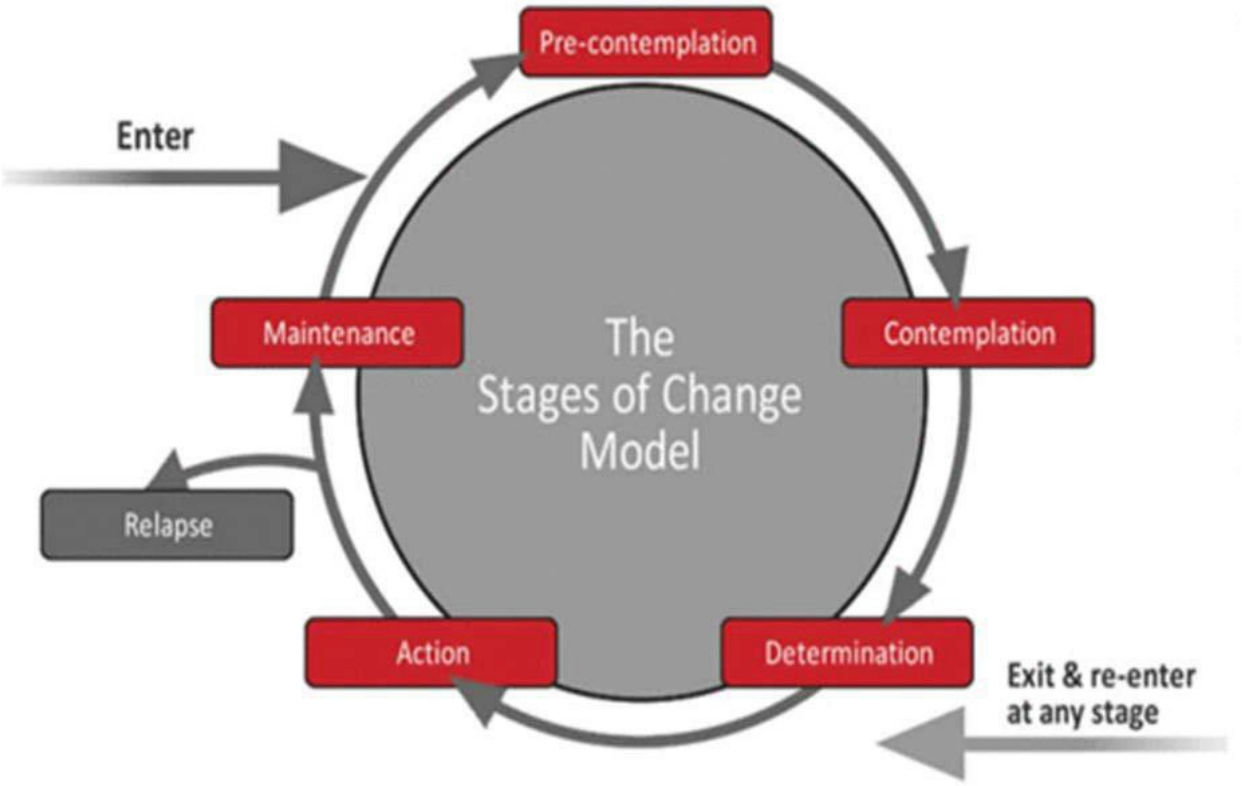
Age of Youngest Child in Case: _____
If under age 3 yrs., Early Intervention Referral? □ **Yes** □ **No** If Yes, are recommended services in the family case plan? □ **Yes** □ **No**

Date of Last Contact: _____ **Frequency of Worker Contacts with Family:** _____

Notes & Questions:

Stages of Change in the Transtheoretical Model (TTM) of Change

By Prochaska & DiClemente (1983)



Stages of Change

Stage of Change	Characteristics	Techniques
Pre-contemplation	Not currently considering change: "Ignorance is bliss"	Validate lack of readiness Clarify: decision is the client's Encourage re-evaluation of current behavior Encourage self-exploration, not action Explain and personalize the risk
Contemplation	Ambivalent about change: "Sitting on the fence" Not considering change within the next month	Validate lack of readiness Clarify: decision is the client's Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations
Preparation	Some experience with change and are trying to change: "Testing the waters" Planning to act within 1 month	Identify and assist in problem solving re: obstacles Help the client identify social supports Verify that the client has underlying skills for behavior change Encourage small initial steps
Action	Practicing new behavior for 3-6 months	Bolster self-efficacy for dealing with obstacles Combat feelings of loss and reiterate long-term benefits
Maintenance	Continued commitment to sustaining new behavior Post-6 months to 5 years	Plan for follow-up support Reinforce internal rewards – satisfaction coming from their own actions Discuss coping with relapse
Relapse	Resumption of old behaviors: "Fall from grace"	Evaluate trigger for relapse Reassess motivation and barriers Plan stronger coping strategies

Home-Visiting Guidelines

During every home visit, workers should assess safety and risk

- Assess family dynamics (i.e., caregiver-child interaction) and caregiver responsiveness to the child's basic needs
- Observe the home environment for any potential hazards and provision of food
- Identify and discuss with the family the risk or safety factors/threats that make the child unsafe
- Identify and discuss with the family strengths and protective factors that mitigate risk
- Engage the family in a discussion about the safety, stability and well-being of the children in the home
- Discuss accessibility and availability of services needed to reduce risk to the children in the home

Workers should encourage and facilitate the family's active participation in identifying other family resources

- Encourage identification of maternal and paternal relatives and kin/fictive kin who may support the children and the immediate safety plan
- Identify and acknowledge other kin/fictive kin who can assist in parenting and model a nurturing relationship

Workers shall encourage positive parenting skills and healthy caregiver-child interaction

- Observe caregiver-child interaction and provide feedback and positive reinforcement
- Discuss the importance of bonding and attachment between caregiver and child
- Model healthy interactions and communication between the adult and child
- Provide examples of developmentally appropriate and non-physical options for discipline
- Be alert to signs of stress in caregivers, normalize caregiver stress when appropriate, and provide a forum for expression of stress
- Coach caregivers toward the development of structure and family routines (e.g., morning and bedtime schedules)
- Work jointly with the family to increase protective factors to help reduce the risk of future maltreatment

Andrews Investigation Summary Review Questions

1. Referral Date

2. Who are the clients?

3. Who is/ are the alleged victim children?

4. Who is/ are the alleged offender?

5. Who is/are a PRFC?

6. How many collaterals are named?

7. What is the grandmother's name?

8. How many allegations were reported?

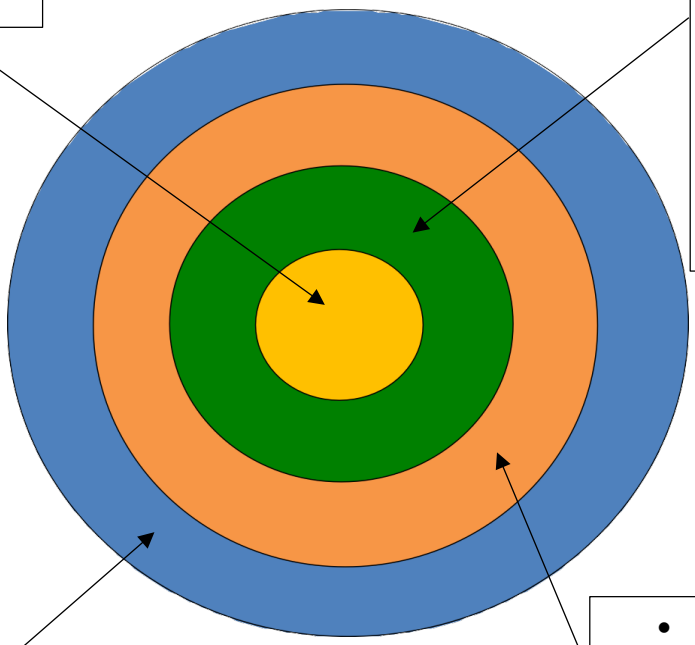
9. What are the allegations with a true finding?

10. What date was Mike Andrews interviewed?

11. What date was a case open?

"Circles of Safety & Support" Tool

Name/Photo/drawing of family



- Who are the people who support you the most?
- Who do the children feel most connected to?
- Who already knows everything that happened?

- Who are the people who support you a little?
- Who do the children feel some connection with?
- Who already knows a little bit about the hard things you've been dealing with?

- Who are the people who you don't ask for support from but maybe could in the future?
- Who are the people who don't support you and maybe make things harder for you and your family?
- Who are the people in your life who don't know anything about the hard things you've been dealing with?

Prompt sheet for using the "Circles of Safety & Support" tool

1. **Talking about the need for a safety and support network**
   The first step in the process of using the "Circles of Safety and Support" tool flows directly out of the conversation with caregivers about what we mean by a safety and support network and the fact that a network needs to be in place for safety planning to progress and to be effective.

2. **Center Circle**
   Ask caregivers to draw, put photo, or write names of family members in the center circle.

3. **The Inner Circle**
   - *Who are the people who support you the most?*
   - *Who do the children feel most connected to?*
   - *Who already knows everything about the difficult things that have happened (e.g. that led to your child/children being in care or to child protection services being involved with your family)?*

   Give compliments
   Pay attention to what caregivers have already done that will help to build future safety and acknowledge this with compliments, wherever and whenever possible.

4. **The Middle Circle**
   - *Who are the people who support you a little?*
   - *Who do the children feel some connection with?*
   - *Who already knows a little bit about the hard things you've been dealing with?*

5. **The Outer Circle**
   - *Who are the people who you don't ask for support from but maybe could in the future?*
   - *Who are the people who don't support you and maybe make things harder for you and your family?*
   - *Who are the people in your life who don't know anything about the hard things you've been dealing with?*

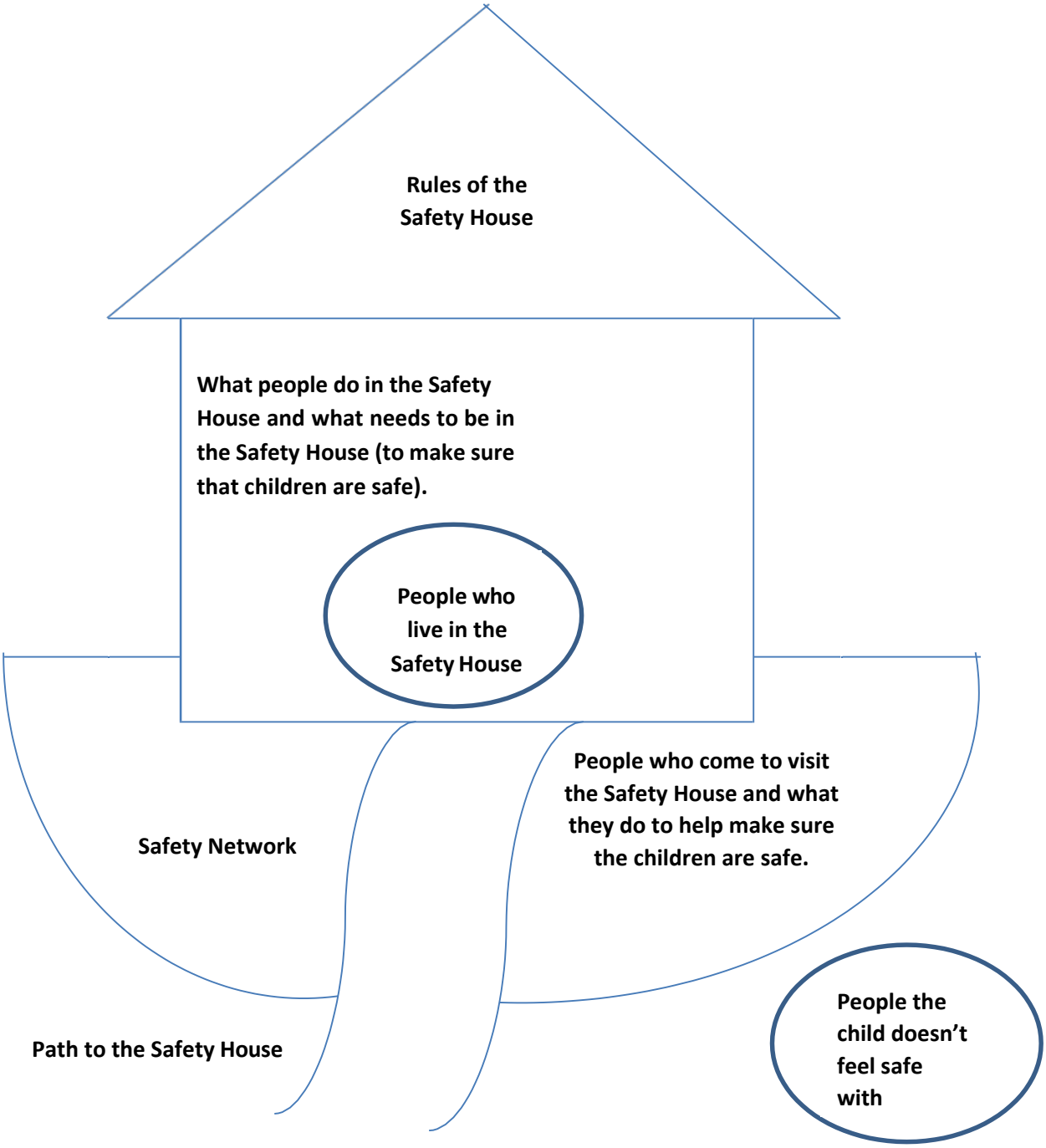
6. **Moving people from the outer circles to the inner circle**
   - *Who else from these outer circles do you think needs to be part of this inner circle?*
   - *Is there anyone in these two outer circles who you have thought about asking for support, or talking with about what has happened, but you haven't quite gotten there yet?*
   - *Who would grandma (for example-pick a person already in the inner circle) say needs to be in this inner circle with her?*
   - *Who would the kids most want to have in this inner circle?*

- *You know all of these people, I don't know them yet, but who do you think I would most want to have in this inner circle?*
- *Who of all of these people do you feel most comfortable with/most understood by and think would be important to have as part of your family's safety and support network?*

7. **Discussing the following:**
   - What is the role of the safety and support network?
   - What's the difference between safety and support?
   - How many people do we need in the safety and support network?
   - How do we decide who can be a safety and/or support person?
   - What do people need to know to be part of the safety and support network?
   - How do we ensure that everyone is informed about the concerns?

The Safety House Tool

Created by Sonja Parker, Australia



A tool for involving children and young people in the safety planning process.

Contact: phildecter@earthlink.net or sonjjapa@iinet.net.au

Further information available in the Safety House booklet available at www.aspirationsconsultancy.com

Prompt sheet for using the Safety House

- **Inside the Safety House: The inner circle and inside the four walls**

  Inner circle:
  - Child draws her or himself in the inner circle (leaving space to draw others).
  - Who else would live in your Safety

  House with you? Inside the house:
  - Imagine that your home/house back with_____(e.g. mommy and daddy) was safe and you felt as safe and happy as possible, what sorts of things would _____(e.g. Mommy, Daddy, big sister) be doing)?
  - What are important things that_____(e.g. Mommy and Daddy) would do in your Safety House to make sure that you are safe?
  - Are there any important objects or things that need to be in your Safety House to make sure that you are always safe?

- **Visiting the Safety House: The outer circle**
  - Who would/will come to visit you in your Safety House to help make sure that you are safe?
  - When_____(each of the safety people identified above) come to visit you in your Safety House, what are the important things that they need to do to help you be safe?

- **The red circle: Unsafe people**
  - When you go home to live with___(e.g. Mom and Dad), is there anyone who might live with you or come to visit who you would not feel completely safe with?

- **The roof**
  - "Remember we talked about how all those adults are talking together to make a safety plan for when you go home? One of the things they are trying to decide is what the rules of the safety plan should be. What do you think? What would the rules of the house be so that you and everyone one would know that nothing like _____(use specific worries) would ever happen again?"
  - "What else and what else?"
  - "If your_____(sister/brother/Nana, etc.) was here, what would they say?"

- **The Safety Path**

- If the beginning of the path is where everyone was very worried and you weren't able to live with mom and dad and you had to go and live with_____, and the end of the path at the front door is where all of those worries have been sorted out and you will be completely safe living with mom and dad, where do you think things are right now?
- If the beginning of the path is that you feel very worried that if you go home to live with mom (or have an overnight stay) that mom will start using drugs again and then not be able to look after you properly, and the end of the path at the door is that everything in your Safety House is happening and you're not worried at all that mom will use drugs again, where are you now?

THREE-COLUMN MAP

What Are We Worried About?	What is Working Well?	What Needs to Happen Next?

The Three-Column Map with framework Prompts is based on the Signs of Safety Assessment and Planning Framework (Turnell & Edwards, 1999; Department of Child Protection, 2011); The Consultation and Information Sharing Framework (Lohrbach, 2000); and The Massachusetts Safety Mapping Framework (Chin, Decter, Madsen, & Vogel, 2010).

Child Inclusion Assessment for Family-Centered Meetings

Remember that it is not a question of **whether** a child will participate in the process, but **how**. The following questions will help you determine how the child should be involved.

- **How old is the child?**

- **How does the child want to participant?**

- **What special needs are there? Developmental and cognitive abilities? Special mental health diagnoses that are difficult to manage in group settings?**

- **What does the family think?**

- **Is there potential for the process to be therapeutic for the child? What does the child's therapist think?**

- **What family members are present?**

- **What kind of support network will the child have?**

- **Who will be the designated support person?**

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*Adopted from North Carolina Family-Centered Meetings Project, 3/2003 Nothing About Them Without Them: Children's Participation in FGDM December 3, 2007 Teleconference

Idea List

- Bring a picture of the child, or child and family
- Use one-step removed approach (puppet, toys, etc., sends the message)
- Record/video the child can appoint a designated spokesperson
- Read a child's favorite story
- Make a message card
- Bring one of the child's toys
- Name card technique
- Tell a story about the child
- Conference Call
- Audio recording of child's message to the family
- Use empty chair technique
- Light a candle to symbolize a child's light
- Play a child's favorite song
- The child can write a letter

Hello Everyone.
I want to say something

When I think about what's going on in my family, I like that:	What I don't like about what's happening is that:
My feelings right now about it are:	So this is who I think should be there: Because:
And these are the people I think should *not* come: Because:	I want you to know that the good things about my family are:
Things that worry me about my family are:	So this is what I especially want my_____to know:
And this is what I really want my_____to know:	And for all of you who are there, I would like to tell you that:
When you all work on figuring this out, this is what I hope for me:	And this is what I would like to see happen for all of us:

I heard about the family meeting today, and because I will not be there, I have some things I want you to know.

Thank you for:

Signed: _____

*Adapted from North Carolina Family-Centered Meetings Project, 3/2003 *Nothing About Them Without Them: Children's Participation in FGDM December 3, 2007 Teleconference*

Three Houses Process

1. **Preparation:** In preparing to do the "Three Houses' with a child or young person, it can be helpful to find out as much background information as you can. The other important part of preparation is working out what materials you will need to take. At a minimum you will need sheets of paper [preferably one for each house, as well as some spares] and some colored pencils and markers. The other important decision is where to meet with the child. If possible, choose a venue where the child is likely to feel most comfortable is important, particularly for your first meeting**.**

2. **Inform caregivers and obtain permission to interview child/ren**. Sometimes, child protection workers have to interview children without advising or seeking the permission of the primary caregivers. Wherever possible, the caregivers should be advised/asked in advance, and showing the "Three Houses" Tool to them can help them to understand what the worker will be doing.

3. **Make decision whether to work with child with/without caregivers present.** Again, sometimes child protection workers need to insist that they speak with the children without caregiver present. Wherever possible, it is good to make this a matter of choice for the caregivers and the child, but when this isn't possible, all efforts should be made to provide an explanation to the caregivers as to why the worker feels it is necessary to speak to the child on their own.

4. **Explain and work through 3 houses with** child using one sheet of paper per house. Use words and drawings as appropriate and anything else you can think of to engage child in the process. They can re- name houses, use toys, Lego houses, picture cut outs, etc. Give child choice about where to start. Often start with "house of good things," particularly when child is anxious or uncertain.

5. **Explain to and involve the child or young person in what will happen next.** Once the "Three Houses" interview is finished it is important to explain to the child or young person what will happen next, and to obtain their permission to show the "Three Houses' to others, whether they be caregivers, extended family, or professionals. Usually children and young people are happy for others to be shown their "Three Houses' assessment of their situation, but for some children there will be concerns and safety issues that must be addressed before proceeding with presenting what they have described to others.

6. **Present to caregivers** usually beginning with "House of Good Things". Before showing the child's "Three Houses", it can be useful to ask the caregivers: "What do you think the child would say is good/worried about/dreams of?"

Andrews Case Scenario

Mike and Melissa Andrews are divorced. Melissa is the primary caregiver for her children. Mike does not currently fulfill any of the caregiver responsibilities for his children due to being in the hospital. He does not reliably pay child support. He was slightly in arrears on child support prior to the accident that resulted in his hospitalization.

Melissa is an RN, and she works full-time at Jefferson Regional Medical Center on the 3:00 pm - 11:00 pm shift, M- F. She also works a part-time job three days a week at Hospice Home Care from 12:00 am to 8:00 am. Her days of employment at Hospice Home Care vary. Melissa has had to pick up extra shifts to cover her home expenses. Melissa has a history of using prescription pain pills due to a work-related back injury that she sustained a couple of years ago. Between lack of sleep due to her work schedule and the use of her pain pills, Melissa sleeps heavily. She depends on her 12-year-old son Greg to supervise his 6-year-old sister Sarah when she is at work or sleeping. Melissa has a good relationship with her children. She has no prior child welfare history.

Mike is a truck driver for CalArk. He was involved in a serious accident that resulted in his hospitalization for the past 2 weeks. It is suspected that Mike was intoxicated at the time of the accident. Mike has no prior child welfare history. Before the accident, the children would spend the weekends with him and their paternal grandmother, Marsha Andrews. They would like to be able to see the children more often, but Melissa is not in favor of this request. Melissa and Marsha have had a rocky relationship ever since she accused Melissa of having an opioid addiction due to her need for pain pills. Marsha told Mike that Melissa sleeps all day, does not clean the house, has mood swings, and isolates herself when she comes to see the kids.

The Andrews family was brought to the attention of DCFS following a call to the hotline on 9/14/17 at 3:00 am regarding concerns for Sarah Andrews, who had been left unsupervised. While home alone on 9/13/17, Sarah accidentally cut her finger. She went to the neighbor's house to get help because she was bleeding. The neighbor (Ms. Jenkins) was afraid to take the child to the hospital because she did not want to be liable for Sarah's medical care; therefore, she contacted 911. Officer Tommy Norman was dispatched to the house, and he immediately transported Sarah to the hospital. Since the hospital personnel knew Sarah's mother, they initiated treatment and began trying to locate Melissa. Sarah needed six stitches in her left index finger and into the palm of her hand. It took hospital personnel some time to locate Melissa because she had already left for her second job. Once Melissa was contacted, she immediately returned to the hospital, and Sarah was released to her care.

Greg arrived home after Sarah was taken to the hospital. Greg was afraid that his mother would find out he wasn't at home and was not watching his sister, so he got up early (on 09/14/2017) and went to school before his mother got up. The investigator interviewed Greg Andrews at Quest Middle School. When questioned, Greg did not deny leaving his sister at home alone last night. He stated that he was at the hospital spending time with his father because his mother was

not willing to take him to the hospital to visit. Greg stated that he caught a ride to the hospital with his friend's older sibling last night. Greg hitch-hiked home.

The DCFS Investigation was closed with a true finding based on the preponderance of evidence, which resulted in an Immediate Safety Plan and an open In-Home Protective Service Case. The department worked diligently with Melissa and her network to create the Immediate Safety plan to ensure that the children were supervised.

Melissa entered into an immediate safety plan. The investigation was found to be true, and a protective service case was opened.

Andrews Immediate Safety Plan

SDM SAFETY ASSESSMENT IMMEDIATE SAFETY PLAN

Arkansas State Police and Division of Children and Family Services

Family Name: Andrews **Case ID:** 22408726

Date: 09/14/2017

Worker Name: John Austin

Harm and/or Worry Statement(s): What harm if anything has already occurred? What is the agency and/or the family worried will happen to the children if nothing else changes?

It was reported that Melissa works nights and leaves her 12-year-old son Greg at home to babysit his 6-year-old Sister, Sarah. On 9/13/2017, Sarah was home alone, and she accidentally cut her finger. Sarah went to the neighbor's house. The neighbor called 911 and Sarah was transported to the hospital for emergency treatment.

DESCRIBE THE SAFETY THREAT (caregiver + behavior + impact on child)	WHAT WILL BE DONE TO ADDRESS THE SAFETY THREAT UNTIL THE REVIEW DATE?	WHO WILL DO IT, BY WHEN?	HOW WILL WE KNOW IT IS WORKING?
Melissa worked an overnight shift and left Sarah and Greg without adult supervision. Greg left the home resulting in Sarah being home alone and accidentally cutting her finger which required immediate medical attention.	Melissa agreed to obtain a babysitter to supervise the children in her home while she is at work.	The neighbor Ms. Jenkins and the paternal grandmother agree to watch Greg and Sarah when Melissa has to work nights beginning today. When Melissa works nights, Melissa agrees to call Ms. Jenkins and/or her mother-in- law Marsha Andrews to ask them to babysit/watch Greg and Sarah until she returns home beginning today.	Greg will reach out to Ms. Jenkins and/or his grandmother, Marsha Andrews if he and his sister are left alone while his mother is at work. Melissa will share her weekly work schedule with Ms. Jenkins and her mother-in-law Marsha Andrews every Monday, so they will know what days Melissa will be working nights and work out a babysitting schedule for the week. Mr. Austin will call Melissa, Ms. Jenkins, and Marsha Andrews every Friday to get an update on the plan.

Who has agreed to be part of this plan? (Must include at least one legal custodian or guardian.)

FAMILY MEMBER OR NETWORK MEMBER	CONTACT DETAILS	
	PHONE	EMAIL
Ms. Melissa Andrews, mother	501-222-3333	ma@gmail.com
Ms. Marsha Andrews, paternal grandmother	501-345-1967	Marsha.Andrews@yahoo.com
Ms. Jenkins, neighbor	501-847-5675	jenkins@aol.com

WHEN WILL THE IMMEDIATE SAFETY PLAN BE REVIEWED? *(Must be within 14 days)*	
Date/time: 09/29/17	**Who will be involved (caregivers, network, and agency)?** The investigator, John Austin will meet with Melissa, Ms. Andrews, and Ms. Jenkins to discuss the immediate safety plan and to determine whether it needs to be modified.

WHAT WILL PEOPLE DO IF THEY ARE WORRIED OR IF THE IMMEDIATE SAFETY PLAN IS NOT WORKING?	
Caregivers/legal guardians	If Melissa feels the plan is no longer effective, she will contact Mr. Austin to have the plan reassessed to address the worries and to ensure the children's safety.
Network members	If the network member is no longer interested or willing to participate in the immediate safety plan, they will contact Mr. Austin and Melissa to discuss their involvement.
Child	If Greg and Sarah are home alone during mom's work hours, they will call Ms. Jenkins or walk over to her home. If Ms. Jenkins is not available, they will call their grandmother.
DCFS	If we are worried or if the immediate safety plan is not working, we will hold a family team meeting to discuss what needs to happen next.

WHOM TO CALL IF THE IMMEDIATE SAFETY PLAN IS NOT WORKING		
NAME	PHONE NUMBER	EMAIL ADDRESS
Assigned worker name: **John Austin**	501-785-4010	Jaustin@dhs.arkansas.gov
Supervisor name: **Lana West**	501-782-4000	LW@dhs.arkansas.gov

On-call contact: (After business hours, weekends, and holidays) Child abuse hotline	1-800-872- 6536	

AGREEMENT TO IMPLEMENT IMMEDIATE SAFETY PLAN

While we may not agree about the details of these worries, we do agree to follow the plan until the review date. We know that if the plan does not keep all children safe, either we must work together again to create a new plan, or the department may need to take legal action. If I am unable to follow this plan, I will contact my DCFS worker to develop a new plan.

Legal custodians or guardians _____

Worker/ Supervisor _____

Children _____

Network Members _____

Andrews Family Case Planning Tool

Reason(s) case opened: Put in all the reasons

	Caregiver 1	Caregiver 2	Caregiver 3	Child 1	Child 2	Child 3	Child 4
Caregiver needs/strengths for family case plan services come from the following domains/modules: FAST: Family Together, Caregiver Status, Caregiver Advocacy CANS: Permanency Planning caregiver Strengths/Needs, Trauma, or SUD Module - Caregiver				Child need/strengths for family case plan services can come from any domain/module unless it specifies a "caregiver" section			
Name:	Melissa Andrews	Mike Andrews	Concurrent Plan	Greg	Sarah		
CANS/FAST 2's							
CANS/FAST 3's							
Any family case plan relevant 0 or 1							

Objective:

History: Write the information from investigation/ on-going case work that pertains to the Needs being addressed.

In order to address this Needs/Strength:

- This is where you write your behavioral objective. What will someone be doing differently and how will you know they are doing it?
- Include in this space the Tasks/Activities that each person will complete and the time frame for completion.

Services: This is a pick list of services. If there is a service that you need and it is not in the list, the suggestion is to set it out in the text section above as part of the objective or task.

Service Type	Responsibility	Date Due

Services Pick List

Acute CRT	Education Services	Physical Exam
Acute Psychiatric Hospital	Educational Advocacy	Physical Therapy
Adoption (Photo Listing)	Educational Assessment	Podiatrist
Adoption (Post-Legal	Emergency Shelter for	Pre-Adoptive Home
Adoption (Web Site)	Employment Services	Private Agency Foster Family
Adoption Assessment Update	EPSDT	Provisional (Fictive Kin)
Adoption Disclosure	Extracurricular Activity	Provisional (Relative)
Adoption Exchange	Family Planning	Psychiatrist
Adoption Home Studies	FFSS (Foster Family Support System)	Psychological Evaluations
Adoption Legal Packet	Fictive Kin Foster Family	Psychologist
Adoption Preparation	Food Assistance	Public Guardianship
Adoption Recruitment (Child Specific)	Foster Family Home	Recreational Programs
Adoption Registration	Gas Card	Recreational Therapy
Adoption Selection	General Practitioner	Reintegration
Adoption Services	Hair Follicle Testing	Relative Foster Family
Adoption Subsidy	Health Department Services	Relative Guardianship
Adoption Subsidy Packet	Home Studies	Residential Care Only
Adoption Summary	Homemaker Services	Residential Treatment Care
Adoption Summary Update	Hospital (Inpatient)	Respite Care/Temporary
Adoptive Home	Hospital (Outpatient)	SafeCare (Parenting)
Advocacy	Housing	Sex Offender Treatment (Inpatient)
Alcohol testing	Human Development Center	Sex Offender Treatment (Outpatient)
Alcohol Treatment (Inpatient)	Human Services Worker in Schools	Sexual Abuse Treatment (Inpatient)
Alcohol Treatment	ICPC	Sexual Abuse Treatment (Outpatient)
Alternative School	ILP (After Care Services)	Sexual Issues Treatment
Anger Management	ILP (Residential)	Sexual Offender
Behavior Management	ILP Sponsor	Sexual Offender Victim
Bus Pass	Incarceration	Socialization Skills
Cash Assistant	Independent Living	Special Medical Needs
Child Care Services	Independent Living Skills	Speech Therapy
Clothing Assistance	Independent Living Subsidies	SRPCRT
Comprehensive Health Assessment	Independent Living-Education	SRP - Outpatient Therapy
Comprehensive Residential Treatment	In-home Nursing LPN	SRP - Residential Treatment
Counseling (Family)	In-Home Nursing RN	SRP - Diag & Asmt

		SRP - Therapeutic Foster
Counseling (Group)	Interdisciplinary Meeting	Sub-Acute Psychiatric Hospital
Counseling (Individual)	Intensive Family Services	Substance Abuse Counseling
Counseling (In-Home)	Interpreter Services	Substance Abuse Treatment (Inpatient)
Crisis Intervention	Legal Services	Substance Abuse Treatment (Outpatient)
Day Care Services	Life Skills Training	Supervised Visitation
Day Treatment	Literacy	Support Groups
DDS Services	Maternity Services (Non-Residential)	Temporary Family Placement (No Board)
DDS Services - ICF-MR	Maternity Services (Residential)	Therapeutic Day Care
DDS Specialized Community Home	Mediation Services	Therapeutic Foster Care
DDA Supportive Living	Medical Services	Therapy (Family)
Dentist	Mental Health Crisis Response	Therapy (Group)
Diag. and Eval.	Mental Health Services (Outpatient)	Therapy (Individual)
Domestic Violence Education	Mentoring Services	Transportation
Driver's License	Nutrition Services	Triple P – Positive Parenting Program
Drug Assessments	OB/GYN	Tutoring
Drug Screening	Occupational Therapy	Visitation
DYS After Care	Ophthalmologist	Vocational Skills
Education Funding	Optometrist	Vacation a1/Technic al (Residential)
Education Services (Non-Residential)	Parent Aids	Youth Services/Serious Offender Program
	Parent/Child Interaction	Youth Villages
	Parenting Education (Group)	Saint Francis Ministries
	Parenting Education (In- Home)	Youth Advocate Programs, INC. (YAP)
	Parenting Skills	
	Paternity/DNA Testing	
	Pharmacy	
	Sub-Acute CRT	

S.M.A.R.T. CHRIS Family Case Plan Components

A collaborative family case plan begins with a ***family-centered assessment*** using the ***FAST/CANS instrument*** and the ***SOP/SDM Harm, Worry, and Goal statements***. This involves:

1. Creating a partnership with the family and developing the plan with their input.
2. Discovering and incorporating the family's objectives toward the goals of safety for the children and empowerment of the family's strengths.

History or **Needs:** These describe a lack of some critical knowledge, skill, or resource (identified by 2 or 3 in CANS/FAST and the harm and worry statements you develop with the family). At least one must address the reason the case is opened – that is, the reason for DCFS involvement.

Goals: These are developed from and should actively respond to the **harm and worry statements** and the identified **history/needs**, focusing on what will be done differently to address the safety threat(s) to the child(ren). Goals should be *behavior-based* and *achievable*.

In order to address the identified needs/strengths or objectives: The worker will write behavioral objectives that specify what a person in the case will be doing differently and/or better and how it will be measured. These are concrete, measurable, and observable behaviors designed to reach a goal. Each objective then has a set of activities, which explain who will be doing what, and when. Look at the "S.M.A.R.T" acronym below to inform how you should approach goal setting.

S. Specific (clear and concrete to all parties)

M. Measurable (reflects a visible change in behavior)

A. Attainable (small, doable steps)

R. Realistic (is this realistic for the client?)

T. Time-Limited (include dates in the plan)

The objective(s) should describe what the client will be doing differently when change occurs. The criteria should identify a positive behavior rather than a negative behavior.

For example, Ms. Bates (during Family Time with her children) will demonstrate age-appropriate and nurturing parenting techniques when she disciplines her children.

Tasks: Necessary activities to achieve a stated objective. Tasks define the steps and the order of the steps needed to reach an objective.

a. Establishes who is responsible for each step*
b. Defines when the activity is to take place
c. Establishes where the activity will take place

***The tasks should be divided *equally* between DCFS and the client.**

Service(s): These are selected from the Pick List in CHRIS. Remember, services in themselves do not equal safety, and the Pick List is not intended to be used as a checklist. The services selected (with the family's input) should be specific to their situation and understood as avenues through which the family can realistically work to achieve safety for the child(ren).

Family Case Plan Worksheet

Identified Client: _____

CANS/FAST Identified Need or Strength (item(s) from CANS/FAST):

_____

_____

History (**Harm and/or Worry statement(s**):

In Order to address this identified Need/ Strength (**Goal Statement and Action Steps**):

Services (from service pick list)

Service	Responsibility	Due Date	Status	Status Date

Identified Client: _____

CANS/FAST Identified Need or Strength (item(s) from CANS/FAST):

_____

_____

History (**Harm and/or Worry statement(s**):

In Order to address this identified Need/ Strength (**Goal Statement and Action Steps**):

Services (from service pick list)

Service	Responsibility	Due Date	Status	Status Date

Identified Client: _____

CANS/FAST Identified Need or Strength (item(s) from CANS/FAST):

_____

_____

History (**Harm and/or Worry statement(s**):

In Order to address this identified Need/ Strength (**Goal Statement and Action Steps**):

Services (from service pick list)

Service	Responsibility	Due Date	Status	Status Date

Identified Client: _____

CANS/FAST Identified Need or Strength (item(s) from CANS/FAST):

_____

_____

History (**Harm and/or Worry statement(s**):

In Order to address this identified Need/ Strength (**Goal Statement and Action Steps**):

Services (from service pick list)

Service	Responsibility	Due Date	Status	Status Date

SDM RISK REASSESSMENT

Family Name: _____ **Case #:** _____

Assessment Date: _____ **Worker Name:** _____

Primary Caregiver Name: _____

Is there a secondary caregiver? ○ Yes ○ No **Secondary Caregiver Name:** _____

Score the first four items based on conditions that were present at the time of the referral that resulted in the case opening. Unless new information has been learned about those conditions, score these the same as on the initial risk assessment.

R1. Prior investigations **Score**

○ a. None 0
○ b. One or two 1
○ c. Three or more ..... 2 _____

R2. Household previously received ongoing child protection services

○ a. No 0
○ b. Yes ..... 1 _____

R3. Primary caregiver has a history of abuse or neglect as a child

○ a. No 0
○ b. Yes ..... 1 _____

R4. Current or historical characteristics of children in the household

○ a. Not applicable 0
○ b. One or more present (*select all applicable for any child*) ..... 1 _____

☐ Developmental disability
☐ Learning disability
☐ Physical disability
☐ Medically fragile or failure to thrive

THE FOLLOWING CASE OBSERVATIONS PERTAIN TO THE PERIOD SINCE THE LAST ASSESSMENT OR REASSESSMENT.

Score

R5. New investigation of abuse or neglect since the initial risk assessment or the last reassessment

○ a. No 0
○ b. Yes ..... 2 _____

R6. Primary or secondary caregiver alcohol and/or drug misuse since the last assessment or reassessment

Score based on the caregiver demonstrating the least progress.

P S

○ ○ a. No history of alcohol or drug misuse 0
○ ○ b. No current alcohol or drug misuse; no intervention needed 0
○ ○ c. Yes, alcohol or drug misuse; problem is being addressed 0
○ ○ d. Yes, alcohol or drug misuse; problem is *not* being addressed ..... 1 _____

R7. Adult relationships in the home

○ a. None applicable 0
○ b. Yes (*select all that apply*) ..... 1 _____
☐ Harmful or tumultuous relationships
☐ Intimate partner violence

R8. Primary caregiver mental health since the last assessment or reassessment

○ a. No history of mental health problem 0
○ b. No current mental health problem; no intervention needed 0
○ c. Yes, mental health problem; problem is being addressed 0
○ d. Yes, mental health problem; problem is *not* being addressed ..... 1 _____

Score

R9. Primary caregiver provides physical care of the child that:

○ a. Meets the child's needs 0
○ b. Does not meet the child's needs ..... 1 _____

R10. Caregiver's progress with family case plan goals (as indicated by behavioral change)
Score based on the caregiver demonstrating the least progress.

P S

○ ○ a. Demonstrates protective behaviors consistent with all family case plan goals and is actively engaged to maintain goals 0
○ ○ b. Demonstrates some protective behaviors consistent with family case plan goals and is actively engaged in activities to achieve goals 0
○ ○ c. Minimally demonstrates protective behaviors consistent with family case plan goals and/or is inconsistently engaged in achieving the goals specified in the family case plan 0
○ ○ d. Does not demonstrate protective behaviors consistent with family case plan goals and/or refuses engagement ..... 1 _____
○ No secondary caregiver

TOTAL SCORE _____

SCORED RISK LEVEL

Assign the family's risk level based on the following chart.

Score	Risk Level
0–1	○ Low
2–4	○ Moderate
5–7	○ High
8+	○ Very High

OVERRIDES

POLICY OVERRIDES

Select *yes* if a condition applies in the current review period. If *any* condition applies, override final risk level to "very high."

○ Yes ○ No 1. Sexual abuse case AND the offender is likely to have access to the child.
○ Yes ○ No 2. Non-accidental injury to a child under age 3.
○ Yes ○ No 3. Severe non-accidental injury.
○ Yes ○ No 4. Caregiver action or inaction resulted in death of a child due to abuse or neglect.

DISCRETIONARY OVERRIDE

If a discretionary override is made, select "Yes," select override risk level, and indicate the reason. Risk level may be overridden one level higher or lower.

○ Yes ○ No 5. If **yes**, override risk level (select one): ○ Low ○ Moderate ○ High ○ Very High

Discretionary override reason: _____

☐ Supervisor's discretionary override approval Date: _____

FINAL RISK LEVEL

○ Low ○ Moderate ○ High ○ Very High

RECOMMENDED DECISION

FINAL RISK LEVEL	RECOMMENDATION
Low	Close unless unresolved safety threats remain
Moderate	Close unless unresolved safety threats remain
High	Continue services
Very High	Continue services

PLANNED ACTION

○ Continue services

○ Close **Note: A closing safety assessment is required.**

If recommended decision and planned action do not match, explain why:

☐ Supervisor's approval of change in planned action Date: _____

DEFINITIONS

R1. Prior investigations

Identify the number of prior child protection investigations (regardless of determination or jurisdiction) involving any current adult household members who were alleged offenders.

Do not count:

- Referrals that were screened out for child protection investigations;
- Investigations where all allegations were on an out-of-home offender (e.g., daycare, substitute care provider) when there is no failure-to-protect allegation against the in-home primary caregiver;
- Investigations in which all alleged offenders are no longer part of the household; or
- Known false reports or administrative closures (if any doubt that it was false, then include it).

a. Select if there were no prior assigned investigations.
b. Select if there were one or two prior assigned investigations.
c. Select if there were three or more prior assigned investigations.

R2. Household previously received ongoing child protection services

Select "Yes" if any adult household members with caregiving responsibilities received or are currently receiving ongoing child protective services (CPS) as a result of a prior child maltreatment investigation or were transferred from Differential Response. Ongoing CPS means in-home and out-of-home services provided by DCFS.

a. Select if the household has not had a prior open CPS case.
b. Select if the household has one or more prior open CPS case.

R3. Primary caregiver has a history of abuse or neglect as a child

The primary caregiver was maltreated as a child. Consider any maltreatment history known to the agency and/or credible statements by the primary caregiver or others. Include situations that would be considered abuse or neglect using current standards, even if the situation was not considered abuse or neglect at the time.

a. Select if the primary caregiver was not maltreated as a child.
b. Select if the primary caregiver was maltreated as a child.

R4. Current or historical characteristics of children in the household

Assess each child in the household and determine the presence of any characteristics below. Select all that apply.

a. Select if no child in the household exhibits characteristics listed below.
b. Select if any child in the household exhibits characteristics listed below, and select all types present.
   - *Developmental disability*. A severe, chronic condition diagnosed by a physician or mental health professional due to mental and/or physical impairments. Examples include but are not limited to cognitive disabilities, autism spectrum disorder, and cerebral palsy.
   - *Learning disability*. Child has an individualized education plan (IEP) to address a learning problem such as dyslexia. Do not include an IEP designed solely to address mental health or behavioral problems. Also include a child with a learning disability diagnosed by a physician or mental health professional who is eligible for an IEP but does not yet have one, or who is in preschool. Examples include but are not limited to dyslexia, dysgraphia, dyspraxia, or auditory or visual processing disorders.
   - *Physical disability*. A severe, acute, or chronic condition diagnosed by a physician that impairs mobility, sensory, or motor functions. Examples include paralysis, amputation, and blindness.
   - *Medically fragile or failure to thrive*. Any child in the household is medically fragile, defined as having a long-term (expected to last six months or more) physical condition requiring medical intervention; or has a diagnosis of malnourishment or failure to thrive.

THE FOLLOWING CASE OBSERVATIONS PERTAIN TO THE PERIOD SINCE THE LAST ASSESSMENT OR REASSESSMENT.

R5. New investigation of abuse or neglect since the initial risk assessment or the last reassessment

Identify whether there was at least one investigation initiated *since the initial risk assessment or last reassessment*. This includes open or completed investigations, regardless of the investigation conclusion, that have been initiated since the initial assessment or last reassessment. Do not include duplicate referrals.

R6. Primary or secondary caregiver alcohol and/or drug misuse since the last assessment or reassessment

Identify alcohol and drug use by any caregiver during the review period; whether there is a current problem that interferes with caregiver functioning or family functioning; and, if so, how the caregiver has addressed the problem during the review period.

Non-abusive use of legal prescription drugs or over-the-counter medications should not be identified as an issue.

If both caregivers have a substance misuse problem, rate the more negative behavior of the two caregivers.

Not addressing the problem since the last assessment or reassessment includes:

- Substance use that affects or affected employment, criminal involvement, or marital or family relationships and/or that affects or affected caregiver's ability to provide protection, supervision, and care for the child;
- An arrest since the last assessment or reassessment for driving under the influence or refusing breathalyzer testing;
- Multiple positive urine samples;
- Medical problems resulting from substance use and/or misuse; or
- The child's diagnosis with fetal alcohol syndrome or exposure, or the child's positive toxicology screen at birth and the primary caregiver was the birth parent, or a child in the home having a positive toxicology screen as a result of exposure.

a. Select if there is no history of alcohol or drug misuse.
b. Select if there is a history of alcohol or drug misuse that is not current and did not require intervention during the review period.
c. Select if there is alcohol or drug misuse, and the problem is being addressed.
d. Select if there is alcohol or drug misuse, and the problem is *not* being addressed.

R7. Adult relationships in the home

Identify the current status of adult relationships in the household.

a. Select if not applicable or there are no problems observed.
b. Select if there are harmful or tumultuous adult relationships and/or intimate partner violence.
    - *Harmful or tumultuous relationships*. There are adult relationships in the household that are harmful to domestic functioning or to the care the child receives (but not at the level of intimate partner violence). Internal or external stressors are present, and the household is experiencing increased disruption of positive interactions, coupled with lack of cooperation and/or emotional or verbal abuse.
    - *Intimate partner violence*. The household has had, since the most recent assessment, a pattern of physical assault/coercive control or periods of intimidation, threats, or harassment by an adult in the household toward their spouse or significant other.

R8. Primary caregiver mental health since the last assessment or reassessment

Determine the primary caregiver's current mental health status. Does the caregiver have a current diagnosis of a significant mental health condition that affects daily functioning, as determined by a mental health clinician (or in some cases without diagnosis if there is enough credible evidence that a mental health condition is present and affected family functioning); and if so, is the condition being addressed?

Not addressing the condition includes a caregiver who during the review period:

- Has a mental health condition that affects or affected the caregiver's employment, criminal involvement, or marital or family relationships; or that affects or affected their ability to provide protection, supervision, and care for the child;
- Had referrals for mental health or psychological evaluations; or
- Was recommended for treatment or hospitalization or was treated or hospitalized for a mental health condition.

a. Select if the primary caregiver does not have a current or past mental health condition that interferes with family functioning.
b. Select if the primary caregiver has been diagnosed with a mental health condition but has been symptom-free for at least 12 months and does not require formal treatment. Caregiver may still participate in support groups or use maintenance doses of psychotropic medication.
c. Select if there is a mental health condition that interferes with family functioning and the caregiver is actively engaged in treatment.
d. Select if there is a mental health condition that interferes with family functioning and the problem is *not* being addressed.

R9. Primary caregiver provides physical care of the child that:

Assess whether during this assessment period, the caregiver has provided age-appropriate physical care for all children in the household. Examples may include the following.

- Providing routine and preventative medical and dental care.
- Obtaining medical care for a severe or chronic illness.
- Providing the child with adequate food.
- Providing the child with adequately clean and weather-appropriate clothing.
- Providing safe and adequate housing free of infestations.
- Ensuring poisonous substances (including medications) or dangerous objects are not within reach of a small child.
- Ensuring age-/developmentally appropriate hygiene (e.g., bathing, brushing teeth, changing diapers).

a. Select if physical care meets the child's needs.
b. Select if physical care does not meet the child's needs.

R10. Caregiver's progress with family case plan goals (as indicated by behavioral change)

Compliance with and attendance of services is not sufficient to indicate behavioral change.

Identify whether a caregiver is actively engaged in achieving the family case plan goals specified in the family case plan and is demonstrating skills and behaviors that will enable the caregiver to create and maintain safety for the child (e.g., ability to manage substance use/misuse; ability to resolve conflict constructively and respectfully; using age-appropriate, non-physical discipline in conjunction with appropriate boundary setting; developing a mutually supportive relationship with a partner).

"Family case plan goal" specifically refers to the services in the family case plan, identifying the changes in caregiver behavior necessary to create and maintain safety.

If there are two caregivers, rate progress for each. If progress differs between caregivers, score the item based on the caregiver who is demonstrating the least participation and progress.

a. *Demonstrates protective behaviors consistent with all family case plan goals and is actively engaged to maintain goals.* Select if the caregiver is regularly demonstrating all behavioral changes identified in the family case plan goals and is able to create long-term safety for children in the household. The caregiver is actively engaged in activities to maintain the goals.
b. *Demonstrates some protective behaviors consistent with family case plan goals and is actively engaged in activities to achieve goals.* Select if the caregiver is demonstrating some new skills and behavioral change consistent with family case plan goals and is actively engaged in achieving the goals but is not regularly demonstrating the behaviors necessary to create long-term safety in all areas.
c. *Minimally demonstrates protective behaviors consistent with family case plan goals and/or is inconsistently engaged in achieving the goals specified in the family case plan.* Select if the caregiver is demonstrating minor behavioral change consistent with family case plan goals but has made little progress toward changing their behavior and is not actively engaged in achieving the goals. Caregiver behavior continues to make it difficult to create safety or may contribute to immediate danger of serious harm.
d. *Does not demonstrate protective behaviors consistent with family case plan goals and/or refuses engagement.* Select if the caregiver has not demonstrated behavioral change consistent with family case plan goals. The caregiver refuses services, sporadically follows the family case plan, or has not demonstrated the necessary skills or behaviors due to a failure or inability to participate. The caregiver is unable to create or maintain safety, or their behavior is likely to contribute to immediate danger of serious harm.

OVERRIDES

After determining the scored risk level, assess whether any override conditions are present. Consider only the most recent review period. If this is the first risk reassessment, consider the period since the initial risk assessment. If this is not the initial risk reassessment, consider the period since the last risk reassessment. Discretionary overrides require supervisory approval.

POLICY OVERRIDES

Indicate whether a policy override condition exists. Consider only the most recent review period. Presence of one or more mandatory override conditions increases the risk level to "very high."

1. *Sexual abuse case AND the offender is likely to have access to the child.* One or more of the children in this household are or have been victims of sexual abuse, AND the offender is likely to have unmanaged access.
2. *Non-accidental injury to a child under age 3.* Any child under age 3 in the household has any kind of physical injury resulting from a caregiver's actions or inactions.
3. *Severe non-accidental injury.* Any child in the household has a serious physical injury resulting from a caregiver's action or inaction. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocation, sprain, internal injury, poisoning, burn, scald, or severe cut; AND the child requires medical treatment.
4. *Caregiver action or inaction resulted in death of a child due to abuse or neglect.* Any child in the household has died as a result of the caregiver's actions or inactions. This child fatality may have occurred prior to the current case.

DISCRETIONARY OVERRIDE

A discretionary override is used by the ongoing worker whenever the worker believes that the risk score does not accurately portray the household's actual risk level. Unlike the initial risk assessment, in which the worker could only increase the risk level, the risk reassessment permits the worker to increase or decrease the risk level by one. The reason a worker may now decrease the risk level is that after a minimum of six months, the worker has acquired significant knowledge about the household. If the worker applies a discretionary override, the reason should be specified, and the final risk level should be selected.

POLICY AND PROCEDURES

The purpose of the risk reassessment is to help assess whether risk has been reduced sufficiently to allow a case to be closed or whether the risk level remains high and services should continue. This is accomplished through evaluating whether *behaviors and actions* of the caregiver have changed as a result of the family case plan.

The risk reassessment combines items from the initial risk assessment with additional items that evaluate a family's progress toward family case plan goals.

Research has demonstrated that for the reassessment, a single index best categorizes risk for future child protective system involvement. Unlike the initial risk assessment, which contains separate indices for risk of system involvement related to neglect and related to abuse, the risk reassessment comprises a single index.

WHICH CASES

All open cases in which all children remain in the home, or cases in which all children have been returned home and family maintenance services will be provided.

WHO

The primary FSW who is assigned to the case.

WHEN

Prior to each required review, which occurs at least once every 90 days, and any recommendation to close the case or keep it open. To ensure that current SDM assessments are available, they should be completed:

- No more than 30 calendar days prior to completing each family case plan; and
- No more than 30 calendar days prior to recommending case closure.

ALL CASES

Should be completed sooner if there are new circumstances or new information that would affect safety or risk level (e.g., network is providing enhanced safety, caregiver received treatment and is actively demonstrating actions of protection).

DECISION

The risk reassessment helps guide the decision of whether to keep ongoing services open or to close the case based on the family's assessed risk level and consideration of safety threats. The risk reassessment classifies a family's likelihood of future involvement with child protection after receiving ongoing services. The recommended action is based on the final risk classification and professional judgment as supported by policy and practice, including the reassessment of household safety. The worker should discuss the outcome and recommendation with their supervisor. If the action taken differs from the recommendation, the worker must provide brief rationale.

RISK-BASED CASE OPEN/CLOSE GUIDE	
FINAL RISK LEVEL	**RECOMMENDATION**
Low	Close unless unresolved safety threats remain
Moderate	Close unless unresolved safety threats remain
High	Continue services
Very High	Continue services

For cases that remain open following reassessment, the *new* risk level guides minimum contact standards that will be in effect until the next reassessment is completed. Use the contact frequency guidelines section of this manual.

APPROPRIATE COMPLETION

SCORING INDIVIDUAL ITEMS

Familiarize yourself with the items that are included on the risk reassessment and the accompanying definitions for those items. Each item's score is derived from your observation of the characteristics it describes during interviews with household members (child, caregivers, and others) and collaterals; referrals and case records; or other reliable sources concerning progress in demonstrating behavioral change and meeting family case plan goals. Some characteristics are objective, such as prior child abuse/neglect history or the child's age. Others require you to use judgment based on your assessment of the family.

Using the definitions for the risk reassessment, complete all items on the risk reassessment and consider whether any override reasons are present.

Items R1 – R4: Score the first four items based on conditions that were present at the time of the referral that resulted in the case opening unless new information has become available about conditions that existed at the time of the initial risk assessment. Review the initial risk assessment to determine the scores and consider all information currently available.

- **R1** will be scored the same as **Item 4** (Prior investigations . . .) on the initial risk assessment unless new information has become available about conditions that existed at time of the initial risk assessment.
- **R2** will be scored the same as **Item 6** (Household previously received . . .) on the initial risk assessment unless new information has become available about conditions that existed at time of the initial risk assessment.
- **R3** will be scored the same as **Item 8** (Primary caregiver's history. . .) on the initial risk assessment unless new information has become available about conditions that existed at time of the initial risk assessment.
- **R4** will be scored the same as **Item 7** (Current or historical characteristics . . .) on the initial risk assessment unless new information has become available about conditions that existed at time of the initial risk assessment.

Items R5 – R10: These items are scored based *only* on observations since the most recent assessment or reassessment.

When all items are scored, total the scores to determine the scored risk level, following the instructions on the tool.

OVERRIDE

Consider both policy and discretionary overrides. If any apply, determine the final risk level. If none apply, the scored and final risk level are the same.

Policy Overrides

As with the initial risk assessment, the agency has determined that there are certain conditions that are so serious that a risk level of "very high" should be assigned regardless of the risk reassessment score. The policy overrides refer to incidents or conditions that have occurred since the initial risk assessment or the last reassessment. If one or more policy override conditions exist, select "yes" for each reason for the override and select "very high" for the final risk level. Policy overrides require supervisory review.

Discretionary Override

A discretionary override is used whenever facts indicate that the risk score does not accurately portray the family's actual risk level. Unlike the initial risk assessment, in which a worker could only *increase* the risk level, the risk reassessment permits you to increase or *decrease* the risk level by one. The reason you may now decrease the risk level is that after a minimum of six months, you have acquired significant knowledge of the family. If a discretionary override applies, select "yes," indicate the reason, and select the override risk level. Discretionary overrides require supervisory approval. You then indicate the final risk level.

DISPOSITION

The agency database will display the recommended response based on the risk-based case open/close guide. Enter the actual case disposition (continuing the case or closing the case). If the recommended response differs from the actual disposition, provide an explanation. Supervisory approval is required for not following the recommended action.

Examples of explanations include the following.

- Continuing a low- or moderate-risk case: *Unresolved safety threats.* Based on the SDM safety assessment, one or more safety threats could not be resolved.
- Closing a high- or very high-risk case:
  - *Family declined supportive services AND no petition filed.* Family was informed of their high or very high risk level and was encouraged to continue voluntary services. The family declined, *and* no petition will be filed. Select this item even if family does accept any non-DCFS services or other agencies' services.
  - *Family is receiving or has been connected with community services that will address priority needs and/or contributing factors.* The family is already engaged in services, OR you will assist the family in making connections to community services. (You must be certain that an appointment was made and verify follow-through.) These services are directly related to the priority needs identified using the family case plan tool or other means to identify factors that contribute to risk.

PRACTICE CONSIDERATIONS

You should explain to the family, at the start of the service period, the structure and process for conducting the reassessment; and you should link the reassessment process to the developed family case plan.

Use formal and informal family engagement strategies during monthly in-person contacts or periodically scheduled family meetings to gather information about change over time, which should be documented in the case record. This aggregate information can then form the basis for scoring the formal reassessment.

Use of formal engagement strategies, such as family team meetings to conduct the formal reassessment and develop an updated family case plan or engage in planning for case closure, is highly recommended.

FINS in my county

Question	Yes	No
Does my county have a Diversion program for some or all cases that might come into court on a FINS petition? *If yes, make some notes. How it works, who the contact person(s) is, who can refer to the program. Put the phone numbers in your contacts.*		
Does my Juvenile Court have a FINS Officer or worker? *If yes, make notes. Who is the contact person(s)? Put the number in your contacts.*		
Does my office or Area have a unit that specializes in FINS cases? *If yes, how do you interact with them?*		
When my office receives a NOI (Notice of Intent) from the court, am I expected to attend the FINS hearing?		
Does my Judge frequently adjudicate dependency-neglect at the first FINS hearing?		
Does my Judge frequently place a 72-hour hold at the first FINS hearing?		
Are there any promising initiatives regarding FINS happening in my county or Area?		

FINS Scenario- Javon

You received a FINS case on 13-year-old Javon Parker. The school filed the petition because Javon is currently, and has been in the past, chronically truant. When he does attend, he is frequently disruptive in class, as he likes to play the clown. His behavior is in part to disguise the fact that he cannot read. The school is also concerned that he may be smoking marijuana.

Javon lives with his maternal grandmother, Carmine Parker, age 51. She is single and employed full-time with another Division in DHS. Javon came to live with his grandmother 6 months ago, after his mother, Andra Parker, left him to move out of state with her boyfriend Jackson Hurley, who was also her drug supplier. Javon's life was very chaotic while he lived with his mother. He witnessed family violence and his Mom's habitual drug use but there was no report of maltreatment to the Hotline. The family (Mom, boyfriend, and Javon) was known to the school during that time. School attendance was not high on Javon's mother's list of priorities, and she rarely followed up on requests for conferences or reports of her child being absent.

Javon came to his grandmother's home during the last month and a half of the previous school year. While Carmine was concerned about his absence and truancy, she focused more on issues such as obtaining power of attorney so that she could sign for medical treatment. Javon is still technically in his mother's custody.

Javon is skipping school again on a regular basis. The school is at the point where they want some action taken. They filed the FINS petition because they did not think the Hotline would accept a report of educational neglect. While they know that Javon is no longer with his mother, they point out that Carmine was aware of the problems during the last school year and "did nothing about them."

Carmine and Javon did not have an attorney at the FINS hearing. The court adjudicated FINS and ordered services but did not specify the type of case to open. Just FYI, the court did not adjudicate and make a finding of dependency/neglect. The court's orders are:

- Family Counseling
- Parenting Classes
- Drug and alcohol assessment for Javon; family to follow the recommendations for the treatment provider
- Random drug screens until the assessment could be completed
- Carmine to walk Javon to his first class every morning
- Carmine to ensure that Javon is present for all classes unless he is sick and has a note from his doctor (subject to contempt and imprisonment for failure to comply)

Information needed for CHRIS work

Address for grandmother and Javon- 5042 Stone Road, Forrest City, AR, 72335

Javon Parker

- DOB 06/03/2004, SSN
- County of Service- ST. Francis
- Race/Ethnicity- White, Hispanic
- Living Arrangement- Relative home with grand mother
- Primary Language- English
- Education Information
    - Forrest City Jr. High School, 1133 N. Division St, Forrest City, AR 72335
    - School District: Forrest City School District
    - Current Grade Level: 8th Grade
    - Education Status: Attending
    - Grade Level Completed: 7th Grade
    - Client Identified in need of Special Education: NO

Carmine Parker

- DOB 03/04/1966; SSN
- County of Service- St. Francis
- Race/ Ethnicity- White/ Hispanic
- Living Arrangement- own home/self/self
- Primary Language- English

Andra Parker

- DOB 03/23/1987, SSN
- County of Service- St. Francis
- Race/ Ethnicity- White/ Hispanic
- Living Arrangement- own home/self/self
    - Last known address- 1123 SW 13th street, Forrest City, AR 72335

Jackson Hurley- Mother's significant other

- DOB unknown; age approximately 40; SSN unknown

Nick Romerez- absent father-whereabouts unknown

- DOB: 02/02/1987

OPENING A NEW CASE WITHOUT AN INVESTIGATION
SUPPORTIVE SERVICE – FINS (CHRIS Tip Sheet)

OPEN CASE WITHOUT INVESTIGATION -FINS	CHRIS SCREEN PATH
Click on Workload, click Case radio button, click New radio button, click OK	Workload

Complete the Summary Screen
• Case Name – typically the last name of the PRFC
• Case Type
  ◦ Adoption
  ◦ Child Protective Services (usually opened from investigation)
  ◦ Transitional Youth Service
  ◦ ICPC
  ◦ ICAMA
  ◦ Subsidized Guardianship
  ◦ Supportive Services
• Click Yes or No radio button
• Check for FINS History – **NOTE: DO NOT DO THIS IN MIDSOUTH LAB**
• Family Location – the county where the family lives
• Address – address of family at the time case is opened
• Comments – why the case was opened
	Workload>Client>Summary

Complete the Client Screen for each family member/household member • Add each client – click Client, click New • This brings up General Information screen • Enter all data you have on the client, click Add	Workload>Client
Complete the Relationship screen for each client	Workload>Client>Relationship
Enter collaterals on the Collateral screen	Workload>Coll. Info
Court Screens – complete all three Hearing screens (Detail, Child, Attorney)	Workload>Court>Hearing>New
Complete all case activities within required time frames – see FINS policy/procedure	

ARKANSAS CHILD ABUSE HOTLINE

PROTECTING CHILDREN SINCE 1992

Hotline Number: 1-800-482-5964

WHO CAN CALL: Anyone with reason to suspect child maltreatment may report to the Hotline.	**WHO MUST REPORT:** People in certain jobs are MANDATED by law to report suspected child maltreatment. As of 8/1/23, ACT 727 adds any adult who witnesses abuse, sexual abuse, or sexual exploitation as a mandated reporter.

Let's start with the call. What happens then?

ASSESS
Does the report meet the criteria for acceptance? If it is true, is it legally child maltreatment?

SCREEN OUT
It would not meet the legal definition of child maltreatment.

ACCEPT & ASSIGN
It would be maltreatment or fall into a category of exempt from a true finding.

Accepted

Assigned to DCFS or CACD Assign Priority Response Time (I or II)

Designate as:

- Differential Response
- Traditional Child Maltreatment
- Substance Exposed Infant
- Child Death

NOTE: As of 8/1/23, ACT 727 prohibits the Child Abuse Hotline from accepting an anonymous report and any faxed reports.

Open 24/7 35 Operators
5 Supervisors
1 Administrator
Over 63,000 Calls

Differential Response
(What We Do & When We Do It)

Differential Response Is:

Goal: .

6 criteria that must be met for a DR referral:

1.
2.
3.
4.
5.
6.

DCFS Policy and Procedure Manual
Policy II-B

13 Types and conditions for acceptance

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.

Critical Worker Time Frames

24 HOURS	LIST PREP WORK (UNLESS WEEKEND OR HOLIDAY)	CALL TO FAMILY - MUST ADDRESS
72 HOURS	HOME VISIT WITH _____	DOCUMENTATION - WHAT AND WHEN
TWICE/WEEK		DOCUMENTATION - WHAT AND WHEN
5 DAYS	HOME VISIT WITH _____	DOCUMENTATION - WHAT AND WHEN
14 DAYS	WHAT MUST BE COMPLETED	DOCUMENTATION
30 DAYS		DOCUMENTATION - WHAT AND WHEN
45 DAYS		DOCUMENTATION - WHAT AND WHEN
60 DAYS		DOCUMENTATION - WHAT AND WHEN
OTHER IMPORTANT NOTES		

DR Time Frames (Group Activity)

We have covered the things that must be done in the first 24 hours after a DR case is assigned to you. But, DR cases are supposed to move quickly. Let's look at the other time frames.

1. How long should Dr cases be opened? _____
2. Can there be any extensions? _____
    a. If yes, how many? _____
3. The report must be initiated within _____ hours.
4. After the initial contact:
    a. Document all activities within _____ hours. (Excluding weekends/holidays – next business day)
    b. Conference with the DRT Supervisor within _____ hours.
    c. Visit the other members of the household (who may not have been there on the initial contact) within _____ days of the _____.
    d. Engage the family in, and complete, a family assessment within ___ days from receipt of the Hotline report.
    e. Establish a family plan within ____ days from the receipt of the Hotline report.
    f. Visit the family a minimum of ____ times per week.

Resource: DCFS Policy and Procedure Manual: Policy II-B through II-B6

WHY IS THE FIRST CONTACT SO IMPORTANT?

(And remember, the first contact is a phone call)

What Do I say after I Say Hello?

There's that pesky telephone call I need to make within 24 hours after I get a DR case assigned to me. I know it's a good idea, but how do I actually DO it?

I know I have to:

A. Explain Differential Response.
B. Schedule the initial in-home family visit that will include at least the victim child(ren) and one caregiver.
C. Verify the names and dates of birth of all family members and other persons living in the household.

Here are three things I could say to get the conversation started and begin introducing the idea of differential response.

1.

2.

3.

Examples of Calling the Family

Calling the Family

Hello, is this Ms. Henderson?

My name is _____ and I am a Differential Response worker with the Division of Children and Family Services.

I'm calling because someone shared with our agency some concerns they had about your son, TJ and your daughter Rose. When our agency gets these types of calls, we feel it's important to respect you and your time by calling to make an appointment that is convenient for you that we may discuss these concerns with your family in person. Is there a time that would be convenient for you in the next day or two?

Ideally, that would be a time when all or most of your family can be there, in particular your children. You are also welcome to have with you any other family members or friends at the meeting as well.

Overcoming Protective Resistance via Telephone

"*My children are fine. We don't have any concern*s"

I'm glad to hear that. I am wondering though if it would still be possible for us to meet so that you can share what is going well with your family and why the concern may be irrelevant. I would like to meet face to face to share more information about what concerns the agency has and you will have the opportunity to share in detail what is going well, along with your children and other family members or friends you would like to have present.

"I didn't do anything wrong so I don't see why you need to come here."

My agency is trying to work with families in a different way than they have in the past. Our program is called Differential Response, which means we are trying to "alter/change" the way we work with families to better fit the family's circumstances and needs. I would like to talk with you more about it when we meet face-to face but essentially my goal in our initial meeting is to discuss what is going well for your family and understand what concerns or needs there might be for the children in the family. Additionally, I want to understand how my agency might help provide whatever support you think would be helpful to address the concerns and those the agency may have for your children. I am not interested in blaming anyone.

If the response is still "NO"…

I can only imagine how difficult it might be to get a call from our agency and I understand your reluctance to meet with me. As I stated earlier, our agency is trying to work with families in a different way than we have in the past. We offer families two options, our Differential Response or the more familiar approach- investigative response. My hope for your family is to avoid that and I believe the best way is to select the Differential Response process but it is of course your choice. Either way, I will need to meet with you and the children in your home. I would prefer to do that at a time that works best for you over the next two days.

"Well, I can't meet with you until next week or the week after, I'm pretty busy"

I hear you and want to respect your time but unfortunately, I am required to meet with you within a certain timeframe. I recognize that may not be convenient for you at this time but I'd really like to work with you so may I suggest we work through some options that work both for you and I. I can come before school or later in the day, whatever works best.

In the event the family cannot be contacted via phone…

Stop by the home:

My name is __ and I am a Differential Response worker with the Division of Children and Family Services. I'm here because someone shared with our agency some concerns they had about your son/daughter. I would have preferred to call, but the telephone number I had wasn't working/ or I could not find a telephone number listed for you. Do you have time now to talk for a couple of minutes?

Explaining Differential Response during the First Visit

Thanks for agreeing to meet with me today. I came to talk with you about some concerns that were brought to the attention of our agency, but just as importantly, to get your sense of how things are going at home right now. My greatest hope is that together we can identify what causes stresses or some of the challenges you feel you are facing to see how I might be helpful. One of the things I would really like to talk about is what you are doing well and what is really working for your family. Then we can build on that to address the stuff that feels hard. It's important for us to work together to address the concerns that brought me here related to your children's safety, and I also want to understand what you may need. In order to do that I need you to help me understand your family and how thing are working for you now.

One thing I really want you to know about is how we can offer help to families through something called differential response. In differential response, I meet with your family, we discuss what the call was about, and I work with you to make sure that your kids are safe. Then we talk about what else your family may want or need help with. It is a little different from what some people know about, a traditional response or investigation. Those require us to find out what specifically happened that caused someone to report a family and to make more official judgements and recommendations to keep kids safe. The best part about this is that we get to collaborate, or work together, to resolve some things that are difficult right now and then say goodbye in a relatively short period. As long as we both agree that, your children are safe, working with me will be up to you, it is voluntary.

Let's Call Ms. Henderson

Six-year-old TJ and eight-year-old Rose have been late for school three times this week. TJ says that his mother, Gail Henderson, leaves for work at 6:00 am and his sister (who is eight) wakes him up, gets him dressed, fixes his breakfast, and gets the two of them off to school. He and Rose stay home alone on those days when there is no school. The children's mother is approximately 30 years old.

For purposes of training, the checks you made before you call Ms. Henderson verify that she has never had an investigation or case before.

Keep in mind:

- How do I introduce myself?
- How do I get the conversation started and begin introducing Differential Response?
- How do I schedule the initial in-home family visit?
- How do I engage the family?
- How do I verify household composition and demographic information?

DR REVIEW

These are the questions submitted by you and your colleagues. They are the things you felt were important to remember about the DR Policy. Feel free to use your policy and procedure manual (on your phone).

Memorizing the policy is not essential, but the most important thing is ensuring you can find the answers you need.

EXPLORING DR IN CHRIS

Referral Acceptance Data:

Date of the Referral: _____

Questions	**Answers**
What is the family address?	
What is the contact phone number?	
What are the injury characteristics (concerns / worries)?	
Other than the family members, who needs to be interviewed, preferably before you call the mom?	

Client Screens:

Questions	**Answers**
What data is missing on **all** of the clients?	
What is Gail's Role in the case?	
What is TJ's role in the case?	
What is Rose's role in the case?	
What other information may you need on from Gail?	

Initial Telephone Contact:

Does your supervisor want the purpose to be Assessment or Other?

Initial Home Visit:

- Type / Location
- Who participated
- Documentation to support that you ensured the health and safety of the children.

Safety Assessment:

- What happens if you find a safety threat when you get out there for that first visit?
- What happens if you find a new Priority 1 Allegation when you get out there for that first visit (or at any time during the life of this case)?
- What if you find a Priority II situation that is different than the one(s) on the report?

Family Plan should be completed _____ days after initial report?

NEEDS, BARRIERS, SERVICES

NEED: resources or capacities that would allow the family members to live free of threats to the children's immediate safety without professional/formal services.

BARRIER: a condition or situation in a family's life that prevents them from meeting their needs (lack of resources/capacities or a condition that keeps them from tapping into resources/capacities)

SERVICE: Professional (formal) or informal resources to assist the family in removing barriers and meeting their needs

1. With this framework, write down the Henderson family's needs. Write one need for each family member (Ms. Gail, Rose, and TJ).

2. Write down one barrier based on the limited information you have received about the Henderson family.

3. Write down services the family might want, or that may be required for the family. These services can be formal or informal).

Case Closure Scenario 1

Linda's protective services case was opened for Neglect: Failure to provide for essential and necessary needs and Neglect: Educational neglect due to absence from school (Previously environmental neglect, inadequate food, and educational neglect). Linda has three children, Sabrina, age 13, Bradley, age 4 and Lindsey, age 12 months. This family was brought to the attention of the agency because Sabrina would come to school with dirty clothes, hungry and tired. Sabrina reported that she was tired because she would be up at night taking care of her younger siblings. Sabrina also disclosed that she and her siblings witnessed on multiple occasions fighting between her mother and her mother's boyfriend in the home.

During the investigation, DCFS workers found the home to be dirty with food and garbage on the floors throughout the apartment and scattered dirty dishes on the counters in the kitchen and living room areas. There was no food in the refrigerator and only a few cans of tuna, Vienna sausages and crackers in the cabinets. When asked about the lack of food in the home, Linda stated that she had not yet received her SSI check.

There was no evidence of physical abuse. Sabrina has a history of being suspended from school on multiple occasions due to some behavioral issues. She also has a pattern of consistent absences and tardiness. Sabrina is in the 7th grade, but she is behind and below grade level in most of her classes due to her absences. Bradley is not currently enrolled in a Head Start program and he displays signs of having some developmental delays; specifically, he exhibits a speech impediment and struggles with fine motor skills. Lindsey is not crawling, and she is underweight.

Linda also has a history of alcohol use; although, she has periods of abstinence that usually last for several months at a time. Linda has never received treatment for her alcohol use. Linda's closest friend who is also her neighbor is an alcoholic and she frequently hangs out at Linda's house, which is a trigger for Linda.

Since being involved with the agency, Linda has started to make some improvements. She is participating in outpatient drug treatment. She has also moved in with her mother to get away from the negative influences at her previous apartment complex and to get support with her children so that she can fully participate in her drug treatment program. Linda has also started to participate and invest in Sabrina's education. She has hired a tutor for Sabrina to help bring her academic skills up to her current grade level. Linda was able to verbalize how her behaviors and lack of interest in her children had negatively impacted their overall well-being.

Group Discussion Questions:

1. Is there a reasonable expectation that the children will be safe, and any remaining risk of harm can be managed solely by the family with additional resources when necessary? Why or why not?

2. Is the family stable? Do they have an adequate means of providing for the basic needs of providing for the basic needs of the children?

3. Have the issues that brought the family to the attention of the agency been resolved? If so, how?

Case Closure Scenario 2

Anna is the 19-year-old mother of Samantha, who is 7 years old. Anna's protective services case was opened due to Neglect: Inadequate supervision by leaving a child alone and Abuse: Mental injury (Previously inadequate supervision and mental injury). Anna has a history of leaving Samantha home alone overnight at least 3-4 times a week. Per the reports of Anna's grandmother, Anna is a "sugar baby" (involved in a romantic relationship in order to receive cash and gifts). As a part of the quid pro quo relationship, Anna is expected to attend weekly engagements with her significant other in order to maintain her allowance.

Anna also has a history of calling her child derogatory names that have at times caused Samantha to engage in self-injurious behaviors (i.e., cutting and carving words on her skin). Samantha is currently receiving mental health treatment to address her symptoms. Anna is supposed to participate in family therapy as recommended by therapist.

Anna's mother has complained about her lack of care for and interest in Samantha and she is actually the one that made the call to the hotline because she does not think that Anna is a safe and responsible caretaker. Anna and her mother have a strained relationship because she does not agree with Anna's lifestyle and relationship. The grandmother makes a habit of regularly checking on her granddaughter because of her concern. She has noticed that Samantha's self-injurious behaviors have increased.

Since the case has been opened, Anna has not fully participated in the recommended services, and she has failed to adhere to the immediate safety plan. During your contact visits with Samantha, she reports that her mother's name calling has not stopped and she continues to be left home alone at least once a week. Samantha has expressed that she doesn't feel like she is "good enough" and she might as well be "dead" because her mother does not love her or care about her.

Group Discussion Questions:

1. Is there a reasonable expectation that Samantha will be safe, and any remaining risk of harm can be managed solely by the family with additional resources when necessary? Why or why not?

2. Does the child report that the abuse/ neglect is still occurring in the home?

3. Have the issues that brought the family to the attention of the agency been resolved? If so, how?

Note to Future Self