Foster Care Assessment Program - Services/Permanency Assessment Report

Preliminary SPAR

Reunification Assessment ☒ **Standard Assessment** ☐

FCAP ID:

Name of Child:

DOB: **Age:** **Gender:** **Ethnicity:**

Date of Referral: **Report Date:**

REASON FOR REFERRAL

- One short paragraph
- Give the referring caseworker's name
- Barriers to reunification
- Summary of questions to be addressed.

SOURCES OF INFORMATION

Interviews/observations:

Sources	Type	Date	Time
	Face-to-face		
	Phone		
	Face-to-face		
	Phone		
	Phone		
	Phone		
	Phone		
	Phone		

Standardized Measures:

Pediatric Symptom Checklist (PSC-17), Child Sexual Behavior Inventory (CSBI), Trauma Symptom Checklist for Children (TSCC), Trauma Symptom Checklist for Young Children (TSCYC), Strengths and Difficulties Questionnaire (SDQ) Youth Version, Strengths and Difficulties Questionnaire (SDQ) Teacher Version, Child and Adolescent Functional Assessment Survey (CAFAS), Preschool and Early Childhood Functional Assessment Survey (PECFAS), Vineland Adaptive Behavior Scales, Parenting Stress Index (PSI). Delete those not used in this report.

Records/materials/reports:

DCFS case records; medical records; educational records (Note the specific reports [name, provider, date] that you refer to in your report)

Team Review:

Reason(s) for report delay beyond 56 days from referral date, if any (circle all that apply):

1 ☐ Referral Backlog
2 ☐ Waiting for key interview(s)
3 ☐ Waiting for completion of tests/specialized assessments
4 ☐ Evaluator absence
5 ☐ Review Team consultation postponed
6 ☐ Other: Enter other reason here

Comments:

CURRENT SITUATION

This section should be short: 5 to 15 lines. Focus is on current situation, not summarizing the case.

- Where the child is living and how long he has been there.
- Frequency and structure of contact with family members.
- **Current** prominent problems in the child or parent that impact reunification.

SOCIAL AND LEGAL HISTORY With rare exceptions, everything in this section should come from written records. Information from interviews will go in other sections below. Summarize the history that led to the current situation as you understand it from the DCFS records and other documents you have reviewed.
This section should be between three-quarters of a page and two pages[ERC1].

- Family structure: number and current situations of siblings from each parent.
- Number and content of CPS referrals on family; history of DCFS intervention.
- Summary of placement history for child.

Mother's History and Compliance:

- *Relevant* background details: race/ethnicity, childhood trauma or family CPS history, criminal activity, substance abuse or mental health symptoms, educational and employment details.
- Services required and parental compliance with them.
- Summary of any specialized assessments.
- Current situation.

Father's History and Compliance:

- *Relevant* background details: race/ethnicity, childhood trauma or family CPS history, criminal activity, substance abuse or mental health symptoms, educational and employment details.
- Services required and parental compliance with them.
- Summary of any specialized assessments.
- Current situation.

Child's development:

- Summarize special needs described in the records or during interviews.
- Note any exceptional behavior problems.
- If problematic, note child's school history[ERC2].

PARENT/CHILD OBSERVATION

Describe the child's visit(s) with their parent(s). Note the level, style, and tone of the interaction. Some issues you might observe and comment upon:

- ✓ How does the child react to the start or end of the visit?
- ✓ Is the play child initiated?
- ✓ Is there also parent initiated activity?
- ✓ Are the parents' expectations of the child age appropriate?
- ✓ Does the parent set clear physical and role boundaries with the child?
- ✓ In what ways does the parent reinforce positive or negative behaviors?
- ✓ If more than one child was present, how did the parent manage conflicting demands?
- ✓ What is the degree of affection? Is it reciprocal?
- ✓ If the child was hurt or frightened, did he/she seek comfort from parent?
- ✓ Did the child rely on the parent for help?
- ✓ How did the parent manage episodes of misbehavior?
- ✓ Did the child comply with parental requests? How did the parent respond?
- ✓ Were there any safety concerns?
- ✓ Did the parent(s) read the child's cues (verbal and non-verbal)?
- ✓ Child's level of comfort with the parent?
- ✓ If the visit is in the parents' home, is the space safe for the child?
- ✓ Any exceptional occurrences.

Conclude with descriptions or observations of third parties about the visits.

STANDARDIZED MEASURES REGARDING THE CHILD

Delete measures that are not used due to the child's age/cognitive functioning.

Pediatric Symptom Checklist (PSC-17) The PSC is a caregiver-completed checklist that measures caregiver assessment of child and adolescent emotional and behavioral problems. Caregivers for children between the ages of 4 and 18 years complete this screening questionnaire. The instrument assesses the overall level of behavior problems and problems in three specific areas (attention, externalizing, and internalizing problems).

Results:

Child Sexual Behavior Inventory (CSBI) Caregivers for children between the ages of 2 and 12 years complete this questionnaire. It measures sexual behaviors of children. It is scored for total sexual behavior problems, and two sub-scales: developmentally related behaviors and behaviors that are more often observed in children who have been sexually abused. Scores in the clinical range indicate behaviors that are seen in < 5% of children and that are potentially problematic and require intervention. It does not confirm or rule out whether a child has been sexually abused.

Results:

Trauma Symptom Checklist for Children (TSCC) This self-report questionnaire is completed by children between the ages of 8 and 16 years. It measures symptoms as subjectively experienced by the child/adolescent. It was developed for use with children who have experienced traumatic experiences. The TSCC contains 6 sub-scales (anxiety, depression, anger, posttraumatic stress, dissociation [overt and fantasy], and sexual concerns [preoccupation and distress]). It also has scales that measure under- or over-responding so that the validity of the responses can be assessed. A sub-scale score in the clinically significant range indicates that <5% of children report this level of distress and that treatment may be necessary. The TSCC-A is an alternate version of the questionnaire which omits the questions related to sexual issues.

Results:

Trauma Symptom Checklist for Young Children (TSCYC) This caregiver-report instrument assesses trauma symptoms in children from ages 3 to 12 years over the past month. The measure ascertains the validity of the caregiver report and evaluates a wide range of potentially posttraumatic symptoms. The TSCYC has eight clinical scales: Anxiety, Depression, Anger/Aggression, Posttraumatic Stress-Intrusion, Posttraumatic Stress-Avoidance, Posttraumatic Stress-Arousal, Dissociation, Sexual Concerns, and a summary Posttraumatic Stress total scale. Because FCAP uses this measure as a screening tool for post-traumatic stress symptoms, only the Post-Traumatic subscales and summary PTS Total score are reported. Please note that a clinical score is not equivalent to a diagnosis of PTSD.

Results:

Strengths and Difficulties Questionnaire (SDQ) Youth Version The SDQ is a youth-completed checklist that measures self-assessment of youth behavior. Youth ages 11-17 years complete this questionnaire. The instrument assesses the overall level of difficulties and problems in specific areas. There are 5 sub-scales: emotional symptoms, conduct problems, hyperactivity, peer problems, and pro-social behavior.

Results:

Child and Adolescent Functional Assessment Scale (CAFAS) FCAP Program Evaluators complete this measure for children between the ages of kindergarten and 19 years (based on information collected from a variety of sources including caseworker(s), case records, teachers/educational records, primary caretaker, service providers, the child and their birth parents (if applicable). The information is based on the child's functioning over the past three months. Functional impairment is rated as severe, moderate, mild, or minimal/none for the following scales: role performance in the areas of school/work, home and community; behavior toward others; moods/emotions; self-harmful behavior; substance abuse; and thinking. Overall dysfunction is calculated based on the youth's total score across the eight scales. Levels of functional impairment are correlated with the amount and intensity of services that are necessary.

Results:

Preschool and Early Childhood Functional Assessment Scale (PECFAS) FCAP Program Evaluators complete this measure for children who are not yet in kindergarten or who are ages 3 to 7 years olds and developmentally delayed based on information collected from a variety of sources including caseworker(s), case records, teachers/educational records, primary caretaker, service providers, the child and their birth parents (if applicable). The information is based on the child's functioning over the past three months. Functional impairment is rated as severe, moderate, mild, or minimal/none for the following scales: role performance in the areas of school/daycare, home and community; behavior toward others; moods/emotions; self-harmful behavior; and thinking/communication. Overall dysfunction is calculated based on the youth's total score across the seven scales. Levels of functional impairment are correlated with the amount and intensity of services that are necessary.

Vineland Adaptive Behavior Scales, Second Edition This measure is completed by the evaluator based on caregiver report. The Vineland Adaptive Behavior Scales are designed to assess personal and social functioning in individuals from birth to adulthood. The measure is divided in to four subscales including Communication, Daily Living Skills, Socialization, and Motor Skills.

Results:

Strengths and Difficulties Questionnaire (SDQ) Teacher Version The SDQ is a teacher-completed checklist that measures teacher assessment of child/adolescent behavior. Teachers for children between the ages of 3 and 17 years complete this questionnaire. The instrument assesses the overall level of behavior problems, problems in specific areas, and strengths in pro-social behavior. There are 5 sub-scales: emotional symptoms, conduct problems, hyperactivity, peer problems, and pro-social behavior.

Results:

HEALTH HISTORY AND STATUS

This section should only be used if the case was referred to our program pediatrician for a written summary/consultation. Use the version edited by HCSATS staff. Delete the heading if not used.

PSYCHIATRIC CONSULTATION

This section should only be used if the case was referred to our program psychiatrists for a written summary/consultation. Please ensure HCSATS staff has reviewed the text you intend to use in this section. Delete the heading if not used.

CULTURE/ETHNICITY

If **only** stating the parents' and child's race or ethnicity, note those details in the descriptions above and delete this section. Otherwise, use this section to summarize information learned about the child's and each parent's background, cultural practices, and what their background means to them. It may also be relevant to comment upon the background and cultural practices in the child's current home. Summarize information provided by third parties that reflects on these issues.

PERMANENCY STATUS

Current Permanency Status: Dependent since _____ and in the current home since _____. The permanent plan is _____.

Describe the Department SW's permanent plan and timeline. Compare the other interviews with the official plan. What is the child's preference for a permanent plan and who is most important to them[ERC3]?

Describe each parent's current situation and views on reunification:

- If not noted in sections above, describe each parent's current living situation: stability of housing, appearance and safety of household, other people living in the home.
- Identify any factors not noted above that impact parenting capability (such as mobility problems, work scheduling issues, knowledge of special needs) and how the parent proposes to address them.
- Describe the parent's view of the dependency, whether or not services have been helpful, and their views on the timing and details of reunification.

Describe the views of third-parties about reunification. If the child is old enough to voice an opinion, provide the child's perspective.

Describe what options are being considered for the child if reunification is not possible [ERC4]

Parenting Stress Index (PSI) The PSI is a caregiver completed inventory for children up to 12 years old. It measures Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. The normal range for scores is within the 15th and 80th percentiles. The profile includes a Defensive Responding scale that assesses the extent to which the respondent approaches the questionnaire with a strong bias to present the most favorable impression of him/herself and to minimize indications of problems or stress in the parent-child relationship. Functional impairment is rated for the following scales: Defensive responding (DR), parental distress (PD), parent-child dysfunctional interaction (P-CDI), difficult child (DC), and total stress (TS). The total stress (TS) score is designed to provide an indication of the overall level of parenting stress an individual is experiencing. A total stress score at or above the 90th percentile is indicative of parents experiencing clinically significant levels of stress.

Results:

IMPRESSIONS

Impressions should take up between three-quarters of a page and two pages. They should outline what the recommended permanency plan is, what the barriers to that plan are, and what the steps are to resolve the barriers. They should also comment on the child's functioning and what services or supports will address problems there. It is appropriate to address services currently being used or considered that are not helpful. To the fullest extent possible, all recommended steps should be based in evidence. If the evidence or intervention is not well-known, it may be appropriate to describe it. For areas in which there is little or no evidence, rely upon the input from review team, other clinical consultation, or your expertise.

Do not put any new factual information in the Impressions.

Impressions is the area that allows the greatest flexibility and creativity. It is also the area where you make the recommendations as clear and convincing as possible.

Consider:

- What are the child's strengths, vulnerabilities, and difficulties?
- What interventions will improve the child's functioning?
- Is the child's current home meeting the child's needs? What will help in this regard?
- What steps are needed to achieve permanency? How can they most quickly be achieved? Provide a timeline for needed steps.
- Are current interventions effective? What should be added, taken out, or changed?
- If reunification is not recommended, what permanent plan is appropriate and what kind of contact with parents and other family members is appropriate? [ERC5]

Include a thorough analysis of why the child can or can not return home and a concrete plan for reunification if possible. Suggestions for organizing the content:
Paragraph 1: Brief synthesis of functioning for both the child and the parents. Describe what lead to the dependency and the primary barriers to reunification.
Paragraphs 2-3: State whether the child should be reunified and then back up your argument in 2-3 paragraphs. Make sure you analyze the court ordered services and compliance rather than just summarizing. Did the initial service requirements match the parental deficits? Is it necessary to have complete compliance? If they have relapsed, does it appear that the relapse was part of their recovery, or have they regressed considerably in their progress since the relapse? Did DCFS miss a parental deficit that could have been improved? (For example, does the parent have an undiagnosed developmental delay? Is the parent depressed, but medication has never been considered?) Aside from specific compliance, are there indications that the parents have developed skills that will support them as parents?
Paragraph 4: Describe the child's special needs and/or temperament and how/whether the parents will be able to meet these needs given their strengths and challenges.
Paragraph 5: Provide DCFS with steps to achieve the permanent plan. If reunification is recommended, how will the child be transitioned home? What is the timeline for reunification? If reunification is not recommended, should rights be terminated? Is adoption the preferred alternative? Or, would guardianship or third party custody be more appropriate in this case? What should contact between the child and parent(s) look like for the upcoming period as well as if/when rights are terminated? If there are siblings or other important family members, address their on-going relationship with the child. [ERC6]

RECOMMENDATIONS

Recommendations list the most important points made in the Impressions. There should not be any recommendations that have not been discussed in Impressions.
You should have 3 to 4 recommendations, at least one of which comments on permanency with specific timelines. For reunification cases, you should make a recommendation with a specific plan for reunification or an alternate permanent plan.
Recommendations should be stated briefly, taking up one to four lines each.

_____

Health History and Status Completed by:

FCAP Evaluator Name:

_____

Signature

Agency:

Date Report Sent to DCFS:

☐ **Long Distance Case**