Reunification SPAR Instructions and Standards
November 2010

This document is to be used in conjunction with the General SPAR Instructions and Standards. Information that is relevant to both Standard Assessments and Reunification Assessments is available in that guide. This guide only includes details specifically applicable to Reunification Assessments.

Reunification Assessments are appropriate for dependent children living in or out of the home when there is clear uncertainty or disagreement about reunification. If the caseworker has already determined whether or not reunification will occur, a reunification assessment is not appropriate. The focus on a reunification assessment is on the parents rather than on the child.

Choose the type of Assessment:

Reunification Assessment ☒ Standard Assessment ☐

Reason for Referral

This section should articulate the reason(s) that reunification is being considered and the caseworker's questions regarding reunification.

Example
Sylvia, a 22 month old Caucasian girl, was referred to the Foster Care Assessment Program by her DCFS social worker, Sue Davis, who would like assistance in determining if Sylvia's parents are capable of meeting her needs, which include special services for developmental delay. Sylvia's parents were both incarcerated when she was born, but have since been released from prison and are in compliance with required services.

Sources of Information

The parent(s) should be interviewed in person. The child should be observed/interviewed during parent-child visitation. A home visit to the foster parent/relative home is not necessary. Interviews should focus on the parents, not the child. (Thus, it is not necessary to interview the teacher or child's therapist, unless necessary to understand the parent's ability to meet special needs.)

Example
Interviews/consultations:

Sources	Type	Date	Time
Larry Smith , father	Face-to-face	8/4/07	70 minutes
Sylvia Smith, child	Observation with father Observation with mother	8/4/07 8/7/07	45 minutes 45 minutes
Sue Davis, DCFS social worker	Face-to-face	8/7/07	30 minutes
Sherry James, mother	Face-to-face	8/7/07	60 minutes
Judy Kasnick, mother's therapist,	Phone	8/20/07	10 minutes
Jim Watson, CASA	Phone	8/21/07	25 minutes
Arthur Emmons, father's treatment provider	Phone	8/26/07	20 minutes
Laura and Kevin W., foster parents	Phone	8/29/07	20 minutes
Penny Simpson, mother's probation officer	Phone	8/29/07	15 minutes

Standardized Measures

List all of the measures relevant to the child and parent depending upon the age of the child, cognitive ability of the parents, and ability to understand written language. All relevant measures should be administered for the child given that these are screening tools and can assist in identifying services to help parents care for the child if recommended.

Example
FCAP Caregiver Survey, Parenting Stress Index (PSI), Vineland Adaptive Behavior Scale.

Records/materials/reports

Categorize and list the records reviewed whether for the parent or child.

Current Situation

Example
Sylvia has been living since birth in the foster-adoptive home of Laura and Kevin W. in Tacoma. When Sylvia was placed in their home, the W's were told that they were very likely to be able to adopt her. Sylvia's foster parents have voiced concerns about Sylvia's motor skills, speech, and attention span. Sylvia is currently receiving several types of therapy. Sylvia has weekly visitation with both of her parents including a five hour monitored visit with her father each Saturday and two supervised visits with her mother each week

Social and Legal History

This section should include information that is relevant to the parents' functioning and compliance with services. Follow the general SPAR Standards. However, this section can be broken down into sub-sections which focus on each parent. Make sure that data on the parents' personal history and service participation is clearly described. A section can be included to focus briefly on the child's development, placement history, or prior evaluation. However, this sub-section should be brief in order to not distract the reader from the focus of the overall assessment.

Example

Sylvia is the first of two girls born to both her mother and her father, Sherry James and Larry Smith, who were twenty-five and thirty years old when she was born. Sylvia's younger sister, Hailey, is three months old and resides with Ms. James in Port Orchard. Sylvia sees Hailey during her twice-weekly visits with Ms. James. On her mother's side, Sylvia has an older half brother, Elliott, now age 12, who was adopted as an infant and has not contact with Ms. James or Sylvia.

Ms. James's History and Compliance

Ms. James was an only child raised by her mother and step-father. As a result of violent physical abuse as well as sexual abuse by her step-father, Ms. James ran away from home at the age of thirteen. During the next five years, Ms. James was primarily homeless and on her own; she occasionally stayed with friends and had several brief relationships with much-older men, one of whom was the father of her son, Elliott, who was born when Ms. James was fourteen. Around the time of Elliott's birth, Ms. James was briefly placed in foster care with Elliott, but she ran away when he was four months old and maintained only sporadic contact with DCFS, ultimately agreeing to relinquish her parental rights when Elliott was ten months old.

Ms. James also began using and selling methamphetamine, for which she was in and out of juvenile detention and later prison. Her most recent prison sentence was from July 2005 until August 2006. Sylvia was born during this incarceration in September 2005. While in prison, Ms. James had visits with Sylvia in December 2005 and January 2006, and she also participated in drug treatment and parenting classes. Ms. James went to work release in August 2006 and began visiting Sylvia once each month. In November 2006, she was released from prison and went to live at Oxford House, a clean-and-sober residence that she shares with six other women in recovery. She began regular weekly supervised visitation with Sylvia. She also participates in UA's twice a week, which have been drug-free.

While in work release, Ms. James completed a parenting evaluation with Michael O'Leary, Ph.D. which consisted of an interview, standardized measures, and an observation of Ms. James with Sylvia. Dr. O'Leary described Ms. James as having average intelligence and good problem solving skills. On several of her personality tests, she produced scores which were markedly positive, likely reflecting the evaluative nature of the assessment (the MMPI and CAPI were both invalid due to this issue). She showed a "very solid grasp of the principals of nurturant parenting" and had appropriate expectations for children. When observed, she was noted to be affectionate, humorous, encouraging, and sensitive to Sylvia's cues. However, she was also somewhat prone to overstimulating Sylvia. Dr. O'Leary expressed concern about Ms. James's past antisocial behavior and drug use but concluded that Ms. James appeared to have the

capacity to parent a young child and was able to place a child's needs above her own. He recommended that if Ms. James could remain sober and if a safety net could be provided, Sylvia's best interest would be served through reunification.

Ms. James gave birth to her third child, Hailey, in May 2007. Hailey's birth was reported to DCFS, and a brief investigation indicated that there were no grounds for DCFS to intervene.

Mr. Smith's History and Compliance

Mr. Smith was raised in Bremerton and his family still lives in the area. He began using alcohol and marijuana at age twelve, and at age sixteen began using methamphetamine daily. He also began to have very frequent legal problems. Beginning in 2000, he was convicted of at least seventeen crimes in five years, including nine convictions for driving without a license. In 2001, he was convicted of assault on a girlfriend, and when he was released from jail, he was convicted twice of violating a protection order. In 2005, he was convicted of two VUCSA offenses. His most recent incarceration was September 2005 to February 2006.

Within days of Sylvia's birth, Mr. Smith had his prison counselor call DCFS to arrange telephone contact between him and DCFS. Shortly afterward, his cousin called DCFS on Mr. Smith's behalf to inquire about the steps Mr. Smith should be taking toward reunification. In prison, Mr. Smith attended numerous programs including completing his GED, participating in drug treatment, going regularly to NA meetings, taking parenting classes and anger management training, and seeking job training. In November 2005 (when Sylvia was two months old), Mr. Smith went to a work release program. He called DCFS to inquire about visits and to say that he was willing to engage in services as soon as possible. Through relatives, Mr. Smith sent gifts to Sylvia.

Mr. Smith had his first visit with Sylvia in February 2006, when Sylvia was five months old and has had visits regularly since March 2006. During initial visits, Mr. Smith was described as nervous but loving and open to learning new skills. He came prepared to visits and was often early. In March 2006, Mr. Smith was allowed to leave work release to live on his own. DCFS discovered that he was living with a woman who had a substantial DCFS history. DCFS confronted Mr. Smith with this fact. Mr. Smith immediately stated that he would find a new place to live. He added that he would not do anything to hinder Sylvia coming home because she was his top priority. He moved and ended his relationship with the woman.

In April 2006, Mr. Smith completed a drug and alcohol assessment which indicated a serious drug abuse history but no medical or mental health problems except a childhood diagnosis of ADHD. It was recommended that he participate in a six month outpatient treatment program. He was compliant with and completed treatment. In June 2006, Mr. Smith underwent a comprehensive parenting assessment with Lori Harrison which included an interview, standardized measures, and an observation of Mr. Smith with Sylvia. Ms. Harrison described Mr. Smith as having a basic but adequate understanding of parenting skills and a high level of parental satisfaction. His CAPI scores were invalid due to faking good. Ms. Harrison felt that Mr. Smith's greatest barrier to parenting was his history of criminal activity and drug abuse, and she emphasized the need for services that would prevent further deviance. Ms. Harrison recommended that if reunification occurred, Mr. Smith should get in-home parent training and FPS services. Additionally, DCFS should ensure that he focus on maintaining his sobriety.

Since 2006, Mr. Smith has maintained regular visitation with Sylvia, first at a visitation center and then in his home. Visits which were initially supervised have become monitored. In November 2006, he also began attending Sylvia's medical appointments and currently attends most of her medical and therapy appointments. He continues to do UA's which are consistently negative, and he has successfully completed his probation.

Sylvia's Development

Sylvia was placed in the home of Laura and Kevin W. immediately after birth. Based upon the parents' legal history and Ms. James's previous termination of parental rights, Mr. and Mrs. W. were told that Sylvia was "fast-tracked" –that termination of parental rights would occur quickly.

In her early days with them, the W's reported that Sylvia was developing normally. However, when she was about eight months old, Mrs. W. noted with concern that Sylvia was not yet pulling herself upright or attempting to crawl. An evaluation at Mary Bridge Children's Hospital in July 2006 indicated that Sylvia had typically-developing social and cognitive skills, but poor trunk control and poor vestibular processing. Her foster parents have also noted a poor attention span. Sylvia receives a range of therapy services intended to improve her strength and sensory integration. These include home-based teaching, occupational therapy, and a therapeutically-oriented play group. Her foster parents have created a specialized gym in their basement to perform therapy with her themselves. They use a prescribed program of 'heavy work' sessions (intense gross motor activity) to help her remain focused.

Health History and Status

If the child meets criteria, this summary is completed by the pediatrician (just as in the Standard Assessments).

Parent-Child Observation

This section should describe the observation of the child with their parent. Focus on the parents together if they will be parenting together, or on each parent individually if the child will be returned to one or the other. Comment on the environment of the visit if it takes place in the parents' home. Describe the quality of the parent-child interaction as it relates to the child's developmental stage. Include summaries of interviews regarding the child as his/her functioning would relate to the parents' ability to care for him/her. Administer and describe the results for standardized instruments pertaining to the child.

Observations on parent-child visitation:

- ✓ Describe the level and style of interaction.
- ✓ If observing at the beginning of a visit, describe the reunion. If at the end, describe how parent and child managed the separation.
- ✓ Is the play child initiated?
- ✓ Is there also parent initiated activity?
- ✓ Are the parents' expectations of the child age appropriate?
- ✓ 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?

Example

Sylvia is a pretty toddler with long light brown hair and an engaging manner. She was observed during visitations with her father and her mother.

When first observed upon arriving at her father's apartment, Sylvia indicated that she wanted something to eat and was given some crackers. She then explored Mr. Smith's apartment, locating her favorite toys (a large stuffed Elmo) and looking into each room to ascertain that things were in their usual locations. Intermittently she returned to the television, pointing at the characters on the screen and naming them. Mr. Smith responded by repeating what she said and elaborating on what the characters were doing. She asked Mr. Smith for his keys and spent time pretending to unlock doors around the house. She enjoyed having Mr. Smith engage her in physical play including tickling, gentle wrestling, and bouncing a large red ball. At one point Mr. Smith put Sylvia on his lap and pretended that they were riding a motorcycle, speeding up, turning corners, screeching to a halt. She giggled throughout the game. Mr. Smith showed good skill in directing Sylvia's activities. For example, when she wanted to play in the bathroom, he deftly distracted her by getting out a favorite toy. His interactions with her were marked by politeness, such as both signing and saying "thank you" when Sylvia fed him a cracker. Throughout the visit time, he praised her, engaged her in physical play, and was affectionate. He showed a strong understanding of her likes and dislikes, using this information to entertain her, engage her, and distract her as needed.

Sylvia enjoyed similar physical play with her mother in a supervised visitation room at DCFS: tickling, being rolled around on the floor, having puzzle pieces gently poured over her head. Sylvia moved quickly from one activity to another, repeatedly returning to a toy tractor that made animal noises. Ms. James was more anxious about the presence of this evaluator than Mr. Smith had been. Her interactions with Sylvia were generally appropriate but were marked by intrusions in which she attempted to get Sylvia to perform for the evaluator. For example, she repeatedly requested that Sylvia make specific animal sounds, and when Sylvia declined, Ms. James anxiously reassured the evaluator that Sylvia does know them. Sylvia seemed wholly comfortable with Ms. James, and they enjoyed physical and pretend play together. Ms. James was adept at mirroring Sylvia's expressions and engaging Sylvia in toddler conversation. Throughout the visit, Ms. James held baby Hailey, balancing well the baby's needs with Sylvia's play. On two or three occasions during the visit, Ms. James spoke rather sharply to Sylvia. For example, Sylvia put a puzzle piece near her mouth, and Ms. James said, "No!" in a loud voice. She then said, "If you put those in your mouth, I will have to take them

away." Ms. James then stated to the evaluator that she knew it was important for parents to be consistent with consequences.

Sylvia's CASA, Jim Watson, was assigned to be Sylvia's advocate within weeks of her birth. He sees her once a month during visits to the foster parents' home. Mr. Watson describes Sylvia as cute, cheerful, smart, and gregarious. He also describes her as a handicapped child and lists the following impairments: she has trouble focusing, can not sit still, and flits from activity to activity. She has temper tantrums that are much more extreme than an average child. Mr. Watson indicates that Sylvia's symptoms are classic of methamphetamine exposure. He believes that with special care, Sylvia has the ability to overcome her handicap.

Sylvia's foster parents, Mr. and Mrs. W., speak articulately about Sylvia's needs. They report that she requires a high degree of structure and routine in order to avoid becoming overstimulated and very fussy. They estimate that in the home they provide her with forty hours a week of therapy to address her sensory integration needs. Sylvia has a complex therapy schedule that includes weekly occupational therapy visits and group therapy on the second and fourth Thursdays of the month, rotating with in-home teaching on the first and third Thursdays. Like Mr. Watson, Mr. and Mrs. W. state that Sylvia's developmental problems are due to the methamphetamine exposure she experienced prenatally. They note that in early infancy, Sylvia had a "stoned, hazy" look that was different from normal babies, and that her developmental problems require a great deal of parental dedication.

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: The Vineland Adaptive Behavior Scale was completed via interview with Sylvia's caregiver, Laura W. Sylvia's scores reflect moderately low functioning in Motor Skills and Daily Living Skills. Areas of relative weakness are gross motor skills (age equivalent 14 months) and fine motor skills (age equivalent about 15 months), with relative strengths in her personal care skills (age equivalent 18 months). Her Communication and Socialization Skills are age-appropriate.

School/Daycare Section is not included in Reunification Assessments

Permanency Status

This section provides information pertaining to the child's permanent plan. Whereas a standard assessment focuses on what others are recommending for the child, the reunification assessment will include detailed information regarding parental progress towards reunification. This is likely to include considerable information from the parental perspective regarding their progress as well as interviews with service providers.

Example
Current Permanency Status: Dependent since December 2005 and in her current foster home since birth. The primary permanency plan is now for adoption by the foster parents with a secondary plan of reunification. According to Sylvia's CASA, DCFS has recently completed a termination petition, although there are doubts about whether termination will be granted, given the parents' compliance with DCFS requirements.

The W's became foster parents with a specific hope of adopting an infant. When Sylvia was born, they were told that she was likely to be available for adoption very soon based upon Ms. James's prior history, particularly her previous termination of parental rights. They find it very frustrating that the adoption has not yet taken place, and they believe that the continued rigorous schedule of visitation with the parents is bad for Sylvia. The W's state adamantly and repeatedly that they are opposed to Sylvia being reunified with her parents, and they cite a long list of specific reasons. Among their biggest concerns is that the parents fail to recognize the severity of Sylvia's needs and deny the negative impact that their methamphetamine use had on her.

Sylvia's DCFS social worker, Sue Davis, would like assistance from FCAP in determining whether Sylvia can safely be reunited with her parents. Ms. Davis believes that the foster parents are providing excellent care for Sylvia. At one time, Ms. Davis felt that Mr. and Mrs. W were exaggerating Sylvia's sensory integration problems, but she is now convinced that Sylvia indeed has substantial developmental concerns. Ms. Davis notes that Mr. Smith and Ms. James have been compliant with court orders and DCFS recommendations. Ms. James, because she has been out of prison for a relatively short period of time and because she has a history of not maintaining sobriety, is less predictable in terms of her long-term stability. Mr. Smith, on the other hand, has been relatively stable and consistent. She has only two concerns about Mr. Smith. First, Ms. Davis says that both she and the CASA told Mr. Smith that he should avoid contact with Ms. James because of her recent release and instability. Mr. Smith has obviously declined to do this. Second, Mr. Smith has been court-ordered to attend Sylvia's medical appointments. According to Ms. Davis, the court wanted Mr. Smith to attend all of the medical appointments, but he has only attended about eighty percent of them. She notes that he is disorganized about the appointments, often calling her for information about when or where the appointments are. Ms. Davis indicates that if Sylvia did not have special medical needs, she would very likely be reunified.

Sylvia's CASA, Jim Watson, advocates strongly for Sylvia to remain permanently with Mr. and Mrs. W. He describes the W's as "educated, employed, dedicated" and notes that they have common sense and a healthy attitude. He notes they are extremely adept at managing Sylvia's handicap and never miss Sylvia's appointments or make excuses. He notes that they live in a very nice, large home in East Tacoma.

Mr. Watson describes the parents in exceptionally negative terms. For example, he notes that Mr. Smith has lost most of his teeth to methamphetamine use (Mr. Smith appears to have most of his teeth), that Mr. Smith "just can't stay away from" Ms. James, and that Mr. Smith intends to put Sylvia in daycare. Regarding Ms. James, Mr. Watson reports that he assumed if a person had relinquished a previous child and committed numerous crimes, their parental rights would be terminated.

<u>The father</u>

Larry Smith is thirty-two years old, lives in Bremerton, and works full time as a concrete layer. He lives in a small apartment across the street from a park. Although the apartment complex is run-down on the outside, Mr. Smith's unit is pleasant, organized,

and meticulously clean. In the living room there is comfortable furniture, a large television, and a collection of safe toys for Sylvia. In the bedroom, there is a dresser, a double bed, and a crib. There were no safety hazards or clutter.

Mr. Smith talked freely about his history. He indicates that becoming a father was a pivotal point in his life and that he has no higher priority than his daughters. Hoping to have Sylvia return home, he has identified local physical therapy providers. However, despite objections from DCFS and the CASA, Mr. Smith has maintained frequent contact with Ms. James. He is not sure what the future of their relationship will be but feels it is important that they parent their daughters cooperatively.

Mr. Smith was able to describe the various therapies Sylvia is receiving and her progress. Mr. Smith feels that Sylvia should be reunited with him as soon as possible and is somewhat frustrated with how long the process is taking. He feels that Sylvia has been well-cared for by Mr. and Mrs. W. and emphasized that he very much appreciates them. Later in the interview, he remarked with some regret that the foster parents are highly critical of him, for example complaining about the foods he feeds Sylvia. Mr. Smith has found it easy to work with Sue Davis, the current DCFS social worker. He feels that he does not get fair treatment from Sylvia's CASA, Jim Watson. If Sylvia is reunited with Mr. Smith, he hopes that she will attend daycare at a center his boss has recommended. He reports that his boss is willing to allow him a flexible schedule in order to accommodate Sylvia's therapy. Mr. Smith feels that Sylvia benefits from therapy but that she is not substantially delayed; he notes that he himself was slow in school. He hopes that Sylvia will have frequent contact with Ms. James, but he states he is willing to abide by any restrictions DCFS might put on that contact.

Mr. Smith has completed all of the conditions of his probation and no longer has a probation officer. Mr. Smith is in the final phase of substance abuse treatment, relapse prevention. His provider, Arthur Emmons, reports that Mr. Smith has participated enthusiastically in individual and group sessions, and that he assumes a leadership role in assisting other recovering addicts.

<u>The mother</u>

Since November 2006, Ms. James has been living in Oxford House. The residence is home to seven women in addiction recovery; each resident has her own room and access to shared living spaces. The house is very clean although somewhat spartan. Ms. James's room, which she shares with three-month old Hailey, is crowded with furniture, baby equipment, and toys, but is neat and well-organized. Ms. James is not currently working.

Ms. James has recently begun attending therapy with Judy Kasnick of Kitsap Mental Health Services. Ms. Kasnick states that Ms. James has been motivated and consistent. The primary therapeutic goals are managing anxiety and remaining drug-free. From what she has seen of Ms. James so far, Ms. Kasnick has no concerns about Ms. James's parenting. Ms. James's probation officer, Penny Simpson reports, "Sherry James is doing phenomenal. I am highly impressed." She describes Ms. James as motivated and in full compliance with all the conditions of her probation. Ms. Simpson indicates that Ms. James will complete her probation in November of this year. Ms. Simpson advises that Ms. James should keep doing exactly what she is doing: live at Oxford House, care for Hailey, focus on her recovery, and maintain a relationship with Mr. Smith.

Ms. James believes that she is capable of caring for both Sylvia and Hailey. However, she understands that the current reunification plan is for Sylvia to be with Mr. Smith, and she does not object to this plan. She believes that Mr. Smith is a good parent and that it may be appropriate for him to care primarily for Sylvia while she cares primarily for Hailey. She is not sure if she and Mr. Smith will continue their relationship in the future. If they do, she hopes that they all can be together as a family. If they do not continue their relationship, she believes that they will work out a parenting agreement between them, with or without DCFS assistance. Mr. Smith and Ms. James talk frequently on the phone, and it appears that Mr. Smith frequently visits Ms. James at Oxford House and participates actively in the care of Hailey.

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 caregiver is attempting 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 the parent experiencing clinically significant levels of stress.

General: The PSI is valid for parents/caregivers of children ages 0-12. It is not recommended for parents whose children have been out of their care for more than 6 months. The parents/caregivers should complete a PSI for each child. This measure can be equally useful with foster/relative caregivers.

Results: State the person's name (biological parent or caregiver) who completed the checklist. State whether the scores are valid based on the Defensive Responding scale. A raw score of 10 or below would indicate that the measure is invalid due to the minimization of problems. Report the Total Stress score as clinical for any score over the 90th percentile. Report subscale scores in the clinical range, which is any score above the 80th percentile. Use the following descriptions for clinical scores in the following subscales:

Total Stress: A clinical score indicates the caregiver's overall level of parenting stress. It reflects stresses related to personal parental distress, stresses derived from the parent's interaction with the child and stresses that result from the child's behavioral characteristics. Parents with clinical scores should be referred for closer diagnostic study and for professional assistance.

Parental Distress (PD): A clinical score indicates the caregiver's level of distress in his/her role as a parent. This includes stress related to an impaired sense of parenting competence, stress associated with the restrictions placed on other life roles, conflict with the child's other parent, lack of social support, and presence of depression. Therapeutic services designed for helping to improve the parent's self-esteem and sense of parental competence may prove to be helpful to the parent-child dyad.

Parent-Child Dysfunctional Interaction (P-CDI): A clinical score indicates the caregiver's perception that his or her child does not meet their expectations, and

the interactions with his or her child are not reinforcing. High scores indicate that the parent-child bond is either threatened or has never been adequately established. Scores above the 95th percentile suggest the potential for child abuse in the form of neglect, rejection, or episodes of physical abuse triggered by frustration.

Difficult Child (DC): A clinical score indicates that the child possesses basic behavioral characteristics that make him/her difficult to manage. Clinical scores in children under 18 months indicate the child may have self-regulation problems. Clinical scores for children over 2 years are related to challenges managing the child's behavior in terms of setting limits and gaining the child's cooperation. If the score is above the 95th percentile, further diagnostic investigations to rule out the presence of signification psychopathology are recommended. Suggested interventions include: short-term parental consultation, a parent-education class focused on management strategies, or an intensive child-oriented intervention program.

Example 1: John's mother, Ms. C completed the inventory. Ms. C's total stress score is not clinically significant. The difficult child (DC) sub-scale score is in the clinical range, which indicates a need for further diagnostic investigations to rule out the presence of significant psychopathology. Regardless of the causes of this problem, parents who produce high scores on the DC subscale usually need professional assistance.

Example 2: Julie's mother Ms. X completed the inventory and has a clinical score for Defensive Responding (DR). Even though she responded to questions defensively, her Total Stress (TS) score is in the clinical range. Ms. X's Difficult Child (DC) sub-scale score is also clinically significant. This is related to challenges Ms. X experiences in setting limits and gaining Julie's cooperation. Suggested interventions include: short-term parental consultation, a parent-education class focused on management strategies, or an intensive child-oriented intervention program. The Parental Distress (PD) score is also in the clinical range indicating Ms. X's level of distress in her role as a parent. This includes stress related to an impaired sense of parenting competence, stress associated with the restrictions placed on other life roles, conflict with the child's other parent, lack of social support, and presence of depression. Therapeutic services designed for helping to improve the parent's self-esteem and sense of parental competence may prove to be helpful to the parent-child dyad. The Parent-Child Dysfunctional Interaction (P-CDI) score is not at a clinically significant level.

Example 3: Sam's father, Mr. H completed the inventory and has a valid profile. Mr. H. does not have any scores in the clinical range.

Example 4: Donovan's mother, Ms. L completed the inventory and has a clinical score for Defensive Responding (DR). The results are invalid given that Ms. L was denying even a normal level of parenting stress.

For this case example: Ms. James completed the PSI with regard to Hailey and had a valid profile. Ms. James did not have any scores in the clinical range.

Ethnic/Cultural

Include relevant information regarding the parents and child. Describe information from interviews as to how the parents' ethnicity and culture impact their parenting practices.

Impressions

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.

Example
Sylvia is a cute, out-going toddler with minor developmental delays that are being comprehensively addressed. The early and consistent attention to her needs has been highly beneficial. Although she is making good progress, it is likely that she will have some degree of special needs during her early childhood or longer. It is important that she continue to receive regular monitoring and therapy. There are questions about the abilities of her parents to meet her special needs as well and maintain a stable home environment for her.

Despite minor arguments to the contrary, Sylvia's parents have been compliant with CPS and court requirements. Ms. James has completed her prison time, been successful in meeting probation requirements, remained drug-free, located stable housing, and made sufficient enough strides that there is no DCFS oversight of infant

Hailey. She has completed a psychological evaluation with a generally favorable report, and she has begun therapy to address long-standing problems that may stem from a highly traumatic childhood. Mr. Smith has also been compliant. He participated in prison programs to address his many parenting deficits. From the time he was aware of Sylvia's birth Mr. Smith persistently maintained contact with DCFS and sought to participate in Sylvia's care. Mr. Smith has a life-long history of substance abuse and repeated crimes. However, he has made important improvements in the last eighteen months in remaining clean, finding adequate housing, and working steadily.

Mr. Smith has maintained an on-going relationship with Ms. James despite being advised to avoid her. Particularly when Ms. James was newly out of prison, there was concern that contact with her would cause Mr. Smith to back-slide into drug use or criminal activity. Ms. James has now been out of prison for nearly ten months, and despite his contact with her, Mr. Smith has not deviated from his work, sobriety, or dedication to Sylvia. In addition, it appears that Mr. Smith is substantially supportive of Ms. James in caring for Hailey. While Mr. Smith would have gained additional trust by following the urging of DCFS and the CASA in staying away from Ms. James, it appears that currently the two are parenting cooperatively in a reasonable manner.

Both Mr. Smith and Ms. James have been involved in criminal activity for many years, and they will be unable to provide a stable household unless they take steps to avoid further legal problems. The most important steps are remaining drug-free and engaging in pro-social activities like employment, mental health services, and parenting. It is important to note that under RCW 13.34.180 (3), only being convicted of assault or worse *on one's own child* is in itself sufficient reason to terminate parental rights.

Given the parents' high level of involvement and compliance, it seems apparent that reunification would be obvious if it were not for Sylvia's developmental problems. Hence it is critical to assess the parents' ability to meet Sylvia's needs.

It has been argued that the parents, particularly Mr. Smith, do not understand the severity of Sylvia's developmental delays, and that they lack the ability to provide the care she needs. While it is obvious that Sylvia is receiving truly optimal care from Mr. and Mrs. W., it is much less obvious that she would not receive adequate care from Mr. Smith. There is debate within the pediatric community about the existence of sensory integration disorders and the effectiveness of treatment. In Sylvia's situation, it appears that Sylvia has benefited from occupational and physical therapy. Mr. Smith states that he understands Sylvia's needs, believes the therapy is useful, and has identified providers who can continue it.

Mr. Smith has been faulted for missing some of Sylvia's appointments. It is not surprising that Mr. Smith may have difficulty attending all of Sylvia's appointments. He has no control over when or where the appointments are scheduled, and he has to travel a significant distance. The W's have reported that when Mr. Smith appears for appointments, he does not actively participate. While this could be due to a lack of concern, there is an alternative explanation. The W's actively dislike Mr. Smith. They report that he dresses poorly, smells offensive, and makes inappropriate comments during appointments. In addition, the W's have informed providers about the parents' histories (for example, medical records regarding Sylvia repeatedly state, "Parents are both incarcerated for drug charges and assault."). These factors create an uncomfortable environment for Mr. Smith.

While it is unlikely that Mr. Smith will be able to provide the same level of care for Sylvia that the W's provide, it appears that he is generally capable of meeting her needs. Although Mr. Smith and Ms. James are too new to sobriety to be certain of their long-term success, their progress to date has been unusual and encouraging. Given the legal standards for termination of parental rights, it seems highly unlikely that Sylvia will become legally free for adoption. Therefore, reunification efforts should begin in earnest.

As reunification is begun, several steps should be taken to ensure Sylvia's well-being. First, Mr. Smith and Sylvia should be given adequate support. Mr. Smith reports that in childhood he suffered from ADHD, and in adulthood he is noted to have some difficulties with organization. It may be very helpful for Mr. Smith to be assessed and treated for adult ADHD. Possible treatments might include medication or training aimed specifically at increasing his skills in concentration and organization. Mr. Smith is also an inexperienced parent in many regards, and he would benefit from having Family Preservation Services. Sylvia is entitled to Early Intervention Services regardless of what county she resides in. Mr. Smith should be informed of these entitlements and have guidance in accessing them. Mr. Smith has already made contact with therapy providers in his area. If he has trouble accessing services, he should receive advocacy and support from DCFS. Mr. Smith should also begin taking Sylvia to some of her medical appointments without Mr. or Mrs. W. present. This arrangement would allow for a neutral assessment and provide an opportunity for Mr. Smith to ask questions and give input freely. Mr. Smith's work schedule requires that Sylvia attend some daycare if she is reunited. Daycare of an appropriate quality for Sylvia's level of need can be complex to locate and expensive to provide, and DCFS should give assistance in this area.

Second, there remains some uncertainty about Ms. James's stability and ability to adequately parent Sylvia. For this reason, safeguards should be put in place to ensure that Sylvia is protected if Ms. James should relapse. It may be appropriate to create a parenting plan for Sylvia and her parents. Such a plan should allow for increasingly liberal contact between Sylvia and Ms. James, but should also make it clear that if Ms. James relapses, it is Mr. Smith's responsibility to protect Sylvia. To support such a plan, DCFS should require that Ms. James continue random UA's, continue living in clean-and-sober living, and have no further arrests for as long as DCFS remains involved. Such a plan would allow both the parents to care for Sylvia, but make it clear that co-parenting is only acceptable as long as Ms. James maintains a pro-social lifestyle. Ms. James has a rudimentary understanding of parenting skills based upon classes she has taken or her own instincts. However, her implementation of those skills is somewhat rough. If Ms. James becomes active in parenting Sylvia (and she is also parenting Hailey), she may benefit from some hands-on parent-training. This is available through Holly Ridge Center or Parent-Child Interaction Therapy (which is available through DCFS contracted providers).

Third, because the parents' stability and sobriety are relatively new, DCFS should provide adequate monitoring. In particular, DCFS should continue to monitor Mr. Smith and should maintain contact with Sylvia's medical providers to insure that the parents are acquiring needed skills and Sylvia is receiving appropriate care. If close monitoring shows that the parents are unable to meet Sylvia's needs, a termination of parental rights should be pursued without delay.

Recommendations

Follow guidelines from general SPAR Standards.

Example

1. Pursue reunification. Reunification should be supported by the provision of FPS therapy, daycare assistance, and careful monitoring during Sylvia's first months with her parents. Ms. James may also benefit from additional parent training.

2. During transition, Mr. Smith should have the option of attending appointments with Sylvia alone.

3. If the parents are unable to meet Sylvia's needs or relapse to drug use or criminal activity, termination of parental rights should proceed without delay.