SPAR Instructions and Standards

September 2013

These SPAR Instructions and Standards are to be used in conjunction with both the Standard SPAR template and the Reunification SPAR template. When writing Reunification SPARs, also refer to the Reunification Instructions and Standards for additional information.

Basic Information:

- Supervisors should edit every SPAR for quality, prior to the final report being sent to DCFS.
- Use the third person (e.g. "this writer" or "this evaluator").
- Acronyms should not be used unless the name has first been written out completely (e.g.: Seattle Children's Hospital (SCH)).
- Final SPAR: Use last names (i.e. Patty Smith and then Ms. Smith) of all parties EXCEPT for licensed foster parents. DO NOT use last names of licensed foster parents due to concerns with confidentiality in the DCFS file. Since last names are used in the Final SPAR, it is important to send this report via email only if you are able to encrypt it.
- Avoid the use of informal or colloquial language. For example, use child rather than kid, mother rather than mom.
- Quotes should be used sparingly. Use quotes to highlight a word or phrase that is not common language or to highlight something someone has said (i.e. Mary was described as a "Jekyll and Hyde"). Otherwise, state the source of the information and summarize what they said (i.e. Ms. Smith related that Mary's behavior changes quickly; she is happy one minute and angry the next). When reporting information from other reports/evaluations, summarize the information and note the source.
- When using quotation marks, make sure punctuation is put inside of the quotes. For example, "…next year."
- In general, information gleaned from reviewing the records should go in Social and Legal History, information from interviews should go in Social/Emotional and Permanency sections, and information from your own ideas and consultation should go in Impressions and Recommendations.

For the Preliminary SPAR:

- Change the template on the first page to say: "Preliminary SPAR. Do not file. Destroy after [specify Team Review date]."
- When referring to biological parents, other family members, or foster parents, initially refer to them using their first names, last initial and their relationship (i.e. Mary's foster mother, Patty S.) Subsequently, when referring to that person, use Mr./Mrs./Ms. and their last initial (i.e. Ms. S.).
- Do not include dates of birth for the child, parents, or siblings. Provide the child's age in year and months. (This is to ensure confidentiality.)
- Use "page break" to insert a cover page where you pose your questions to the Review Team consultants. It is important that your questions are specific and will assist you in formulating your impressions and recommendations.

Example Questions for Consultants:

General: Could Robert benefit from further evaluation?

Specific: Would a psychological evaluation be helpful in determining Robert's current level of functioning and recommended interventions for home and school? What questions would be helpful to ask when making a referral for an evaluation? Would a school evaluation be adequate, or is a more comprehensive evaluation needed?

Choose the type of Assessment:

Reunification Assessment ☐ Standard Assessment ☒

Date of Referral

This is the date that the referral was assigned to you. Note: this is different than the date the caseworker completed or submitted the referral. Use this date when completing the reason(s) for report delay beyond 56 days. (The Children's Administration tracks how many days it takes to complete referrals, and suggests 56 days as a maximum.)

Reason for Referral

This section should include the child's age, gender and ethnicity. State who made the referral and the specific assistance they are requesting. Summarize the concerns about permanency and well-being that were developed in the caseworker interview. Briefly mention the primary barrier to achieving permanency.

Example

Maria is a twelve year old Caucasian and Latina girl referred to the Foster Care Assessment Program (FCAP) by her DCFS social worker, Jennifer Daniels. Maria is legally free, and her long-time foster parents recently asked that she be moved due to problems with compliance and attachment. Ms. Daniels requests assistance in stabilizing the placement and in finding a more suitable home for Maria if needed.

Sources of Information

Include all of the people who have been interviewed or observed. If you discuss siblings who are both being assessed by FCAP during an interview with a foster parent or other provider, estimate the time spent discussing each child or divide by 2 instead of noting the total time more than once. Do not list consultations with the FCAP consultants. Do not list people you attempted to reach who did not respond. Do not include participation in FTDMs or other staffings.

Example

Interviews/Observations:

Sources	Type	Date	Time
Michelle Smith, CASA	Phone	1/3/09	30 minutes
Alex Lewis, therapist, Compass Health	Phone	1/4/09	30 minutes
Denise Patton, Family Preservation Therapist	Phone	1/8/09	35 minutes
Jennifer Daniels, DCFS worker	Face-to-face	1/11/09	25 minutes
Stacy and Phillip R., current caregivers	Face-to-face Phone	1/17/09 1/22/09	90 minutes 20 minutes
Maria Sanchez, child	Observation at school Face-to-face	1/11/09 1/17/09	60 minutes 30 minutes
Jessie Maxwell, school counselor, Lincoln Middle School	Phone	1/18/09	10 minutes
Dana Porter, teacher, Lincoln Middle School	Phone	1/22/09	15 minutes

Records/Materials/reports

Categorize the records reviewed (i.e. school records, DCFS records, medical records). Identify a specific record/report/evaluation only when it is specifically cited in the SPAR (e.g. IEP, psychological evaluation, medical consultation). Do not list ISSPs, court records or other DCFS generated documents.

Standardized Measures

List the measures that should be a part of the assessment (based on the child's age and situation) even if they are not completed or returned. Do not identify the measures that are not administered because of the child's age, cognitive functioning, or other characteristics.

Example
Pediatric Symptoms Checklist-17 (PSC-17), Child Sexual Behavior Inventory (CSBI), Trauma Symptom Checklist for Children (TSCC) or Trauma Symptom Checklist for Children-Alternate (TSCC-A), 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 Scale (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS), Vineland, Parenting Stress Index (PSI).

Current Situation

This section should only be one short-to-medium paragraph to orient the reader. Describe the child's legal status (including the date dependency was established and whether the child is legally free). State where the child is living and how long they have been living there. Describe the caregiver (for example: ethnicity, , geographical location, whether they are licensed and/or relatives, and notable details if relevant to the case such as experience as foster parents.) Include other members of the household and their relationships. State the child's current frequency of visitation with biological family members. Note the permanent plan(s). Do not give detailed descriptions of behavior problems, diagnoses, etc.

Example
Maria has been dependent since July 2009 and legally free since August 2011. Maria was placed in the licensed foster home of Stacy and Phillip R. in August 2011, and the home

was considered a pre-adoptive placement. The R's are a Caucasian couple who have one biological daughter, Ashley (14). Maria is the second child they have fostered. Since shortly after Maria was placed with them, the R's have continually expressed doubt about adopting Maria and have recently requested that DCFS seek an alternate home immediately. Problems cited are Maria's lack of attachment to the family, her arguing, and her lack of basic hygiene. Maria has no contact with any of her extended family members.

Social and Legal History

This section should include information that is relevant to understanding the child's current functioning and permanency status. It is also helpful to include or gather information that will help address the assessment questions or reason for referral. This information should be a chronological account that leads up to an understanding of the child's current situation. It can be helpful to organize this section in the following paragraphs:
1) Brief family background: child's mother and father, number of siblings, general abuse history,
2) CPS history (summarize number and type of referrals, whether founded or unfounded, and give an example or two),
3) Events leading to the child's removal and Dependency,
4) History of placements and permanent plans – including the reasons for the disruptions (e.g. child's behaviors, CPS allegations, etc.) and referrals (and effectiveness) for any services to the child and/or foster family/relative,
5) Results of evaluations and services that the biological parents/relatives participated in that are applicable to understanding the child. If there were failed attempts at reunification, include information that states why reunification failed.
The amount of detail regarding CPS history and information pertaining to the parents will depend on the permanent plan (i.e.: if rights have been terminated, there should be less detail and if reunification is imminent, there should be more detail).

Example
Maria is the only child born to her mother, Bernadette O'Brien, who was seventeen years old when Maria was born. Maria's father is identified on her birth certificate as Hernando Sanchez. It does not appear that Mr. Sanchez has a relationship with Maria, and DCFS has never had any contact with him.

In December 2004, when Maria was four years old, she was placed in foster care when her mother was arrested for drunken driving. When Ms. O'Brien was released from jail three weeks later, she agreed to cooperate with DCFS in seeking drug treatment, attending parenting classes, and enrolling Maria in daycare. Maria was returned to her

care while DCFS continued involvement with the family. Ms. O'Brien's compliance with services was erratic, sometimes nearly appropriate and at other times entirely non-compliant. This initiated a pattern that lasted over the ensuing five years: Maria was repeatedly placed in foster care when her mother was arrested or failed to provide basic care for her, only to be returned when Ms. O'Brien became marginally compliant. On two occasions, petitions for the termination of parental rights were submitted, only to be withdrawn when Ms. O'Brien appeared to stabilize. On both occasions, Maria was pulled out of apparently stable pre-adoptive placements. During the times that Maria was with her mother, CPS received frequent referrals about the family, noting that she was left home alone, that there was no food in the house, that Maria's attendance at school was extremely poor, and that Ms. O'Brien's behavior was noted by others to be erratic, volatile, and at times aggressive.

In May 2009, while Maria was home unattended, Ms. O'Brien and a paramour were arrested in a motel room during a domestic violence episode in which methamphetamine was also found. Maria (now age 8) was not taken into protective custody until two days later when a neighbor alerted police that she had been home alone throughout that time. Although Ms. O'Brien was released from jail after two weeks, she did not respond to DCFS efforts to contact her. Eventually DCFS became unable to locate her. Maria has not seen her since coming into care, and parental rights were terminated by default in August 2011.

Maria lived in a temporary foster home before being returned to one of her previous pre-adoptive placements with foster mother, Mary L. However, Ms. L. decided after eight months that Maria's presence in the home was having a negative effect on her other children and requested that Maria be moved. Maria then went to the home of Margaret K., who also initially expressed interest in caring for Maria permanently. Once again, after seven months, Ms. K. expressed doubts about permanency, citing Maria's ungrateful behavior and her own financial concerns. Maria went to two temporary foster homes while another pre-adoptive placement was sought, and in August 2011, Maria went to the home of Stacy and Phillip R. who were seeking to adopt a child close in age to their daughter, Ashley. She has been there since. The R family had complaints about Maria almost immediately. They complained that she was overweight, demanding, self-centered, and spoiled; they noted that she refused to help with chores, argued constantly, demanded junk food, and refused to listen. Although initially optimistic that things would improve, the R's have voiced doubt about their willingness to adopt Maria throughout the past year, and in December 2012 reached a firm decision that Maria needs to be moved.

Emotional and Behavioral

This section should provide information regarding the child's current functioning in various settings. First discuss the child interview (i.e. how the child presented, and their interactions during the interview). Then, provide the information that was obtained during the interviews with foster parents and other key people. How did they describe the child? How did they describe the child's relationships and ability to connect with others? Specify the problem behaviors they think the child exhibits (antecedents, frequency, intensity, and duration). State what the foster parents and other key people think is effective in managing the child and what is ineffective. Summarize the parents' understanding of the child's strengths and challenges. The child's emotional/behavioral functioning at school can be included in this section or in the Education Section. Describe the child's strengths and interests.

Discuss recent evaluations the child has participated in, including any diagnoses. Describe the current or recent mental health treatment that the child is receiving. Include treatment goals and provider's opinions on progress in treatment, prognosis and risk levels (if applicable).

Past evaluations, diagnoses, and treatment should be presented in the Social and Legal History section.

When writing about the collateral contacts' thoughts, beliefs, and descriptions, do not use "said." Rather use words such as: stated, believed, explained, remarked, expressed, etc.

Example

Maria is an attractive and plump adolescent with dark curling hair, an appealing smile, glasses, and braces. Although reserved upon meeting this evaluator, she showed good manners in shaking hands, and she was cooperative and easily engaged. She answered questions readily, completed the lengthy standardized measures without complaint, and enjoyed having her picture taken. Maria reports that her favorite activities are drawing cartoons and playing soccer. She has a number of close female friends at school, and she likes having them over to her house. She is looking forward to returning to Girl Scout camp this summer, where she enjoyed riding horses, taking early-morning swims, and doing yoga.

Maria's foster parents are Stacy and Phillip R. Both were present in the home, and both initially participated in an interview, but Mr. R. excused himself after twenty minutes. Mrs. R. spoke about Maria for an hour and a half with only minor direction from this evaluator. Even when Maria arrived home from school and was within hearing distance, Mrs. R. did not have anything positive to say about Maria. The R's both report that Maria

is extremely difficult to live with because she demands constant attention, does not think about anyone except for herself, has poor hygiene, and argues continuously. With regard to Maria's desire for attention, the R's report that being with Maria is exhausting. Mrs. R. states, "She sucks the life out of everyone around her." At meal times, if she is not talking, she is making smacking noises with her food. With regard to her selfishness, the R's report that Maria never considers the needs of other people. She will not do any chores or make any improvements in her behavior unless a material reward is offered. Recently the family discussed New Year's resolutions, and Maria reported that she did not have any resolutions because she was fine just the way she was, which the R's felt was inappropriate.

With regard to hygiene issues, the R's report that they have had a constant struggle to get Maria to attend to basic cleanliness. If pressed, Maria will shower, but will not use soap or shampoo unless specifically instructed. The family reports that her bedroom smells bad because her hygiene is poor. Related to concerns about hygiene is the R's distress about Maria's weight. When she arrived in their home, Maria was 5 feet tall and weighed 160 pounds. Although she has grown somewhat taller, she has not slimmed down. Mrs. R. notes that there is no reason that she should not be slimmer because her physical exam revealed no endocrine problems, and she notes that Maria ignores her prodding to eat less. The R's also note that Maria is physically clumsy.

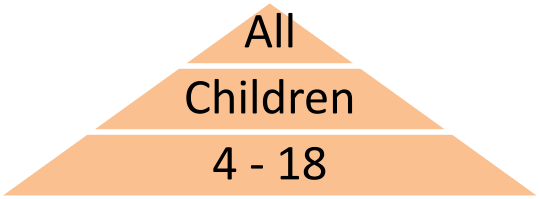
With regard to arguing, Mrs. R. reports that Maria seems to argue reflexively. For example, if Mrs. R. says, "That red shirt looks nice on you," Maria will reply that the shirt is purple, not red. When Maria does not actively argue, she complies in a manner so half-hearted as to be hostile. The R's note that with people outside of the immediate family, including school teachers and Mrs. R's extended family, Maria is typically very sweet, friendly, and considerate. The R's are upset by this because they believe it indicates that Maria is capable of being cheerful and thoughtful, but that she chooses to be bad at home. They note that Maria's sweetness to outsiders has the effect of making them look bad for complaining about her.

Maria's therapist is Alex Lewis at Compass Health. Mr. Lewis reports that Maria was previously in individual therapy at Alliance Behavioral Health, but the R family felt that the therapist was not spending enough time addressing the issues of Maria's interactions within the family. The family has been coming for weekly sessions since July 2012. Mr. Lewis states that the goals for therapy have been to improve Maria's integration into the family, particularly by improving Maria's behavior and addressing her attachment problems. Mr. Lewis has not seen improvement in the family dynamics. He notes that Maria needs to have a lot of control and that she takes a lot and gives very little in return. He also indicates that the R family has high expectations that they are not willing to lower. He notes that Maria is in a defensive posture in the family and in therapy. The R's have felt that Maria would benefit from attachment therapy, based upon their perception that Maria has little understanding of family bonds and often seems uninterested in being part of a family.

Standardized instruments

The results should be written precisely as described below and included in the Emotional and Behavioral section. (Note: The teacher version of the SDQ should be included in the School section and the PSI pertains to the parent or other caregiver so should be included in the Permanency Section.)

Do not administer the measures (except the CAFAS/PECFAS and Vineland) if the child is significantly developmentally delayed (IQ of 70 or below or a diagnosis of Autism).



PSC-17

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: State the person who completed the checklist's name and role (usually the foster parent or relative caregiver). Report scores in the clinical range. Total scores and internalizing, externalizing, and attention scores should be noted. If the total problem, internalizing, externalizing, and/or attention scores are not in the clinical range this should be reported as well. (The PSC-17 does not produce subclinical scores, so these are not reported for this instrument.)

Example 1: A child has a total score in the clinical range, the externalizing factor is in the clinical range, but the internalizing factor is not. The attention sub-scale score is also in the clinical range.

Name the person who completed this checklist. [Child's name] scored in the clinical range for Total Problems, Externalizing Problems and Attention Problems. The Internalizing Problems subscale was in the normal range.

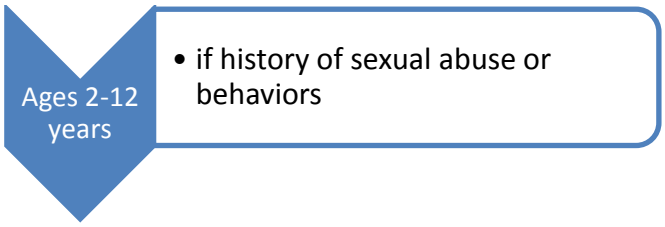
Example 2: A child had only an elevation on the attention problems score.

Name the person who completed the checklist. [Child's name] is reported to exhibit Attention problems. Externalizing and internalizing problems were not reported.

Example 3: The total score and subscales are not in the clinical range.

Name the person who completed the checklist. [Child's name] is not reported to exhibit emotional or behavioral problems at home.

For this case example: Mrs. R., Maria's foster mother, completed the PSC-17. Maria scored in the clinical range for Attention Problems. Total Problems, Externalizing Problems and Internalizing Problems were in the normal range.



CSBI

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: State the name of the person who completed the checklist. Report clinically significant score (T score 65 or above) for total behavior. If a child does not have clinically significant scores this should be reported. It is not necessary to report the subscales (DRSB/SASI) specifically. However, if a subscale is clinical, but the total score is not (this rarely happens), report that the score is in the borderline clinical range. A brief description of the types of behaviors accounting for the elevation can also be included.

Example 1: Child has total score in the clinical range.

Child has sexual behaviors that are unusual for his/her age and gender. This score is accounted for by elevated levels of behaviors that are more common in sexually abused children although they may be present in children who have not been sexually abused.

Alternative: These scores are accounted for by elevated levels of behaviors that are more common in sexually abused children, or those who have been exposed to adult sexuality—directly or indirectly—although they may be present in children who have not been sexually abused.

Example 2: Child has no scores in the clinical range.

Child is not reported to exhibit sexual behavior problems.

Example 3: The child's total score is not elevated, but the SASI score or the DRSB score is elevated.

Child has a borderline clinical score indicating that he/she displays some behaviors that are more common in children who have been sexually abused and/or have been exposed to adult sexuality. Some of these behaviors are: is very interested in the opposite sex and draws sex parts when drawing pictures of people.

For this case example: Mrs. R. completed the CSBI. Maria is not reported to exhibit sexual behavior problems.

TSCC

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: First state whether it is a valid profile. If it is not valid, explain what this indicates. Report the scales that are clinically significant. If the child has no clinically significant elevations this should be noted. If the child has a valid or under-responding profile and has endorsed critical items, these should be noted.

Example 1: Child has a valid profile and elevations on anxiety, posttraumatic stress, and dissociation.

Child has a valid profile and clinically significant levels of self-reported anxiety, depression and dissociation.

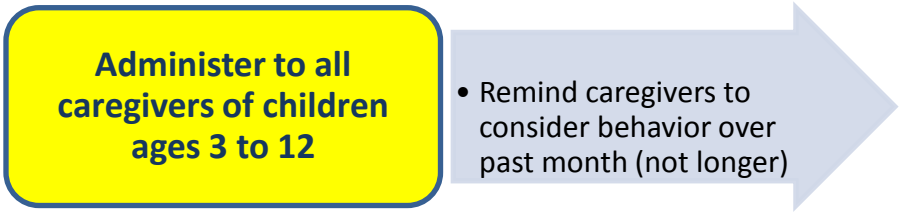
Example 2: Child has an invalid profile of under response. The critical items of feeling scared of men and not trusting people because they might want sex were endorsed.

Child has an invalid under responding profile. This means that the child was denying even a normal level of emotional responses. Despite the child's under response, he/she endorsed the critical items of feeling scared of men almost all the time and not trusting people because they might want sex most of the time.

Example 3: Child has an invalid profile of hyper-response. The child may or may not have clinical scores on the sub-scales. If the child endorsed critical items, these do not need to be noted because they over-endorsed so many items.

Child has an invalid hyper-response profile. Children that over respond on the TSCC are those that indiscriminately over-endorse uncommon items, have a desire to appear especially distressed or dysfunctional, or could be expressing a cry for help.

For this case example: Maria completed the TSCC and had a valid score. Maria did not self-report trauma symptoms. Maria endorsed the following critical item: getting into fights (sometimes).



TSCYC

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: Identify who completed the measure. First state whether it is a valid profile (based on the RL and ATR scores). If it is not valid, explain what this indicates based on the descriptions below. If it is valid, report on the Post Traumatic Stress scales that are clinically elevated.

A TSCYC with a RL (Response Level) score of 70 or higher cannot be considered valid. This caregiver has denied many or most normal items and thus they are likely to be especially reluctant or avoidant to endorse even minor problem behaviors about their child or for some other reason unwilling to endorse common items. If the score is from 65-69, there is significant caregiver under endorsement, although not at a level that renders the TSCYC invalid.

A TSCYC with an elevated ATR (Atypical Response) score of 70 or higher indicates that a caregiver has indiscriminately endorsed unusual symptomatology in a child regardless of the child's true symptomatic state and therefore cannot be considered valid. Caregivers with elevated ATR scale scores are those who report relatively high levels of uncommon TSCYC symptoms in their child, typically reflecting a generalized over-reporting style, a desire to have their child appear especially distressed or dysfunctional, or as a "cry for help" regarding their child.

Example 1: The results are valid because neither the RL nor ATR are elevated. None of the sub-scales are clinically elevated.

The foster father completed the TSCYC. His scores indicate a valid profile. This child is not reported to exhibit trauma symptoms.

Example 2: The RL is clinically elevated. (Given the lack of validity, do not report on any sub-scale scores.)

The foster mother completed the TSCYC. The results are invalid given that the caregiver denied even normal, minor problematic behavior in the child. It appears that the caregiver is especially reluctant or avoidant to endorse even minor problem behaviors about the child.

Example 3: The ATR is clinically elevated. Given the lack of validity, do not report on any sub-scale scores.)

The foster father completed the TSCYC. The results are invalid given that the caregiver has indiscriminately endorsed unusual symptomatology. This means that the caregiver has identified uncommon symptoms in the child, typically reflecting a generalized over-reporting style, a desire to have their child appear especially distressed or dysfunctional, or as a "cry for help" regarding their child.

Example 4: The results are valid and the Post-Traumatic Stress—Total score is in the clinical range as are the three subscales.

The relative caregiver completed the TSCYC. The Posttraumatic Stress—Total score is high enough to suggest relatively severe posttraumatic disturbance. The clinical score on the PTS—Intrusion score suggests that the child's current thoughts and behaviors are significantly affected by the intrusion of trauma-related memories. The clinical score on the PTS—Avoidance suggests that the child is using cognitive, behavioral and/or emotional avoidance strategies in an attempt to avoid posttraumatic distress. The PTS—Arousal clinical score reflects the extent of the "fight or flight" hyper arousal the child is observed to experience. Children with clinical scores are often hyperactive, easily startled and tense. Also frequently present are attention and concentration problems, sleep disturbance, irritability, and hyper vigilance or preoccupation with danger.

Example 5: The results are valid and the Post-Traumatic Stress—Total score is in the subclinical range as are the three subscales.

The relative caregiver completed the TSCYC. The Posttraumatic Stress—Total score suggests mild to moderate posttraumatic stress. The subclinical score on the PTS—Intrusion score suggests some level of posttraumatic intrusion that may or may not be clinically meaningful. The child's current thoughts and behaviors are affected by the intrusion of trauma-related memories. The subclinical score on the PTS—Avoidance suggests some level of avoidance that may or may not be clinically meaningful. The child is using cognitive, behavioral and/or emotional avoidance strategies in an attempt to avoid posttraumatic distress. The PTS—Arousal subclinical score suggests some level of hyper arousal that, while suggestive of posttraumatic stress, also may occasionally reflect more generalized anxiety. The score reflects the extent of the "fight or flight" hyper arousal the child is observed to experience. Children with clinical scores are often hyperactive, easily startled and tense. Also frequently present are attention and concentration problems, sleep disturbance, irritability, and hyper vigilance or preoccupation with danger.

SDQ-Y

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: State the name of the youth who completed this checklist. Report scores in the clinical and borderline clinical range. Total scores should be noted first and then the subscales. If the total problem or subscale scores are not in the clinical/borderline range this should be noted. Note: for most of the subscales, clinical problems are indicated by high scores. However, in the Pro-Social Behavior subscale, a higher score indicates better pro-social skills, and clinical problems are indicated by low scores (e.g. low pro-social skills).

Example 1: A child/youth has no scores in the clinical or subclinical range.

Identify the child/youth who completed this checklist. [Child's name] does not self-report any behavioral, emotional or peer problems.

Example 2: A child has a total score in the clinical range with conduct problems and peer problems also clinically elevated.

Identify the child/youth who completed this checklist. [Child's name] scored in the clinical range for total difficulties. Conduct problems and peer problems were also elevated. [Child's name] does not report problems with hyperactivity, emotional problems, or social skills.

Example 3: A child has a total score in the borderline clinical range with hyperactivity problems clinically elevated.

Identify the child/youth who completed this checklist. [Child's name] scored in the subclinical range for total difficulties. Problems with hyperactivity were also elevated. Emotional problems, conduct problems, and peer problems were not reported. Problems with pro-social skills are not indicated.

For this case example: Maria completed the SDQ. Maria self-reported emotional problems. She did not indicate problems with conduct, peers, or hyperactivity.

Complete regardless of child/youth's IQ or diagnosis

CAFAS

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: Identify where the child has problems by indicating their level of impairment for the scale. Start with stating the scales where the child has the most severe impairment. Do not report scores, instead state the level of overall impairment (i.e.., none/minimal, mild, moderate, or severe) and the level of impairment in sub-scale areas of functioning. Then state the child's total level of functional impairment based on their total score.

CAFAS Scoring on 8 Scale Sum:
0-10 (None/Minimal):
20-40(Mild)
50-90 (Moderate)
100-130 (Moderate to Severe)
140 + (Severe)

Example: Child has a total score of 70. The home, school, and behavior with others are the sub-scales that are elevated.

This writer completed the CAFAS. Child's scores indicate a severe degree of impairment in his role performance at home and a moderate degree of impairment in his role performance at school and in his behavior toward others. The child is not reported to have functional problems in the community or in moods/emotions, self-harmful behavior, or substance abuse. This child is functionally impaired at a moderate level.

For this case example: This evaluator completed the CAFAS. Maria's scores indicate a mild degree of impairment in her role performance at home, her behavior toward others, and her moods and emotions. Maria's overall score indicates mild impairment in her functioning.

Complete regardless of child/youth's IQ or diagnosis

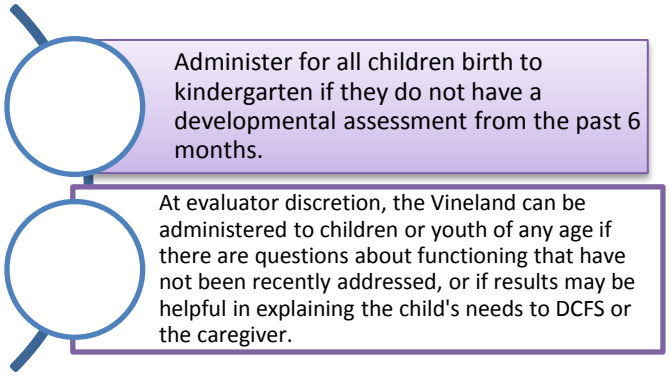
PECFAS

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.

PECFAS The reporting is the same, but the child's functioning is based on a seven scale sum, so the numbers are different.

0-10 (None/Minimal) intervention is not indicated at this time
20-30 (Mild)
40-60 (Moderate)
60-90 (Moderate to Severe)
90 + (Severe)

Examples: See CAFAS description above.



Vineland

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: State who provided input for the measure. Report scores that are moderately low or low, noting the percentile rank or age equivalent for those scores. Areas of relative strength or high scores may also be noted. Use greater specificity for children with more complex needs.

Example 1: Two year old with adequate scores in all areas.

The Vineland was completed via observation of [child] and interview with [caregiver]. [Child's] scores indicate age-appropriate development in all areas, with particular strengths in expressive language and fine motor skills.

Example 2: Four year old with adequate scores except in the Socialization subscales.

The Vineland Survey was completed via interview with [caregiver]. [Child's] scores for Socialization were in the 5th percentile, which is the low range, equivalent to the skills of a typically-developing child at 26 months. [Child's] scores for Communication, Daily Living Skills, and Motor Skills were age-appropriate.

Example 3: Six year old with most scores in the low or moderately low range.

The Vineland was completed via interview with [child's] foster mother, [name]. [Child's] scores reflect moderately low functioning in Communication, Daily Living Skills, and Socialization. Areas of relative weakness are receptive language skills (age equivalent 2.7 years) and socialization skills (age equivalent about 2 years), with relative strengths in interpersonal relations (age equivalent 4.6 years) and personal care skills (age equivalent 5 years). [Child's] Motor Skills are age-appropriate.

Health History and Status

This section is only included if our pediatrician has provided a written medical review given the child's complex medical conditions. If there has not been a review, simply delete the heading.

Psychiatric Consultation

The great majority of the time, your report will not contain a section for psychiatric consultation. Instead, use the written or oral input from the psychiatrist to inform the Impressions (in the same manner that you use oral input from the psychologist at review team). Do not include the words of the psychiatrist or even a synopsis of what was said, and do not attribute the input to the psychiatrist. However, there is one exception. If the psychiatrist has provided specific information about medications, and if this information is key to the case, the report can contain this independent section. Give the section a heading like the Health History section titled "Psychiatric Consultation by Lee Carlisle, MD (or by Terry Lee, MD)" and copy or summarize the medication feedback in that section. **Any report that contains this special section should be reviewed by Laura or Rima before the report is finalized.** We want to ensure consistent use of psychiatric consultation in all FCAP reports.

School/Daycare and Educational Status

This section summarizes the child's functioning at school and/or daycare. First state the child's current grade, teacher's name and school they are attending. Specify whether they are in regular or special education, including the specific assistance they are receiving (IEP or other accommodations). Report any school or developmental evaluations (i.e. psychological evaluations, Battelle Developmental Inventories) they have participated in, including the results of IQ testing. Include information about the child's academic performance, ability to complete assignments and stay on task, behavior at school/daycare, peer relationships, suspensions and expulsions. It is helpful to give examples of problem behaviors and note the reason(s) for any suspensions/expulsions.

It is important to state current school information first and then summarize past relevant school history toward the end of this section.

Example

Maria attends sixth grade at Lincoln Middle School in Mukilteo. She receives no special education assistance. Her attendance is excellent, and she has not had behavior problems. Her grades are average or above: A's and B's in all subjects except for math, in which she has a C. The school counselor, Jessie Maxwell, describes Maria as "happy-go-lucky," and she observes that she does not know Maria well because Maria has not had any problems at school. Maria's Language Arts teacher is Dana Porter. Ms. Porter describes Maria as cheerful and respectful. She notes that Maria enjoys joking and having fun, but that she is also good at completing her work and paying attention. She has no social problems with the other children; she is well-liked and does not bully others. Ms. Porter reports that the school is planning to test Maria's math skills to see if she could benefit from additional assistance in math. Maria reports that she likes school, particularly reading. She acknowledges that math is her most difficult subject.

According to school records in the DCFS files, Maria's early school performance was substantially hindered by very frequent absences, multiple changes of school (five different schools from first to fourth grade), and lack of homework support. Her academic performance was generally below average and particularly low in math. Her behavior was noted to be good, but her ability to work independently, stay organized, and persist in her work when frustrated were notably poor. An Iowa Test of Basic Skills administered during third grade indicated that Maria was at grade level in verbal skills but near the first percentile in math. Although testing for special education services was considered during second grade, Maria moved out of the district before testing began, and the new school was apparently unaware of the concern.

SDQ-T

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: State the name of the person who completed the form and their role (e.g.: classroom teacher). Report scores in the clinical and borderline clinical range. Total scores should be noted first and then the subscales. If the total problem or subscale scores are not in the clinical/borderline range this should be noted. Note: for most of the subscales, clinical problems are indicated by high scores. However, in the Pro-Social Behavior subscale, a higher score indicates better pro-social skills, and clinical problems are indicated by low scores (e.g. low pro-social skills).

Example 1: A child has no scores in the clinical or subclinical range.

Name the person who completed this checklist. [Child's name] is not reported to exhibit any behavioral or emotional problems at school.

Example 2: A child has a total score in the clinical range with conduct problems and peer problems also clinically elevated.

Name the person who completed this checklist. [Child's name] scored in the clinical range for total difficulties. Conduct problems and peer problems were also elevated. [Child's name] is not reported to show problems with hyperactivity, emotional problems, or social skills.

Example 3: A child has a total score in the borderline clinical range with hyperactivity problems clinically elevated.

Name the person who completed this checklist. [Child's name] scored in the subclinical range for total difficulties. Problems with hyperactivity were also elevated. [Child's name] is not reported to show problems with conduct problems, emotional problems, peer problems or social skills.

For this case example: Maria's teacher, Dana Porter, completed the SDQ. Maria is not reported to exhibit any behavior or emotional problems at school.

CULTURE/ETHNICITY

This is the section to include information from the interviews regarding the child's cultural identity and information obtained from the questions about culture and religion. Impressions and recommendations regarding these issues should be included in the sections below. Cultural consultation is recommended. However, if no specific cultural/ethnic/religious issues, concerns, or thoughts can be elicited, delete the section.

Example

Maria identifies herself ethnically as Caucasian and Latina, and when asked she notes that most of her friends are Caucasian. She would like to know more about Latina culture. Mrs. R. reports that when Maria first came to live with them, Maria stated that she was fluent in Spanish, and the R's later found out that she does not speak the language at all. The R's have made an effort to help Maria learn more about her heritage by helping her to form a relationship with the mother of a Latina classmate. According to Mrs. R., this effort was ultimately unsuccessful because Maria's behavior was offensive to that family.

PERMANENCY STATUS

For the sub-section titled "Current Permanency Status" briefly describe the child's legal and permanency situation (in one to two sentences).

Next, state what the caseworker described as the permanent plan and his or her timeline for achieving the plan, as well as other relevant information from the interview. For reunification cases, include the caseworker's understanding of the progress on the service plan. This information from the caseworker helps to clarify the Department's plan for the child. Other interviews can be compared to the "official" plan. Next, describe what the child stated regarding their living situation and permanency during the child interview.

For reunification cases, summarize the parents' timeline for reunification, their understanding of their progress with the service plan, and how services have improved their ability to care for their child(ren).

Discuss the current caregiver's intentions about permanency and perceived barriers. If a barrier is the child's behaviors, describe the problematic behaviors and what the caregiver would like to change in order to commit to a certain permanent plan. Then relate what other key people stated about the current placement and recommended permanent plan.

It is important in this section to include all of the information (past and current) regarding placement options. For example, if the caseworker is concerned about the ability of the current home to meet the child's needs, present information that relates to this concern. Mention current services that are being provided to assist with stabilizing the placement and achieving permanency. State whether these services have been effective or ineffective. This includes information in current evaluations, information/observations reported by key people, and child's relationships with others in the home. If in the same case, the caseworker is considering placement with a relative as an alternative, present all of the relevant information about the relative's home and their relationship with the child. This section should lay the foundation for the impressions and recommendations regarding achieving permanency.

Finally, if the caseworker is looking for assistance in determining an appropriate visitation schedule/plan with family members, report information that relates to past and current visits with family members (i.e. frequency of visits, relationships, child's reactions to the visits, what others state about the visits).

Example

Current Permanency Status: Dependent since July 2009 and legally free since August 2012; the permanent plan is adoption. Current placement with the R's was previously considered a pre-adoptive home, but the foster family has asked that Maria be moved.

Stacy and Phillip R. are in their late forties and have a fourteen year old daughter, Ashley. They became foster parents three years ago. Mr. and Mrs. R. indicate that they have clear and specific ideas about how their family functions. Everyone is expected to participate in household chores and in family activities such as attending church. Each of the children is required to participate in at least one sport. Above all, they value family members accommodating one another and making choices that benefit the common good over individual desires.

The R's discuss three main issues when asked whether they can provide permanent care for Maria. First, they note that Maria's extreme demands for attention are having a negative impact on Ashley. Mrs. R. feels guilty that Ashley is not getting positive attention because of Maria's competing demands. Second, the R's feel that Maria does not function as a full member of the family, that she takes without giving anything in return, and that this characteristic has not improved despite their best efforts. Finally, Mrs. R. notes that she feels constantly stressed and upset by Maria, and that having her move will be a great relief. Mrs. R. states that she would be ready for Maria to move "tomorrow." However, Mrs. R. believes that it will not be easy to find a new home for Maria. She asks rhetorically, "Do you want a little girl who is really a pain and smells

bad?" The R's have let Maria know that they will not be adopting her, telling her that she seems to need more than they can give.

When Maria was asked where she would like to live, she was unable to give a reply. Pressed hard for an answer, she finally stated that she would like to remain in Washington State and that she would like to live in a family with four children: herself, a fourteen year old, and two little ones, five or six years old. She would also like to have cats, dogs, horses, goats, and pigs. She believes there is a "fifty-one and a half percent chance" that she will be living with the R. family one year from now, and she stated with some hesitation that she would rather remain with them than move to a new home. Although Maria reported to this evaluator that she knows she will never live with her mother again, she has often reported to the CASA and others that she continues to miss Ms. O'Brien a great deal.

Katie Daniels has been the DCFS social worker for Maria since February 2010. She reports having a close and affectionate relationship with Maria, and she would very much like to find Maria a good permanent home. Despite her warmth towards Maria, Ms. Daniels points out that three consecutive caregivers for Maria have declined to pursue permanency for her after initially voicing interest, and that each of the caregivers have had similar complaints: that Maria was ungrateful, demanding, and showed little affection. Ms. Daniels concludes from this experience that living with Maria is substantially more difficult than knowing her in other circumstances. She would like to find ways to improve the fit between Maria and the R family in order to help the adoption proceed, and she initiated Family Preservation Services with that goal. Denise Patton is the Family Preservation therapist who is working with Maria and the R's. Like others, she voices pessimism about Maria continuing to reside in the household. She notes that Maria has often been difficult to manage: defensive, moody, and unwilling to take responsibility for her actions. Ms. Patton notes that Mrs. R. in particular has a very positive memory of what the family was like before Maria arrived, and she seems to want to blame Maria for many problems that are seemingly not her fault, such as tension in the R's marriage. Ms. Patton believes that in some ways moving to another family might be helpful to Maria because it would allow her to escape being the target of blame.

Describe the Parenting Stress Index as it pertains to current or recent caregivers. The PSI cannot be used if the child has been out of the caregiver's home more than 6 months. If the child is visiting more than two nights per week, the measure can be considered for administration with the parent. It can be used with biological parents, relative caregivers, and foster parents. It should be used with current caregivers when there is concern about the caregiver's stress level and/or relationship with the child. If there is more than one child, use your clinical judgment to determine whether to administer for multiple children or only the most difficult child.

Can not be administered if the child has been out of the caregiver's home more than 6 months

- Administer the PSI to caregivers for children up to 12 years when there are concerns about the caregiver's stress level and/or relationship with the child.

PSI

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: 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 stresses related to an impaired sense of parenting competence, stresses

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 high 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 investigation to rule out the presence of significant psychopathology is recommended. Interventions such as: short-term parental consultation, a parent-education class focused on management strategies, or an intensive child-oriented intervention program.

Example 1: The profile is valid and none of the scores are clinical.

The PSI was completed by caregiver (name), and the scores are valid. Ms. (name) did not self-report overall stress or stress related to parenting (child's name).

Example 2: The profile is invalid due to under-responding.

The PSI was completed by caregiver (name) and was invalid due to under-responding. This profile indicates that (name) is denying even a normal level of stress.

Example 3: The profile is valid and the scores for total stress and parental distress were in the clinical range.

The PSI was completed by caregiver (name) and the scores were valid. Ms. (name) reports clinically significant levels of parental distress which may indicate an impaired sense of parenting competence, stresses associated with the restrictions on other life roles, lack of social support, and presence of depression. The scores for total stress was also elevated, indicating 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.

Example for this case: *The PSI was completed by current foster parent Stacy R. Scores for Parent-Child Dysfunctional Interaction were elevated above the 95th percentile. This score indicates Ms. R's perception is that Maria does not meet her expectations, and the interactions with Maria are not reinforcing. High scores indicate that the parent-child bond is either threatened or has never been adequately established, and scores above the 95th percentile suggest high potential for child abuse in the form of neglect, rejection, or episodes of physical abuse triggered by frustration.*

IMPRESSIONS

In the **Preliminary** SPAR, leave this area blank. This will enable the consultation team to objectively review the report and formulate their own case impressions, and will allow you to incorporate the team's feedback into the Final SPAR. This could eliminate the possibility of re-writing your impressions after the team meeting.

In the **Final** SPAR, think of this section as the place to present the case hypothesis. New information should not be introduced in this section, nor should previously reported information be repeated except in summary form. It is helpful to think about the recommendations that will address the child's needs, and then develop the impressions to support the recommendations. The impressions should back up the recommendations. Before writing the impressions think about the main areas that are important to address in almost every case: mental health needs, school, permanency, visitation, and case planning, and then organize the information in each of these sections. An **example** to organize your thoughts:

- 1st paragraph: Brief synthesis of the child's strengths and current functioning and what has contributed to their functioning (i.e. developmental delays, history of abuse, multiple placement disruptions).
- 2nd paragraph: Describe the child's individual service needs. What is warranted to address their current level of functioning? What type of mental health treatment will improve their current symptoms?
- 3rd paragraph: School functioning and needs. What will improve their academic skills? Is school behavior impacting academic functioning? Do they need an educational advocate to improve school services?
- 4th paragraph: Permanency. What placement and permanent plan would be in the child's best interest? What does the child need to secure permanency? Is the current placement meeting the child's needs? If not, do we know why and what needs to change to meet the child's needs and prevent a disruption. Address scenarios for possible disruptions, possible outcomes of caregiver inaction, and services/resources needed in the home to meet the child's needs. For cases when reunification is considered: Is reunification recommended? Under what type of timeline? Are the current services relevant to the parents' needs? Are additional services needed? What type of visitation plan is appropriate? What are the risk factors related to reunification? What is the potential impact (positive/negative) for the child?
- 5th paragraph: Provide DCFS with steps to achieve permanency. Can also address family contact/visitation schedules.

Example

Given her history, Maria's academic and social functioning is exceptional. Even among children in the foster care system, Maria's history of failed reunifications, sudden abandonment by her mother, and unsuccessful pre-adoptive placements is extraordinary. The surprising thing is not that Maria is having difficulty settling into a permanent family; the surprising thing is that she is doing so well in so many areas of her life.

Within families, the behavior of most children is moderated by a sense of affiliation or affection for family members. Maria's exceptional history has understandably impaired her ability to form affiliations, and a lasting sense of loyalty to her mother may make her ambivalent about forming strong attachments. Some of her behaviors, such as her arguing against a compliment, may indicate that she is actively avoiding a close connection with others. In her current setting, her ability to build affiliation has likely also been impaired by the R family's judgmental or hostile stance toward her. Lacking a sense of attachment, her behavior is motivated to a much greater extent by the expectation of specific rewards and the avoidance of unpleasant tasks. In spite of her lack of attachments, Maria's behavior is substantially functional. Although she can be passively resistant, she is generally not oppositional. Unlike many children who lack attachments, she does not engage in anti-social behavior. She is willing, even happy, to abide by most rules for good behavior. If adequately motivated, she makes an effort to perform well even in areas she does not particularly enjoy.

Based upon this pattern, the ideal living situation for Maria should de-emphasize interpersonal bonds. Caregivers should initially have very low expectations for affiliative behavior and may do well to keep the relationship somewhat formal, allowing Maria to develop an attachment at her own speed. Her caregivers should not be detached, but rather should be capable of maintaining affection for Maria even when Maria shows little affection in return. By reducing expectations for attachment, Maria may feel less threatened and paradoxically more capable of forming bonds. Her caregiver's level of formality can decrease when or if Maria initiates a greater level of affection. Naturally, the ultimate goal is for Maria to develop both a strong attachment to her caregivers and the ability to form solid relationships with others throughout her lifetime.

Maria will not benefit from therapy specifically targeting attachment. Instead, she and her caregivers should have access to a skilled therapist who can assist the family in moderating their frustrations and in creating a traditional behavior management regimen. An effort should be made to teach Maria appropriate behavior in a home setting by outlining explicit expectations for behavior and administering specific rewards and consequences based upon Maria's performance. For example, Maria might earn points or tokens for doing chores as specified and completing individual hygiene tasks. In addition, because Maria appears to have good intuition about behaviors that other people value, it would be reasonable for caregivers to be prepared to give her

unanticipated rewards for spontaneous pro-social behavior such as not interrupting at the dinner table or helping out in the household without being asked. A skilled therapist will be useful to Maria and her caregivers in designing and regularly updating a behavior modification plan. In her current setting, Maria's misbehavior is viewed as a personal failing or an attack against the family. Under a behavior modification plan, her misbehavior can be handled in a less personal, matter-of-fact manner. Similarly, a behavior modification plan can be strength-based, rewarding Maria for doing tasks well rather than finding fault with her for doing them poorly.

In spite of her difficulties within several families, Maria displays many strengths and talents. Outside of the family setting, Maria maintains a range of social relationships which are beneficial to her. At school, she is well-regarded by teachers and fellow students. A variety of people involved in her case describe Maria in affectionate terms. She is doing well in school despite many early set-backs. All of these strengths should be developed and encouraged in years to come.

Academically, Maria is working at grade level in all areas except for math. In light of Maria's history, this average performance is exceptional. It is important that Maria's academic success be encouraged and celebrated because school success has the potential to shield Maria from many difficulties in the future. Continued engagement with academic settings through high school and into college offers Maria a non-threatening source of affiliation, concrete achievements upon which she can build her self-esteem, and the opportunity for material reward. Several steps should be taken to promote Maria's school success. First, her math ability should be tested and any deficits should be addressed. Her current school plans to do this, but if Maria moves to a new school district, DCFS and caregivers may need to advocate for this. Second, Maria should be encouraged to engage fully at school, not only academically but in extracurricular activities. Because Maria may have difficulty with relationships that have a lot of depth, it would be sensible to encourage Maria to build relationships around shared activities or interests such as sports, volunteer opportunities, crafts or games. As noted above, increasing the depth of her emotional connections to others is a good goal for Maria both in therapy and in the skills her caregivers focus on developing.

Maria has directly and indirectly expressed interest in knowing more about her Latina heritage. It would be beneficial for Maria's caregivers to continue efforts in this area. Some actions that might be taken include observing Mexican or Hispanic holidays and customs in the home, building social connections with other Latino families, and encouraging Maria to study Spanish at school.

RECOMMENDATIONS

Recommendations are a brief summary of your most important impressions. Do not include additional details that were not discussed in the Impressions section. Keep the number of recommendations low (typically 3-4), keep them realistic, and ensure that they are directly tied to the identified problem or need (i.e.: wellbeing or permanency). The action plan and follow-up activities should be developed from the recommendations. It is important not to recommend specific treatment centers or providers in this section, but instead specifically describe what interventions will improve the child/caregiver's functioning. Specific agencies and providers should be discussed and decided upon during follow up meetings/conversations with the DCFS Social Worker.

Example

1. Seek a new permanent placement. Potential caregivers should be able to maintain a behavior modification program, be able to tolerate a relationship in which Maria shows little true affection, be willing to actively support Maria's academic and social development, and be available to participate in Maria's therapy.
2. Appropriate therapeutic goals include the development and maintenance of a behavior modification program and the provision of support to caregivers to decrease the frustrations they may encounter in caring for Maria.
3. Ensure that Maria's academic needs are met through further testing and support for her math abilities and encouragement to participate in school activities.