

Section 3 Overview

This section focuses on the actual delivery of treatment services to the family. The information in this section will assist staff in understanding procedures used throughout the entire service delivery process, from opening to termination. Including other professionals in the service delivery process is often vital for improved family functioning. This section will provide procedures for accessing and utilizing contracted services. Another important aspect of the service delivery process includes case evaluation and clinical supervision. Information pertaining to these topics can also be found in this section.

Chapter 3 Overview

This chapter covers information pertaining to conducting family assessments for Family-Centered Service (FCS) and Family-Centered Out-of-Home Care (FCOOHC) Cases. The **NCFAS G+R and attachments** are used in both FCS and FCOOHC cases and is essentially the same process. FCOOHC cases also utilize the **Child Assessment and Service Plan, CS-1**, which is specific to each child in out-of-home care. This chapter will focus on the assessment of the family.

Additionally, this chapter will describe the procedures for assisting a family in developing a Written Service Agreement.

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3.1 Family-Centered Service Assessment

The Family-Centered Services assessment is integral in determining appropriate services for intact families with open FCS Cases or with families of children in out-of-home care. Accurate, comprehensive assessments that engage the family lead to service plans that appropriately address the family's needs.

The Family-Centered Services assessment is defined **as an on-going process which evaluates and identifies the current level of family functioning, the current risk to the child(ren) and the family strengths and service needs.**

The Children's Service Worker will use the NCFAS G+R and attachments to complete the FCS Family Assessment. These tools are designed to assist staff in conducting thorough and comprehensive assessments of:

- Family history
- Child safety
- Family structure and functioning
- Family strengths and supports
- The family's level of risk for future child maltreatment and
- The family's need for services

A good family assessment should lead directly to a meaningful treatment plan designed to reduce risk of future child maltreatment and to promote and maintain positive change in family functioning.

3.1.1 Philosophical Considerations

Family-Centered Services seek to empower the family and minimize its dependence upon the social service system. The Family-Centered Services assessment is an integral part of this approach.

The conceptual framework from which a Family-Centered Services assessment is conducted greatly influences the type of intervention and thereby affects treatment. When successfully implemented, a Family-Centered Services assessment will actively involve the family and serve as a means to engage them in treatment. In addition, it will assist in building mutual trust and respect between the family and Children's Service Worker.

It is important the Children's Service Worker embrace certain basic beliefs and convey certain attitudes in his/her initial and subsequent contacts with the family. Some of these basic beliefs are:

- Problems that affect individuals are usually symptoms of other underlying problems within the family system. From this viewpoint, the problem is not within the individual, but a result of dysfunctional relationships between individuals
- Blaming an individual is essentially counter-productive. It does not reflect the goal of strengthening the entire family system. More than one person usually contributes to the presenting problems
- Eliciting family participation in an assessment process enhances the likelihood of case success. Families are the most knowledgeable source about themselves. Involving them in the process signals empowerment and allows them to identify their own needs. Their input may provide new insight into the situation and offset the Children's Service Worker's pre-conceived notions
- The assessment should focus upon family strengths as well as needs. Acknowledging family strengths can help the worker and the family to identify areas of hope and opportunity for the family which will in turn empower and engage the family in the treatment development process.

3.1.2 Children's Services Worker's Personal Framework

Before approaching an assessment of a family it is important for workers to recognize their own personal history, belief system and frame of reference. Throughout the assessment the worker should consider the following questions:

- How is my personal bias influencing the family assessment?
- Are "labels" influencing the family assessment?
- Have I considered the family's cultural background?
- What evidence supports my conclusions?
- What evidence disputes my conclusions?

3.1.3 Case Assignment

The supervisor shall assign cases opened from CA/N reports or CA/N referrals within one (1) working day of the CA/N investigation/family assessment conclusion or receipt of the case from the CA/N Investigation Unit/worker.

3.1.4 Priority of Initial Client Contact After a Case Opening Based on SDM Risk

The supervisor assigning the open case will determine the priority of initial contact based on the most recent SDM risk assessment. This will determine the timeframe of the initial face to face interview with the family by the assigned Family Centered Services (FCS) worker based on the following SDM risk levels:

- High or Very High Risk - within one (1) working day
- Moderate Risk - within five (5) working days and
- Low Risk - within ten (10) working days.

If the FCS case referral was not due to a CA/N investigation/family assessment, the supervisor's appraisal of the potential risk to the children and overall family situation will determine when treatment follow-up contact by the FCS worker is needed. **This Should Not Exceed Ten (10) Working Days From Case Assignment.**

3.1.5 Minimum Contact Standard for In-Home Cases

The Family Risk Assessment provides reliable, valid information on the risk to children of continued abuse and neglect. Appropriate use of this assessment data is key to ensuring better protection of children. Therefore, for cases that have been opened for ongoing services, the risk level is used to guide the minimum amount of contact with the family each month. These guidelines are considered "best practice" and help focus staff resources on the highest risk cases.

These guidelines apply to families where children are in the home, and reflect the minimum number of face-to-face and collateral contacts with the family each month. Workers should use judgment in each case to best determine whether more contacts are needed. The definition and purpose of a face-to-face "contact" is to monitor developments in the case, to observe interaction between the caregiver and the child(ren) in the family home, to assure the safety of the child in the home, to facilitate implementation of the Case Plan, and to assess progress with the plan.

The Family Case Contact Guidelines provide a recommendation regarding the minimum number of contacts the worker should have with the family based on

the assessed risk level. It is used to guide monthly contacts while the case is open, and is reviewed at each risk reassessment until the case is closed.

The risk level determines the overall minimum contact standards for the family. The “Children’s Division Minimum Contact Standards” represent how many of the overall contact standards must be met by the CD worker. The remaining contacts may be met by a contracted **in-home** service provider who is working with the family as part of the family’s case plan. However, if the contracted service provider was unable to complete monthly contacts, the CD worker is responsible for meeting the overall contact standards. Face to face contact by the CD worker should occur in the family’s home. The Parental Home Visit Checklist (form CD-83) should be utilized during these contacts.

The CD worker is responsible for making all collateral contacts. Collateral contacts include face to face contact, phone contact, and e-mail correspondence. When corresponding via e-mail to individuals not employed by the State of Missouri, staff should encrypt all outgoing messages which contain protected health and identifying information. In addition, staff should communicate with collateral contacts using the initials of the individual being discussed to ensure privacy and ask the collateral contact to do the same.

Possible collateral contacts may include, but not limited to:

- School professionals/School liaison (teacher, counselor, Principal, school nurse)
- Therapist/Counselor
- Parent’s as Teachers Coordinator
- Child Care personnel
- Parent Aide
- Physician or other health care professional
- Neighbor
- Extended family member(s) not in the household

“Minimum Contact Guidelines for In-Home Family Cases” refers to the time period after a CA/N report conclusion/delayed conclusion has been made or FCS Cases or for FCOOHC cases where children are in the home and represents the recommended number of contacts that workers should have with families according to their assessed risk level.(likelihood of future maltreatment)

Risk Level	Minimum Contact Guidelines for CD	Overall Contact Guidelines for FCS Case
	CD Staff are required to meet these requirements. The remaining contacts for the overall contact guidelines may be met by a contracted in-home service provider who is working with the family as part of the family's case plan. However, if the contracted service provider was unable to complete monthly contacts, the CD worker is responsible for meeting the overall contact standards. Face to face contact by the CD worker should occur in the family's home.	Overall contact by CD staff and other in home Service Providers. If in home Service Provider does not make the one face to face contact above CD standards listed in Minimum Contact column, then CD is responsible for making the additional contact.
Very High	2 face to face per month and 3 collateral contacts per month	3 face to face contacts per month
High	1 face to face per month and 3 collateral contacts per month	2 face to face contacts per month
Moderate	1 face to face per month and 2 collateral contacts per month	1 face to face contact per month
Low	1 face to face per month and 1 collateral contact per month	1 face to face contact per month

For minimum contact standards after a CA/N report conclusion date or delayed conclusion date see:

Related Subject: Section 2, Chapter 5.3.17 [Minimum Contact Standards After A CA/N Report has been Concluded](#) and Section 2. Chapter 5.3.18.1 [Minimum Contact Standards for Delayed Conclusions](#)

For FCOOHC cases, where there are no children in the home, to determine the frequency of worker visits with parent/caretaker see:

Related Subject: Section 4, Chapter 7.3.1 [Meeting and Working with the Family](#)

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3.2 Completion of the Family-Centered Services Assessment Process

- **The entire FCS assessment process will be completed within thirty (30) days from the date the case is assigned to the completion of the Written Service Agreement.** This will include, at minimum, the completion of the NCFAS G+R (intake fields), Genogram, CD-14-G, Culturagram, CD-14F, Safety Assessment, CD-17, and Risk Assessment, if not completed with a hotline and Written Service Agreement ,CD-14B. The assessment should be updated when necessary throughout the treatment plan process.

3.2.1 Tools for Completing an FCS Family Assessment

The NCFAS G+R and attachments are comprised of the following tools:

- NCFAS G+R (intake, interim, and closure fields)
- CD-17- Safety Assessment
- CD-18 - Safety Plan (if required)
- Risk Assessment or CS-16E - Re-assessment
- CD-14B – Written Service Agreement
- CD-14C – Formal/Informal Provider Contact Sheet or Resource Service Log in FACES
- CD-14D – Termination of Services/Aftercare Plan
- CD-14F – Culturagram
- CD14G – Genogram
- CD-14H – Ecomap (optional tool)

3.2.2 Identifying Formal/Informal Provider History

A review of formal/informal providers and supports can be very useful in assessing the family's current situation and identifying resources for the treatment plan development.

The *Formal/Informal Provider Contact Sheet (CD-14C)* or the *Resource Service Log in FACES* should be a running document that can be attached to the front of the case file. It can be used as a reference when a family has multiple open cases. The worker should be documenting resources available to

the family or providers involved with the family currently or in the past. This is a running list of informal providers the family has identified such as relatives or neighbors; or training, counseling or rehabilitation history the family has attempted or completed.

3.2.3 Case Identifying Information and Household Members

The Children's Service Worker shall document household member information on the Family-Centered Services Information screen in FACES.

3.2.4 Identifying Children with American Indian Heritage

The worker will identify American Indian Heritage for children listed on the report, including the specific tribe. This information is documented by the family using the Indian Ancestry Questionnaire, CD-116, within 24 hours of case opening. The Children's Service Worker then uses the Indian Child Welfare Act Checklist, CD-123, to collect and document findings as required by the Indian Child Welfare Act, ICWA. The CD-116 and CD-123 should be maintained in the child's section of the case record. Any initial American Indian heritage obtained should be documented in the opening summary. Follow up information should be documented in the monthly summaries.

3.2.5 History with the Agency

Prior to making contact with the family the worker should document in the narrative a brief description of prior reports of abuse/neglect, as well as a summary of concerns identified in unsubstantiated reports. Due to expungement criteria for **unsubstantiated reports, incident numbers will NOT** be listed. Workers should use such phrases as "**Concerns have been identified in the past that include.**", rather than stating "These concerns were from prior reports" in their documentation.

3.2.6 Reason for CD Involvement

To help track the case history, the Children's Service Worker shall identify its origin, i.e. whether from a CA/N investigation, initial Family Assessment, self-referral, court order, etc. This should not be a definition of the problem, but rather how the Division became involved with the family. The worker should document the findings in the case opening summary.

Other agencies and community systems which were involved with the family immediately prior to, or during, the referral process should also be listed.

Enter additional information provided by the reporter or other collateral. A brief description of prior reports of child abuse/neglect should also be given, including a summary of concerns identified in unsubstantiated reports.

Due to expungement criteria for unsubstantiated reports and reports substantiated prior to August 28, 1999, the incident numbers will not be listed here. Phrases such as “Concerns have been confirmed in the past that include...”, rather than stating these concerns were from prior reports.

3.2.7 Family’s Perception of CD Involvement

The Children’s Service Worker shall allow all family members to state their opinions about the presenting (and underlying) problems. Encouraging this ventilation of opinions signals respect of the family and the importance of their cooperation. The Children’s Service Worker should key into who is being blamed for the family discord and how the family perceives its relationship to outside systems. The worker will document in the narrative the family’s perception/relationship toward CD involvement. (Example: family was hostile/cooperative or family considers CD an asset/intrusive/indifferent...etc.)

3.2.8 Assessment of Safety

Assessment of child safety is always a primary concern of the division and whether the workers are formally or informally assessing the child’s safety, assessment continues throughout the life of the case. Workers should always be alert to changes in the family circumstances or household composition that pose a threat to the safety of the child. If changes in circumstances cause concern for the safety of a child formal safety assessment using the CD-17 should be completed.

The CD-17 results in a safety decision of “safe” or “unsafe”. If the safety decision is “unsafe” a Safety Plan, CD-18, is required.

A safety plan is a written, mutually agreed upon, arrangement between the worker and the family that establishes how threats of danger to child safety will be managed.

Safety interventions utilized in a safety plan may be seen on a continuum from least intrusive (such as in-home interventions that utilize the family’s own resources) to most intrusive (such as out-of-home placement). Workers will utilize the least intrusive interventions that will assure the child is safe.

Related Subject: Section 2, Chapter 9.2, [Assessment of Safety](#) and Section 2, Chapter 9.3 [Safety Planning](#)

3.2.9 Description of Family System

The comprehensive assessment includes family-centered services tools for engaging and diagramming families, such as the **genogram and the culturagram**. The purpose of the culturagram is to help staff recognize the cultural differences between families. Culture is the thoughts, ideas, behavior patterns, customs, values, skills, language, and religion a person holds. The purpose of the genogram is to gain information regarding the structure and history of the family/household.

By using the various methods of diagramming, the Children's Service Worker and family may learn something about the relationships within the family, the location of the family's boundaries, and the variety and quality of the family's connections to outside systems. In addition to assessment, the use of these diagramming methods may be useful as:

- Helpful additions to the case recording, since they give a clear quick view of the family, and
- Tools for organizing information to assist in the case planning and preparation for services.

Engagement and relationship building is of central importance in gathering meaningful information from families, children, and youth regarding their needs and strengths and essential for achieving safety, permanence and well-being for children. Staff are to encourage and work with parents to be cooperative and engaging of the non-resident or non-custodial parent as appropriate in preserving the best interest and safety of their child/ren. Involving a non-custodial or non-resident parent may be beneficial as:

- A child's identity is strongly influenced by his or her family. Encouraging the engagement of a non-custodial or non-resident parent may introduce a child to members of his or her family previously unknown or uninvolved.
- A non-custodial or non-resident parent may provide valuable family history or health information.
- Essential family information will be gathered should the need for future alternative care placement arise.
- The non-custodial or non-resident parent may have relatives who are willing to be involved in a supportive role to the family as part of the FCS case, and

- Children may benefit from their parent's social security benefits or inheritance.

Children's Division staff have the responsibility to preserve confidentiality in these voluntary cases; however, for successful treatment services, families are to be encouraged to engage the non-custodial or non-resident parent as appropriate in preserving the best interest and safety of their child/ren. The client with the open FCS case should be reminded that any biological parent of child/ren involved in the FCS treatment case has the right to access the case record, provided they only receive information regarding the child.

3.2.10 Study of the Presenting Problem (Optional Techniques)

It is often useful for the Children's Service Worker to study the family's presenting problem. The presenting problem is usually the behavior that brought the family to the attention of the Division.

Timelines - Used to identify "critical events" experienced by the family. By plotting these events on a linear line, this method can help determine the onset of the presenting problem, what was going on before and after the onset.

Ecomap – Is completed to map the family system and its relationships with individuals and systems outside the family. Family systems may include recreation, faith/cultural, social/community, court system, housing, healthcare, employment, school/education, extended family, friends or other sources for family support not named. The ecomap will include important nurturing or conflictual connections between the family and environment. It also demonstrates the flow of resources, as well as resources the family needs that are conflictual or non-existent.

"Sequences of behavior" - This technique allows the Children's Service Worker and family to see how the presenting problem is embedded in sequences of family behaviors. It can help gain insight into how these repetitious sequences serve an underlying purpose for the family and assist the worker and the family in identifying appropriate points of intervention to interrupt dysfunctional patterns.

3.2.11 Assessment of Risk

The SDM risk assessment tools are only used for families in which there are children in the home.

By completing the risk assessment, the worker obtains an objective appraisal of the likelihood a family will maltreat their children in the next 18 to 24 months. The difference between risk levels is substantial. High risk families have

significantly higher rates of subsequent referral and substantiation than low risk families, and are more often involved in serious abuse or neglect incidents.

When risk is clearly defined and objectively quantified the agency can ensure that resources are targeted to higher risk families in order to enhance the caregiver's capacity to protect their children from threats of danger and to lessen the families need for outside intervention.

3.2.12 Collaterals

Through the family assessment approach collateral contacts are used to gain information regarding the family's strengths, needs, and overall supports. Collateral contacts include face to face contact, phone contact, and e-mail correspondence. When corresponding via e-mail to individuals not employed by the State of Missouri, staff should encrypt all outgoing messages which contain protected health and identifying information. In addition, staff should communicate with collateral contacts using the initials of the individual being discussed to ensure privacy and ask the collateral contact to do the same.

It may be necessary to contact collaterals to verify information that is provided by the family. Information obtained from collaterals may contradict the family's account of the presenting problems. Inconsistencies may not be intentional lies by the family but merely their understanding or version of reality and should be viewed as such.

In addition to providing the worker and the family with differing perspectives on the strengths and needs of the family, collateral contacts also assist the worker in meeting minimum contact standards as well alerting the worker to changes in the family dynamics that may give the worker cause for concern.

The purpose of the collateral contact is to provide staff with information concerning, but not limited to, the following:

- To locate the family if the family is not home
- Child's safety, health and well-being
- Assessment of child's vulnerability
- Parenting/disciplining techniques
- Parent/child interaction
- Assessment history of the caregiver demonstrating sufficient caregiver protective capacity

- Household condition
- Additional household members
- Changes in child's/parent's behavior
- Current/potential supports for the family

Collateral contacts shall correlate with the area of concern. Staff should thoughtfully choose collateral contacts from among those people who have enough contact with the family and/or child to give pertinent information. This collateral contact should be able to address a particular concern.

For example, if the FCS case is opened on a family due to an injury or medical condition, collateral contacts may include, but not be limited to: a professional health care provider or a close family member or a neighbor who has information related to the injury/medical condition.

Possible collateral contacts may include, but not limited to:

- School professionals/School liaison (teacher, counselor, Principal, school nurse)
- Therapist/Counselor
- Parent's as Teachers Coordinator
- Child Care personnel
- Parent Aide
- Physician or other health care professional
- Neighbor
- Extended family member(s) not in the household

The Children's Service Worker shall exercise professional judgment in the selection of information sources. To protect the family's right to privacy and the confidentiality of the case use the Authorization for Release of Medical/Health Information, SS-6, when necessary.

Supervisors must assure that staff has contacted collaterals as required, and that the information provided by collateral sources has been given appropriate consideration.

Related Subject: Section 3, Chapter 3.1 [Minimum Contact Standards for In-Home Cases](#)

3.2.13 Assessment of Family Functioning

The *NCFAS G+R* is designed to assist staff in conducting a thorough and comprehensive assessment of family's history, structure and functioning, identifying protective capacities and child vulnerabilities. A comprehensive assessment should be completed on each open family case.

The *NFCAS G+R* measures change over a period of time. A key indicator in reunification or case closure is whether or not the family has made the changes necessary to remedy child abuse or neglect. The *NCFAS G+R* has a readiness for reunification domain which allows staff to quickly determine whether reunification or case closure should occur. The evidence based tool utilizes a six-point scale ranging from clear strength to serious problem and allows staff to calculate an overall domain score. The tool also allows staff to choose whether the item is not applicable or unknown. A comprehensive assessment of the family should be conducted to aid in the development of the case plan.

Workers may draw from the following methods of collection to rate family function items addressed on the *NCFAS G+R*:

- Direct interview of family members individually and/or together
- Information collected from family members through activities such as drawing genograms and ecomaps,
- Personal observation of the family members and their interactions at home or in the community,
- Examining written materials such as case records, school reports, etc.,
- Collateral contacts with other agencies or individuals involved with the family, and
- Referring the family members for an evaluation by a qualified examiner

The worker may use the *NCFAS G+R* to compile and organize information that was previously collected, or use it as a reference tool when working directly with

the family. The NCFAS G+R provides a systematic and comprehensive way to address significant areas of family functioning that have direct impact on the caregiver's capacity to protect their children from threats of danger which in turn will reduce the probability for future occurrences of child maltreatment.

The NCFAS G+R addresses family functioning under general domains (Environment, Parental Capabilities, Family Interactions, Family Safety, Child Well-Being, Caregiver/Child Ambivalence, Readiness for Reunification, Social/Community Life, Self-Sufficiency, and Family Health). Sub-scales are addressed under each domain.

3.2.13.1 Discrepancies in Family Functioning Ratings

Staff may find that what the worker considers a serious problem in a particular sub-scale may be considered by the family to have no impact or to be a strength. Differing opinions with regards a particular sub-scale can provide an excellent opportunity for discussion and may ultimately lead to the discovery of underlying causes to dysfunctional behavior.

Ratings for sub-scales may also differ from worker to worker or between worker and supervisor. If the case is transferred from one worker to another, the newly assigned worker should conduct an interim assessment within 30 days of case assignment.

3.2.14 Family Strengths and Competencies

No assessment is complete without a thorough evaluation of a family's strengths, protective capacities, and accomplishments.

Sometimes it is easy to become so problem-oriented that the Children's Service Worker and family fail to recognize what the family is already doing well. Children's Service Workers should look for, and acknowledge, the strengths observed within the family members and system. This should be done in an ongoing manner. Often these strengths have been over-looked or hidden. Operating from this perspective inspires hope, reinforces the family's own problem-solving, and encourages family empowerment. The identified strengths and protective capacities of caregivers provide areas for the Children's Service Worker and family to build upon in the treatment plan.

3.2.14.1 Relabeling

One way to help identify family strengths is through relabeling (sometimes called reframing). Relabeling is a process in which a person's point of view is changed, usually from a negative to a more positive viewpoint.

Relabeling is done by identifying and describing behavior from a different perspective and by recognizing that most things can be seen legitimately in at least two ways. We all experience reality differently; what we say about something reflects our attitudes and feelings about it. By altering the meaning we attribute to a behavior, one can change the person's perspective and his/her responses to the behavior.

For instance, a father's hostile or resistive behavior toward the Children's Service Worker could be relabeled as his protectiveness of his family. By recognizing the protectiveness, the Children's Service Worker may be more apt to elicit cooperation. A child who is said to be argumentative could be relabeled as independent and a free-thinker. Once the behavior is relabeled, his/her parents may react differently to the child's behavior.

The Children's Service Worker is cautioned not to relabel abusive behavior. This could be perceived as acknowledgment that abusive behavior is acceptable and it may minimize the perpetrator's responsibility for the abuse.

3.2.14.2 Guidelines to Formulate a Relabeling Statement:

- Identify the individual's behavior that is to be relabeled. This is usually a behavior that, when described, carries a negative connotation.
- Relabel the behavior by identifying a way it can be perceived as helping the family. The relabeling statement should contain a "ring of truth" and build upon the idea that most things can be legitimately seen at least two ways.
- Inquire into how the individual's behavior impacts upon other family members and how they usually respond to the behavior.
- Tie the relabeling statement of the individual's behavior to the family system. Once the individual's behavior is relabeled, consider how the family interactions that surround the identified behavior could now be looked at differently. Relabel the interactions in such a way that the family members could react and interact differently.
- Decide if the family will perceive the relabel as helpful, and if they will accept it. The family should be able to feel support and view themselves differently, and

- Present the relabeled behavior or action and reframe in a tentative manner (i.e., "I wonder if...", or "Have you considered that...").

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3.3 Developing a Written Service Agreement

3.3.1 Definition and Policy Requirement

A Written Service Agreement is the written working agreement between the family and the Children's Service Worker. It documents what each party agrees is required to address the family's service needs. The service needs are identified during the family assessment process.

The entire family assessment and case planning process will be completed within thirty (30) days from case assignment.

3.3.2 Purpose of the Written Service Agreement

- To provide overall structure and direction to the casework process
- To document the family's willingness to participate in treatment services and the Division's willingness to assist by providing services
- To provide an instrument to evaluate case progress and accountability of participants and
- To document the required reasonable efforts on behalf of the Division to prevent the out-of-home placement of children.

3.3.3 Components of Written Service Agreement

It is essential that the plan of the family be specific about:

- **What** the family and Children's Service Worker hope to accomplish during the treatment process (**Treatment Goals**)
- **How** the family and Children's Service Worker intend to accomplish the defined goals (**Tasks**) and
- **When** the tasks will be performed and completed (**Time Limitations**).

The main components of the Written Service Agreement are identified as:

Treatment Goals which identify what the family is to accomplish in the time-limited treatment process; and,

Tasks which the family members and the agency will do to help the family reach the treatment goals.

3.3.4 Written Service Agreement Development

The language in the plan shall be clear and understandable to all family members. The plan must be written in simple, behaviorally specific, descriptive terms.

Below are five (5) steps that are important in developing an effective Written Service Agreement with the family:

1. The Children's Service Worker shall actively involve the family in the planning process. As in the family assessment process, the Written Service Agreement is developed **with** the family, not for them. Family involvement serves to:
 - Facilitate the development of a therapeutic alliance between the family and Children's Service Worker. It provides evidence that the feelings and concerns of the family have been heard and considered
 - Promote the investment of the entire family in the treatment process. People who are involved are more likely to change
 - Empower parents to take the necessary actions to change dysfunctional behavior patterns and
 - Help ensure that the Children's Service Worker and family are working toward the same goals.

Initially, the family and Children's Service Worker may have differing perspectives on the reasons for the Division's intervention. The Children's Service Worker's active efforts to involve all family members in the assessment and planning process are essential in overcoming these obstacles.

2. The Children's Service Worker and family shall select reasonable and achievable goals and tasks that address identified risk factors. Important points to consider when selecting goals and tasks are:
 - Goals and tasks should be measurable and time-limited. Behaviors which can be measured by frequency within certain time frames will enable the Children's Service Worker and family to evaluate progress
 - Goals and tasks should be behaviorally stated so that the family and Children's Service Worker know when change has occurred

- Goals and tasks should be phrased in a positive manner. They should specify what change needs to take place, not what should be stopped
 - Goals and tasks should be phrased in a clear and understandable language
 - Tasks should be very specific. The family members should know exactly what has to be done within the specified time frame and
 - Initial tasks should be meaningful to the person or family. They should be achievable in a two (2) to four (4) week period. These tasks should be viewed as a need and a priority by the family member(s).
3. The Children's Service Worker shall address the relevant needs that impact the caregiver's capacity to be protective. The family's strengths and resources are to be considered when determining the tasks needed to achieve treatment goals. The Children's Service Worker should
- Focus on diminished caregiver protective capacities (thinking, feeling and behaving) that impacts family functioning and increases the probability of future maltreatment
 - Consider the environmental and other influences upon the family. Start where the family members are and help them select goals which can realistically be achieved in the time frame and
 - Recognize and reinforce family efforts and history of being protective. Acknowledge their achievements.
4. The Children's Service Worker shall be able to document what all participants in the plan will do and when. Therefore, the plan should:
- Describe what family members, the Children's Service Worker, and any other service provider will do and
 - Identify time frames for accomplishing each task and the overall treatment goals. Treatment plans must not exceed 90 days.
5. The participants (the Children's Service Worker, family, and service providers) shall decide how they will determine achievements and goal attainment. The Children's Service Worker should

- Specify when the plan will be reviewed. This review will include the Children's Service Worker and the family members. It will evaluate case progress and the need for plan revision and
- Confer regularly with any service provider. Agree on a method of ongoing communication to evaluate the effectiveness of the services of the provider to the family. (Marsha Salus, 1988)

3.3.5 Treatment Goals

Treatment goals are statements of what the Children's Service Worker and family intend to accomplish during the treatment process. Establishing sound treatment goals requires the Children's Service Worker and family to have a common understanding of what needs to be accomplished to enhance the caregiver's protective capacity and improve family functioning. These goals must relate to the reasons for family dysfunction identified in the family assessment. They will identify what the family will be doing differently when change occurs.

Usually the family assessment will indicate several critical areas, or underlying problems, for casework intervention. Focusing upon the underlying problems requires the Children's Service Worker and family to establish desired outcomes that will improve family functioning. The desired outcome(s) of the casework intervention is stated in the treatment goal. The treatment goals are written on the Written Service Agreement and serve as a "roadmap" for the Division's intervention with the family.

Achievement of the goals should enhance the caregiver's capacity to protect the children from threats of danger and improve family functioning which will in turn reduce risk of future child maltreatment. When the caregiver's protective capacity is enhanced and the need for outside intervention is reduced case closure is considered.

Goals may reflect both direct and indirect interventions:

- **Direct interventions** address the presenting problem directly. In a more permanent way than a safety plan, direct interventions address behaviors that create immediate safety issues.
- **Indirect interventions** address the behaviors and circumstances that may be contributing to the presenting problem. Indirect interventions can be identified through the use of sequencing behaviors technique and by determining the function of the presenting problem (symptom).

3.3.6 Family Involvement in Goal Development

The following steps may be helpful in setting behaviorally specific goals and tasks with the family

1. As the family responds to the questions in the preceding section, the problem is defined more explicitly. The goals that will tell the Children's Service Worker and family that the problem has been (or how it will be) resolved are discovered
2. Develop the goal to meet the following criteria. It should
 - Focus on child vulnerability, how threats of danger operate within the family system and diminished caregiver protective capacities (thinking, feeling and behaving)
 - Describe what the family will be doing differently when change occurs
 - Use the client's definition of the problem, whenever possible
 - Be achievable
 - Phrased positively, such as "Mrs. J. will..," rather than "Mrs. Jones will not...." If people are asked to give up a behavior, an alternative behavior that meets the underlying need should be identified and
 - Identify increments of change, whenever possible, so the Children's Service Worker and family can monitor progress. Using increments may not be appropriate with goals that directly address physical and sexual abuse, and other immediate safety issues.
3. Brainstorm with the family about what action, steps, or tasks, will be necessary to achieve the goal(s) and
4. Assist the family in the provider selection process to meet the treatment goals.

3.3.7 Writing Goals

The specified goals should be

- Clearly phrased in a manner that is concise and understandable by the family
- Written in behaviorally specific terms and identify what the family will be doing differently when change occurs. Goals should not be defined as services. For instance, rather than having a goal identified as "Mrs. Jones will attend parenting classes," the goal should focus on what needs to be achieved by her attendance at parenting classes
- Measurable and time-limited. Behaviors which can be measured by frequency within certain time frames will enable the Children's Service Worker and family to evaluate progress
- Realistically obtainable and recognize minimally acceptable expectations and standards and
- Mutually agreed upon by the Children's Service Worker and family. The skills of the Children's Service Worker must be utilized to set goals **with** the family and not for them.

3.3.8 Identifying Increments of Change

When possible, goals should identify increments of change to allow the family and the Children's Service Worker to see that change is beginning to occur. Using increments may not be possible with goals that directly address physical and sexual abuse, and other immediate safety issues.

For example, an 18-month old child is left alone several times throughout the week. We cannot establish a direct goal to eliminate the lack of supervision incrementally (i.e., the child is left alone only one day per week). A toddler cannot be left alone for any amount of time; change must occur rapidly to ensure the child's safety. The necessary change to ensure the child's safety will be a direct goal that addresses the presenting problem and will be behaviorally specific. Indirect goals, to address contributing and underlying factors, may be used in conjunction with the direct goal. Indirect goals may be written incrementally and will also be behaviorally specific.

The timeframes for the goals may vary. The time frames may be written into the goal itself, or specified in the time limit section of the CD-14B. Also, more than one CD-14B may be used in a treatment period to allow for goals of differing time frames.

Short-term goals will be more easily and quickly obtainable. They provide the family some measure of success within a brief period of time. Long-term goals will require a longer period of time. Generally, they are more difficult and will

require more consistent effort on the part of the family. Subsequent treatment periods which build upon previous successes, may be required for accomplishment of long-term goals. Accomplishing long-term goals should result in the achievement by the family of a minimal level of functioning.

3.3.9 Prioritizing Goals

A large number of goals on the Written Service Agreement will overwhelm the family. Generally, there should be no more than two (2) goals written on the Written Service Agreement at any one time. This allows the family to focus upon one or two critical issues, build upon success and move on. Because of this, it is important for the Children's Service Worker to fully explain the rationale for limiting the number of goals on the treatment plan. Questions to ask the family in order to help them process and prioritize goals are:

- If this need is not attended to, what will happen?
- Does this need impact safety?
- How much and how often does this need bother you?
- Is there a time limit to this need?

It is important also that the Children's Service Worker clearly identifies goals and issues that cannot, or should not, be pursued at the present time. He/She should explain that there may be other identified treatment goals if it appears that more than one treatment period will be necessary. Furthermore, more than one CD-14B may be used within a treatment period to cover all the goals that need to be addressed. Identifying the most critical treatment goals with the family, then planning the order in which each goal will be addressed, should help the family work through the treatment plan.

By establishing goals related directly to an underlying problem and selecting the easiest goals first, the Children's Service Worker and family can help facilitate a successful plan.

3.3.10 Use of the Scaling Technique

Scaling is a useful method to create specificity in goals and identify increments of change. Numbers, from 1 to 10, are used to describe a person's behavior, the frequency of behavior, or a person's feelings.

On a scale from 1 to 10, with 1 being never and 10 being constant, we ask the person to pick a number to describe how often the behavior currently occurs. Once this is, you can determine a number representing the progress they would

like to make within a specified timeframe. This becomes a marker, or increment of change. Once this increment is reached, additional increments, or scaling numbers, can be set and reached.

3.3.11 Treatment Tasks

To achieve a treatment goal(s), the Children's Service Worker and family must identify tasks that, when completed, will achieve the specific goal(s). Tasks can be specified for the family unit, an individual, Children's Service Worker, or other provider or resource.

The Children's Service Worker must take care not to overwhelm the family with tasks. The number of tasks for the Children's Service Worker and the family should be roughly the same. The tasks of the Children's Service Worker should complement the tasks of the family. They should encourage family empowerment and enhance the family's ability to solve problems. To help prevent failure, family tasks should take into account the following:

- The cognitive and social abilities of the family members
- The family's level of cooperation and motivation
- The ability and willingness of the family to use community resources and
- Practical limitations, such as transportation.

3.3.12 Time Limits

Time limits must be included in the plan. Recognizing that families have a right to be free of unnecessary interference, Division intervention should not be open-ended.

The Written Service Agreement, CD14B, is used to document the case goals in addition to what the family, Children's Service Worker, and others will do to accomplish the case goals during the 90 day period. **In some instances, it may be beneficial to use more than one CD-14B during this 90 - day period.** A formal evaluation of the case is required by the Children's Service Worker and supervisor at the end of the treatment period.

Time limits are needed to evaluate the success of the specific goals and tasks. They help the Children's Service Worker and family to measure progress on an ongoing basis and help prevent the family from being overwhelmed. Measuring progress in time increments make goal attainment more manageable. More than one CD-14B may be used in a treatment period to allow for goals of differing time frames.

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It is important not to mislead the family when discussing the time limits of the Written Service Agreement with the family. The Children's Service Worker should explain, depending on case progress, more than one CD-14B might be used, or successive treatment periods may be necessary.

The Family Assessment process will not only address the reported concern alleged in the hotline report, but will take into account the family's situation as a whole. The Children's Service Worker will carefully review all information available at the time the report is first received before engaging the family in the family assessment process. The development and implementation of a Written Service Agreement, CD14B,, is ninety (90) days from the date the case is assigned to the reassessment date. Treatment goals identified in the plan are expected to be achieved during this period.

If it appears unresolved treatment issues exist at the end of the treatment period, the Children's Service Worker and supervisor must decide, based on assessed risk, if the case should remain open. A NCFAS G+R (interim), CS-16E, and CD-14B is due within thirty (30) days of the expiration of the treatment period.

3.3.13 Family Approval

As the Written Service Agreement is to reflect a cooperative agreement between the Children's Service Worker and the family, the parent(s) or caretaker(s) should sign the plan. Other family members should sign the plan, if needed.

The plan will be written on the designated self-carboning page, CD-14B, included in the NCFAS G+R and attachments.. The Children's Service Worker should make an effort to elicit family participation in the planning process. This process should be as informal as possible. The family's approval of the plan should convey their agreement to the goals and requirements of the plan.

Family refusal to sign the plan should not automatically indicate their refusal to participate in treatment services. If they refuse to sign, yet agree to participate, a copy of the plan shall still be provided to them.

If the family refuses to participate in the planning process, the Children's Service worker shall consult with his/her supervisor to decide the appropriate action to take.

3.3.14 Questions to ask Resistant Families in Goal Planning

To identify goals to work on in a Written Service Agreement, the following questions may be particularly useful when the family is resistant and may not be accepting ownership of the behavior:

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1. Whose idea was it that you receive services?
2. What makes the referral source (i.e., Children's Division (CD) investigator, juvenile court) think we need to meet together?
3. What does the referral source think the reason is that you have this need?
4. What does the referral source think will happen as a result of us meeting together?
5. What will it take to "convince" the referral source that we do not need to meet together? (This is a particularly useful question when the family denies having the need.)
6. What will be different in your life then?

Chapter Memoranda History: (prior to 01-31-07)

[CS03-51](#), [CD04-79](#), [CD05-72](#)

Memoranda History:

CD10-53, CD11-86, CD13-90

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3.4 Potential for Juvenile Court Referral

When appropriate, the plan should identify what the response of the Division will be if the family refuses, or is unable, to accomplish the goals in the Written Service Agreement. The consequences should be discussed during the negotiation of the plan. This information is particularly important if the case was opened due to a "Preponderance of Evidence" CA/N determination. It may be necessary to conduct a safety assessment (CD-17). If the CD-17 results in a safety decision of "unsafe" the development of a Safety Plan (CD-18) is required in order to develop the least intrusive safety interventions that control identified threats of danger. Out-of-home placement may be the necessary safety intervention if a less intrusive intervention cannot be developed and agreed upon.

Chapter Memoranda History: (prior to 01-31-07)

[CS03-51](#), [CD04-79](#), [CD05-72](#)

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CD11-86

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3.5 Children's Service Worker And Supervisor Considerations

Decide which service needs of the family must be addressed immediately and which can be accomplished within a maximum 90-day timeframe. Service needs that need to be addressed immediately, where child safety is an issue would require an assessment of safety and the development of a safety plan.

Related Subject: Section 2, Chapter 9.2 Assessment of Safety

To help the Children's Service Worker and supervisor weigh the demands of the case, the Children's Service Worker should estimate the "in-person contact frequency" and the "service intensity" that the case will require. These estimates should be based on the most recent SDM risk assessment or (CS-16e) risk reassessment.

Related Subject: Section 2, Chapter 9.5.2 Minimum Contact Standards for In-Home Family Cases

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[CS03-51](#), [CD04-79](#), [CD05-72](#)

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3.6 Family Support Team Meetings for Intact Families

Many intact families with multiple needs could benefit greatly from a Family Support Team (FST) meeting. By bringing together the necessary formal and informal participants, a family support team process can assist the worker in moving the family closer to achieving and maintaining positive change and reducing the risk for future maltreatment or the need for out-of-home care.

3.6.1 Composition of the Family Support Team for Intact Families

Support Team meetings for intact families may look somewhat different from Family Centered Out-of-Home Care (FCOOHC) cases, lacking the structure of a court presence and mandated timeframes for completion. This allows the worker and the family more flexibility in inviting and assembling participants that can address the family's specific needs. FST meetings may be composed of parents, children (if appropriate), relatives, neighbors, school personnel, medical personnel, substance abuse personnel, legal counsel for the parents, GALs, Juvenile Officers, CASA personnel, etc.

The family will be involved in selecting participants to invite, however the worker should emphasize to the family the importance of having participants that can address critical issues.

The Children's Service Worker shall ensure that accommodations are made for special needs of Family Support Team members (i.e., English as second language/sign language interpreters, accessibility for physical disability or handicap).

3.6.2 Community Partnerships

An essential component to having consistent, effective family support team meetings is an established network of community partners and resources to draw from.

Community partnerships are made up of members or agencies from diverse disciplines that regularly assemble and address issues relevant to family well-being and child protection. When the community begins to see child protection as a community issue and not just a Children's Division issue, families will be identified sooner and resources can be made available more readily, sometimes before the family comes to the attention of the Division. Staff will see greater participation from the community in the family support team process, which means more resources at the table during plan development; less duplication of services from agencies not communicating; and more concise and individualized treatment plans designed to meet the particular needs of that family.

3.6.3 Conducting a Family Support Team Meeting

The Children's Service Worker serves as facilitator for team meetings. As facilitator, the worker should:

1. Facilitate team members in allowing them to introduce themselves to the team by stating their role and responsibility with or within the family and to state why they are participating with the team.
2. Clarify the purpose of the meeting.
3. Present the ground rules. The meeting is informal with everyone having equal voice and opportunity to voice their views. The team should remember:
 - a. No idea is a bad idea
 - b. Ideas should not be judged
 - c. The team should consider needs not pathology
 - d. The team should focus on current treatment needs rather than comprehensive life history
 - e. The team should consider all possibilities not just traditional services known to be available and
 - f. Ideas should be driven by goals, not limited by available resources.
4. Facilitate in allowing the team members to discuss the strengths of the family and strengths of individuals within the family. Not all of the team members will be as knowledgeable about the family as the Children's Service Worker.
5. Normalize behavior. Help the team to think about what all families need in each of life's domains, i.e., safety, behavioral/psychiatric, home/residence, education, social/recreational, spiritual, medical, legal, and financial and advocacy.
6. Identify needs. The Children's Service Worker will need to use skill in translating problems as needs for some team members.
7. Prioritize needs. Begin with the most critical needs. It is important that the parent agrees with the priority of an identified need.

8. Develop the plan. The Children's Service Worker should check often with the family and other team members to assure they are invested in the plan.

3.6.4 Family Support Team Meeting Agenda

At the beginning of each Family Support Team Meeting the Children's Division Children's Service Worker should state: **"All information provided in this meeting is confidential. Any one not agreeing to keep information disclosed confidential can be asked to leave the meeting for any portion in which he/she is not testifying."** Participants will sign a Family Support Team Meeting Confidentiality Statement, FST-1, to document that they agree to the terms of confidentiality and whether they are in agreement or disagreement with the plan.

- Have the completed Family Centered Services (FCS) comprehensive assessment, NCFAS G+R and attachments available to document service needs identified.
- Review issues precipitating the family's involvement with the agency, specifics of child abuse/neglect allegations and what actions the agency and family members have taken up to this point.
- Determine what specific services are needed for the family to reduce risk for future child maltreatment or to prevent the need for the children coming into out-of-home care.
- Develop a Written Service Agreement CD-14B, including specific tasks for the family and treatment provider, time lines for expected completion and review dates. The team should be sensitive to the parent's schedule and responsibilities when assigning those tasks.
- Determine current treatment needs of individual family members and the family as a unit, and incorporate them into the treatment plan.

3.6.4.1 Family Support Team (FST) Meeting with Families Reaching TANF Lifetime Limit

For families reaching their sixty (60) month lifetime limit for Temporary Assistance, the format of the plan should include the goal of achieving self-sufficiency. A self-sufficiency component should be addressed in a FST at least six months prior to a family reaching their lifetime limit and in every subsequent FST, until the issue is resolved. The Children's Service

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Worker will be responsible for contacting the Family Support Division (FSD) worker to begin the planning process for the FST.

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[CS03-51](#), [CD04-79](#), [CD05-72](#)

Memoranda History:

[CD07-77](#), [CD10-53](#), CD13-