



## **Handout 2.1: CONCURRENT PLANNING REVIEW**

- Engaging families in culturally competent, early comprehensive assessments, case planning and services needed to achieve timely permanency.
- Engaging in a “Assessment” process to identify family situations in which a concurrent permanency plan/placement with a resource family is needed.
- Using the crisis of placement as a motivator to engage families in case planning and to make behavioral changes.
- Identifying relatives and tribal resources who can be placement/permanency resources early on in the case planning process.
- Respectfully using full disclosure with birth families and foster/adoptive families throughout the life of the case.
- Recruiting, training and supporting permanency planning resource families in addition to other types of foster families.
- Increasing birth and foster parent partnerships in case planning
- Engaging in discussions with foster families about the need for a concurrent permanency plan and their interest in serving as a permanency resource for children who may not return to their birth parents.
- Collaborating with courts, attorneys and service providers to better serve children and families.
- Determining when to pursue goals such as adoption or guardianship



## **Handout 2.2: MEANINGFUL COMPREHENSIVE FAMILY ASSESSMENTS IN CHILD WELFARE**

- Are collaborative – focus on doing with/not for
- Depend on extensive family input
- Build on resources, strengths, and potential capacity
- Identify and explore the core problems that brought child into care
- Explore underlying history of problems and family needs
- Consider the child in context of family, culture and community
- Elicit the parent's perception of the problems, what they'd like to see happen
- Describe CPS and courts' perception of problems and recommendations
- Build on what may have been learned in other assessments
- Include an assessment of family's environment, physical health, psychological factors
- Explore social networks - friends, family, buddies, acquaintances
- Explores relatives and resources for support, placement and possible permanency
- Are ongoing
- Can be used to enhance motivation to change
- Can create windows of opportunity for movement into process of change
- Explore options for the present and future – goals and activities
- Include a plan that articulates who does what, when
- Explore alternatives for safety, permanency and developmental well-being

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**Handout – TO BE ADDED STATE FAMILY ASSESSMENT TOOL**

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## **Handout 2.3: CONCURRENT PLANNING CASE REVIEW WORKSHEET**



**Handout 2.4: CONCURRENT PLANNING STAFFING TOOL**



## **Handout 2.5: CONCURRENT PERMANENCY PLANNING – ASSESSMENT TOOLS**

*(Adapted by NRCFCPP from Concurrent Planning Materials from Lutheran Social Services of Washington and Idaho and the Colorado Concurrent Planning Guide)*

### **FAMILY STRENGTHS/EARLY REUNIFICATION INDICATORS –**

*These are some of the strengths and resources which can be called upon to help the family plan for timely reunification and improve children’s well-being.*

#### **Parent – Child Relationship**

- Parent shows empathy and concern for child
- Parent responds positively and supportively to the child’s verbal and non-verbal signals
- Parent shows the ability to put the child’s needs ahead of his/her own
- When they are together, child shows comfort in parent’s presence
- The parent has raised the child for a significant period of time
- In the past, the parent has met the child’s basic physical and emotional needs
- Parent accepts some responsibility for the problems that brought the child into care or the attention of the authorities
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#### **Parent Support System**

- Parent has positive, significant relationships with other adults who seem not to have overt problems (spouse, parents, friends, relatives)
- Parent has a meaningful support system that can help him/her now (church, job, counselor)
- Extended family is nearby and capable of providing support

#### **Past Support System**

- Extended family history shows family members able to help out/provide support when one member is not functioning well
- Relatives came forward to offer help when child needed placement
- Relatives have followed through on commitments in the past
- There are significant other adults, not blood relatives, who have helped in the past
- Significant other adults have followed through on commitments in the past

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**Family History**

- Family’s ethnic, cultural, or religious heritage includes an emphasis on mutual caretaking and shared parenting in times of crisis
- Parent’s own history shows consistency of parent caretaker
- Parent’s history shows evidence of his/her childhood needs being met adequately

**Child’s Overall Development**

- Child’ shows age-appropriate cognitive abilities
- Child is able to attend to tasks at an age appropriate level
- Child shows evidence of conscience development
- Child has age-appropriate social skills
- Child’s behavioral problems are managed/redirected positively
- Child’s health care needs have been met routinely



## **INDICATORS OF CONCERN ABOUT REUNIFICATION – PERMANENCY PLANNING RED FLAGS –**

These are conditions, which might make timely reunification difficult or unlikely and indicate a need for more intensive casework services with the parents as well as a concurrent plan for placement with a permanency planning resource family. Conditions with an (\*) are associated with a very low probability for family reunification and for the most part have been incorporated in ASFA’s “aggravated circumstances” when Reasonable Efforts to reunify may not be required.

### **Factors Related to Abuse or Neglect**

- Parent has killed or seriously harmed another child through abuse or neglect and no significant change has occurred in the interim (\*)
- Parent has repeatedly and with premeditation harmed or tortured this child (\*)
- Child has experienced physical or sexual abuse in infancy
- Diagnosed failure to thrive infants
- Child has been a victim of drug-exposure at time of birth
- Significant neglect
- In addition to emotional trauma the child has suffered more than one form of abuse, neglect or sexual abuse
- There have been three or more CPS interventions for serious incidents, indicating a chronic pattern of abuse, or serve neglect.
- CPS preventive measures have failed to keep the child safe with the parent.
- This child has been abandoned with friends, relatives, hospital or in foster care; or once the child is placed in subsequent care, the parent does not visit on his or her own accord

### **Factors Related to Ambivalence**

- Previous placement of this child or other children
- Parent has asked to relinquish child on more than one occasion following initial intervention; previous relinquishment of a child
- Repeated pattern of uncertainty as to desire to parent
- Inconsistent contacts with the child
- Lack of emotional commitment to the child; parent dislikes child due to child’s paternity
- Parent(s) consistently acknowledge ongoing problems with parenting

### **Factors Related to Parental History and Functioning**

- Parental rights to another child have been terminated following a period of service delivery to the parent and no significant change has occurred in the interim (\*)
- Siblings have been placed in foster care or with relatives for periods of time or have had placements by CPS
- Parent is under the age of 16 with no parenting support systems, and placement of the child and parent together has failed due to parent’s behavior
- Parent is addicted to debilitating illegal drugs or alcohol
- Mother abused drugs/alcohol during pregnancy, despite medical advice to the contrary
- Pattern of documented domestic violence and refusal to separate
- Parent has a recent history of serious criminal activity and jail

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*Factors Related to Parental History and Functioning (continued)*

- Parent grew up in care with multiple placements or in a family of intergenerational abuse
- Parent has degenerative or terminal illness
- Visible means of support derived from prostitution, drugs or other crimes
- Parent diagnosed with severe mental illness which has not responded to previous mental health services
- Parent diagnosed with a severe mental illness that responds slowly or not at all to current treatment modalities
- Parent is developmentally disabled, has shown significant problems in self-care, had has no kinship support system able to share parenting.



## **Handout 2.6: CASE SCENARIO 1 – CONCURRENT PLANNING**

### **CASE EXAMPLE: TERESA**

Teresa is a 29 year old mother of 4 children - all in out-of-home care. The older two (ages 10 and 8) are placed out of state with a paternal aunt who has agreed to adopt them. The third child (age 6) is placed with her paternal aunt in another county and tpr proceedings have been filed against Teresa and the father. The last child was born 8 months ago testing positive for Cocaine. Teresa has a long history of drug addiction - having entered and left drug treatment programs three times in the past 5 years.

After the last baby, Tanya, was born, Teresa realized that she couldn't take having another child permanently taken away from her. She entered a 28 day drug treatment program that she had not attended before and made a “fresh start” as she put it. She has been involved in NA in her community and has seen an outpatient drug counselor twice a week for 6-7 months. She has visited with the baby twice a week since leaving the inpatient program, and her interactions are described as positive, nurturing and connected to the baby. The foster mother has served as a “mentor” and support to Teresa - helping her during visits to interact with the baby and engage in age-appropriate activities. Teresa has recently been able to take the baby to the park on her own during these visits. Parenting skills have not been described as a problem for Teresa.

You are aware by reading the record that Teresa has reached this plateau several times, and then for some reason relapses and begins to use again. Teresa was in foster care herself, and had been sexually abused by her mother's boyfriend. She had spent most of her teenage years in 3 different group homes. Tanya is described as a happy baby who plays easily with the foster mom and others. She has not experienced any serious developmental delays as a result of the prenatal crack exposure.

As her child welfare social worker newly assigned to her case, you have encouraged her progress and feel quite pleased that she has sustained change over time. You have made numerous community-based referrals for services and supports and are helping Teresa to find housing that would be suitable for a mother and child. Your supervisor is more skeptical, and says that Teresa may be a “relapse waiting to happen” and wants you to explore other permanency goals for Tanya.

- What strengths do you see?
- What concerns/worries or permanency red flags should we be concerned about?
- What permanency options exist?
- What should the next steps be?



**Handout 2.7: CASE SCENARIO 2 – CONCURRENT PLANNING**  
**CASE EXAMPLE: TERESA – ANDY, AMANDA AND TANYA**

Teresa’s two children (Andy age 8 and Amanda age 6) have been in foster care with the same foster mother for 14 months. When they were placed in care, Teresa was drinking and using drugs heavily. She enrolled in a 28-day drug treatment program and successfully completed it. She had been in out-patient counseling since leaving the residential program; she experienced several relapses, but has not appeared to be “using” when visiting the children. This is the children’s second placement in foster care – with the same foster mother.

However, Teresa gave birth to Tanya when Andy and Amanda had been in care for 11 months. At birth, Tanya tested positive for cocaine and was placed in the same foster home as her older siblings. Teresa agreed to enter another 28-day in-patient drug treatment program when Tanya was born and she is just now leaving the program to return to the community. She states that she didn’t want to loose her children to the “system”.

She has returned to her part-time job as a waitress and lives with her brother to save money. She attends NA three times a week, and has entered a counseling program as ordered by the court. Teresa has a long history of drug addiction - having entered and left drug treatment programs three times in the past 5 years. She has a history of relapsing after periods of 3-6 months of drug-free behavior. Her mother had helped her raise Andy and Amanda before she died two years ago. There were no other maternal relatives available to help out when Teresa left the children with a neighbor and didn’t return. After two days, the neighbor called CPS and the two children were placed with the current foster mother – someone they were once placed with for 6 months several years before. Teresa reappeared after the children had been in care for 2 weeks and denied that she had abandoned them, saying she had told the neighbor she needed to go away for a few weeks. She agreed, however, to enter an in-patient drug treatment program as she had just found out she was pregnant again and didn’t want to hurt the baby. Teresa was in foster care herself as an adolescent due to being abused sexually by her step father, whom her mother then divorced.

All the children have the same father – Eugene, age 30 – who lives in a nearby town and works on and off at day construction jobs. He and Teresa have not lived together, but they have been involved for 10 years. Eugene reportedly has no family resources nearby to help out, and he himself is described as a heavy week-end drinker.

Teresa visits the children in their foster home every week, which is easy for her to get to by public transportation. The foster mother has “taken her under her wing” and provided mentoring and opportunities for involvement with Tanya and the older children’s school and social life.

The agency worker is new and believes Teresa wants her children and is making progress towards getting ‘clean’. She has provided many referrals for housing and counseling services. The agency supervisor describes Teresa a relapse waiting to happen. The agency is obligated to consider filing a termination of parental rights petition because the two older children have been in care for 14 months and Teresa has shown inconsistent progress towards becoming and remaining drug-free, and finding an apartment for her family.

Andy and Amanda like living with their foster mother and are happy that their new sister is living with them. They were worried about what would happen to her because of their mother’s drug and alcohol use – which kept her from feeding them regularly and making sure they went to

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school each day. They also miss their mother - and their grandmother who used to care for them. They talk easily about sometimes being left alone for long periods of time before they were placed in foster care. They are described as connected to their mother and look forward to her visits.

- What strengths do you see?
- What red flags should we be concerned about?
- What permanency options exist?
- What should the next steps be?



**Handout 2.8: CHILD ATTACHMENT CHART**