Division of Children and Family Services Protection and Safety Procedure # 13-2016	
Regarding:	Mandatory Monthly Visits With Children
Replace:	#8-2014 Mandatory Monthly Visits with Children
Date Effective:	04/01/2016
Contact:	Connie Pfeifer at 402-471-9245 or connie.pfeifer@nebraska.gov
Issued by:	Douglas J. Weinberg, Director, Division of Children and Family Services

Philosophy:

The Division of Children and Family Services (DCFS) believes that consistent contact with children and families allows the CFS Specialist to continually assess child safety; to review progress and address barriers toward achieving permanency; and identify child needs that impact well-being. Visiting with the child gives the CFS Specialist valuable information about the child's safety, development and care, allows the child an opportunity for input, and opportunities to develop a relationship with the CFS Specialist. Visits also give the CFS Specialist the opportunity to communicate with the child about what is occurring or will occur in their life due to their involvement in the child welfare system. Regular contact by the same CFS Specialist is best for the child and will provide valuable information necessary for effective case management.

Procedure:

CFS Specialists will have face to face visits with children and parents as prescribed by the Risk or Prevention Level in the most recent SDM Risk or Prevention Assessment. When no SDM Assessment is required, the CFS Specialist with have face-to-face visits with children a minimum of once per month.

I. **Who will Conduct the Visit**

A. The assigned CFS Specialist or DCFS contractor for case management will conduct the visit. On rare occasions, a different CFS Specialist, the CFS Supervisor, DCFS contractor for case management or Resource Development worker may conduct the visit.

B. When multiple children are placed in a facility such as a group home or residential treatment facility, DCFS can designate one or more CFS Specialists to make the monthly visit to a number of children and report individually to each child's CFS Specialist.

C. Wards placed out of State may have a person designated in the other state to conduct the visit. Such individuals may be staff of a private agency with a contract with Nebraska for the service or a courtesy worker assigned by the other state under Interstate Compact for the Placement of Children (ICPC) or Interstate Compact for Juveniles (ICJ).

1. The CFS Specialist will not visit a child in another state without first notifying the Nebraska ICPC Office in DCFS Central Office to determine if the other state allows Nebraska staff to conduct visits in the other state.
2. When DCFS has several children placed in one setting, e.g., a group home or residential treatment facility, DCFS can designate someone to make the required

monthly visits with all of the children and report individually to each child's CFS Specialist. In all situations, it remains the responsibility of the assigned CFS Specialist to ensure that the visits are made and appropriately documented on N-FOCUS in the Required Contacts narrative.

II. Visitation/Contact Guidelines with Child(ren)

A. The CFS Specialist will have a private face-to-face visit with children based on the following:
   1. In Home Cases: The CFS Specialist is required to assess for safety and risk, conduct needs assessment and provide services and, have a face to face contact with all the children in the home this includes:
      a. State Wards (DHHS and DHHS-OJS); and
      b. Non-Wards
   2. Out of Home Cases: The CFS Specialist is required to assess for safety and risk for all children (child in out-of-home care and any other children remaining in the family home.

B. When a parent chooses to prohibit the CFS Specialist from having contact with the non-ward minor siblings of state wards, the CFS Specialist will document and discuss this with their supervisor. The CFS Specialist and supervisor will discuss alternative ways to engage the parent to allow access.

C. All children placed in Nebraska under the auspices of the Interstate Compact on Placement of Children (ICPC) or Interstate Compact on Juveniles (ICJ) in non-facility placements;

D. For a child living outside the Service Area or local office area, a courtesy worker in the area where the child resides can be assigned to conduct the monthly visit.

E. All visits with children must occur in the home where they reside. When a visit cannot occur in the home, the CFS Specialist must obtain approval from their supervisor and document the approval in Consultation Point narrative.

F. To Locate Child: If the child cannot be located at his or her residence, the CFS Specialist will notify his or her supervisor immediately in writing. For youth missing from placement, the CFS Specialist or contractor will immediately contact law enforcement and continue to follow up with law enforcement on a monthly basis. All contacts will be documented as described in the program guidance on "Youth Who Cannot be Located".

G. The frequency of face-to-face contact is based on the risk levels.
   1. In Home Cases
      a. Low or Moderate Risk – One face-to-face contact per month.
      b. High or Very High Risk – Two face-to-face contacts per month.
   2. Out-of home Cases
      a. Low or Moderate Risk – One face-to-face contact per month.
      b. High or Very High Risk – Two face-to-face contacts per month. One of the two contacts may be made by the agency supported foster care worker assigned to the specific child.

H. With supervisory approval, one contact can be via SKYPE or other electronic means if an in-person contact cannot occur.

I. All visits with children age 18 months and older must be private. Others may be present with children who are less than 18 months old, non-verbal (involving little or no use of words) or have a disability. This will be considered and documented as a private contact.

J. All children in out-of-home care will have contact with the CFS Specialist within the first 7 calendar days of placement of any out-of-home placement.

III. Visitation/Contact Guidelines with Parent(s)

A. The CFS Specialist will have a private face-to-face visit with:
   1. Legal parents and non-custodial parents of all children who are wards whose parental rights are not terminated regardless of the permanency objective; and
   2. Legal parents and non-custodial parents of children involved in a non-court case; and
   3. Legal parents and non-custodial parents providing care to a child placed under the auspices of ICPC or ICJ.

B. Visits with custodial and non-custodial parents must be confidential. Every other month the visit must occur in the parent's residence unless otherwise instructed below.
   1. For a parent receiving treatment in a residential facility, monthly face to face contact is required unless there is a clear barrier to having contact with the parent. When a clear barrier exists, phone contact can replace the face to face visit. The barriers identified must be documented in the Required Contact narrative;
   2. For a parent who is incarcerated, face to face contact is required unless there is a clear barrier to having contact with the parent. When a clear barrier exists, phone contact can replace the face to face visit. The barriers identified must be documented in the Required Contact narrative;
   3. For a parent living outside the Service Area or local office area, a courtesy worker in the area where the parent resides could be assigned to conduct the monthly visit; or
   4. For a parent living out of state, monthly contact can be made by phone.
   5. Refusal to meet or appointments that are missed without good cause will be documented in the Required Contact Narrative – Efforts to Contact.

C. The frequency of contact is based on the risk levels.
   1. Low or Moderate Risk – One face-to-face contact per month.
   2. High or Very High Risk – Two face-to-face contacts per month.

D. One contact can be via SKYPE or other electronic means if an in-person contact cannot occur, with supervisory approval.

E. The CFS Specialist will have a monthly private face-to-face visit with the non-custodial parent.
   1. Regular efforts to locate and engage the non-custodial parent must be documented in the Required Contacts Narrative – Efforts to Contact.

IV. Visitation/Contact Guidelines with Out-of-Home Care Provider

A. The CFS Specialist will have monthly contact with the child's out-of-home care provider as follows:
   1. Caregiver of each ward in out of home care;
   2. Caregiver of each child in an Informal Living Arrangement in a non-court involved case; and
   3. Caregiver of each child in out of home care under the auspices of ICPC and ICJ.

B. At a minimum every other month the visit must be face-to-face, in the caregiver's home. For caregivers out of state, the visit may be by phone.

C. Refusal of Caregiver to Have Required Contact: If the refusal or cancellations are without good cause the CFS Specialist will document this in the Required Contacts –

Efforts to Contact and consult with the supervisor to consider whether or not the current placement continues to be suitable and in the child's best interest.

V. Waiver of Workers Contacting Parent in the Parent's Home:

A. When the home environment of the parent presents a threat to the safety of a CFS Specialist, a supervisor may waive the requirement for face-to-face contact with the parent in the home. This decision must be documented in N-FOCUS. The decision to waive the requirement must be made and reviewed and documented each month.

VI. Topics to be Covered/Focus of the Visit:

A. **Child**: Visits should address the strengths and needs of the child; evaluation of current services; discussion about permanency, establishment and evaluation of goals; assessment of the child's safety in the residence and safety of the community; discussion about school; and discussion about visits with parents and siblings. The child should be provided information about court hearings, court ordered expectations, and requirements of probation or parole, and given an opportunity to ask questions or express concerns. Discussion about Transitional Living plans for state wards age 14 or older and discussions on Independent Living should occur with every child age 14 or older. This discussion should center on assessment of the youth's knowledge, skills and abilities; areas needing more education/training/mentoring; and plans for the future. Discussion should include asking the child for his or her input and hopes for the future as well as how he or she is doing in school; medical issues or concerns; and mental health/substance use issues or concerns including discussion of how psychotropic medications are working and any side effects the youth may be experiencing. For children who are non-verbal due to age or disability, the CFS Specialist or contractor must observe and document the child's general growth, whether this youth is meeting developmental milestones, behavior, and any concerns/progress shared by the caregiver. Refer to Program Guidance on "Health Care Coordination and Psychotropic Medication Guidelines".

B. **Parents**: Discussion should include current safety threat(s) identified, safety plan, risk levels, family strengths and needs, establishing a permanency objective and case plan, ongoing evaluation of the permanency objective and case plan and discussion of concurrent planning (when needed); and visitation issues. Discussion should also include information on the child's health and treatment needs, school performance and peer relationships. This includes discussion about older children and their skills and abilities towards achieving independence and discussion on psychotropic medications being taken by the child and the parent's observations of how psychotropic medications are working and any side effects the youth may be experiencing. The CFS Specialist should also discuss any upcoming court hearings such as the Permanency Hearing and the 15/22 Month provisions.

C. **Foster Parent/Placement Provider**: Discussion should include child's health status including any recent treatment, unmet medical needs, and current medications, including psychotropic medications. Discussion should also include child's school performance, educational plan, peer relationships or needs. For children 14 and older discussion of the child's independent living knowledge, skills and abilities should occur with a plan as to what action the foster family/caregiver will do to support teaching/coaching/mentoring. Issues around visitation with parents and siblings; status of court process; and any issues, concerns and/or needs in the caregivers' household should also be discussed. The CFS Specialist should regularly reassess the caregiver's commitment to the child and willingness to provide continued care including the caregiver's willingness and ability to

provide permanency when needed.

VII. Documentation of Visits:

A. Documentation of all monthly contacts (and information about contacts that were attempted and not successful) with children, parents, and caregivers must be documented in the Required Contacts narrative within 7 calendar days of the contact. The following information must be included:

1. Location of visit;
2. Date of visit;
3. Who was present at the visit by first and last name;
4. If the visit was not private, describe why;
5. Observations of the child, parent, and caregivers and interactions noted;
6. Assessment of child safety and risk which reflects the child and/or parent's input;
7. Issues discussed which reflect the child and/or parents input; and
8. Actions needed by whom and by when.

VIII. Immediate Alternative: In situations in which a visit cannot be made due to an unforeseen emergency, the supervisor must be notified in advance. The supervisor will make arrangements for alternative coverage. If alternative coverage cannot be arranged a written exception to this requirement must be approved by a CFS Administrator. Exceptions will be documented by the CFS Specialist in the Consultation Narrative within 7 calendar days of the decision, and include the name of the administrator approving the decision.

References:

Protection and Safety Procedure on Health Care Coordination and Psychotropic Medication Guidelines.