



2011 Annual Training Conference



When is Sufficient Enough? Assessing Parental Progress





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Lindsay Soto, Attorney at Law

Lindsay Soto has been in private practice in the area of Juvenile and Family Law as well as part of the Juvenile Advocacy Consortium from 2005 to the present. He was an Associate Attorney with The VanderMay Law Firm from 2002 to 2005. He holds a Bachelor degree in Political Science from the University of Oregon as well as a Law Degree from Howard University School of Law.

Linda Lawing, Supervisor, Marion County DHS

Linda Lawing is currently a supervisor with the Department of Human Services Child Welfare Program in Marion County. Within Child Welfare, she has worked as a Housing Specialist with the Family Support Team unit to support families in recovery gain access to services and housing. She has also previously held positions within Child Welfare as a Residential/Adolescent caseworker, as a Permanency and Legal Assistance caseworker, and as a Consultant, Educator and Trainer. Linda holds a Bachelor's Degree in Social Sciences. In addition to her employment with Child Welfare, Linda has worked directly with youth providing educational and job training. She was previously employed with the Switzer Center for Educational Therapy in Torrance, CA where she worked under child psychologist, Dr. Jane Switzer, as an employment coordinator for special needs youth. Linda has also coordinated and led orientations for the Job Council and worked a youth employment coordinator at the high school level teaching vocational training.

Michal Lansdon, Caseworker, Marion County DHS

Michal Lansdon is a caseworker at DHS's Marion County Adolescent/Residential Unit for over 2 ½ years, along with 18 months experience as an intern in the Child Protective Services (CPS) and Permanency Units. Her background includes 11 years in Special Education classrooms and 10 years in Nursing.



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Rebecca Orf, Senior Judge

Rebecca G. Orf is currently a staff attorney for the Oregon Judicial Department (OJD), for issues involving family violence, elderly and disabled persons abuse, and civil stalking. From 2009-2010, she also worked as the staff attorney for the Juvenile Court Improvement Program (JCIP). She served as a Circuit Court Judge in Jackson County, Oregon, from 1994-2008. She is currently a member of the State Family Law Advisory Committee (SFLAC) and SFLAC's Domestic Violence Subcommittee, the Violence Against Women Act (VAWA) Advisory Board, the Batterers' Intervention Programs (BIP) Advisory Board, the Oregon Domestic Violence and Firearms Task Force, the Oregon Law Commission's Juvenile Workgroup, and the Interbranch Juvenile Workgroup. She served as a member the Chief Justice's Treatment Court Advisory Committee, the Oregon Family Law Task Force, and the Oregon Family Law Legal Services Commission. She served as the first president of the Jackson County Council Against Domestic & Sexual Violence. She has been a speaker on juvenile law, treatment courts, domestic violence and family law issues for many local, statewide, and national conferences. In 2003, she was a recipient of the Oregon Chief Justice's Juvenile Court Champion Award.

Gary Heard, Program Supervisor, Marion County Alcohol and Drug Treatment Services

Gary Heard is a certified Alcohol and Drug Counselor and is currently a Program Supervisor with Marion County Alcohol and Drug Treatment Services. He has a wide variety of experience in the Drug and Alcohol field working with adults, adolescents and within the adult correctional population. In addition to his clinical experience through Marion County Health, he has worked for Adult Detoxification Services; Harmony House and Serenity Lane. Mr. Heard has a Bachelor of Arts Degree with an emphasis on Management and Organizational Leadership from George Fox University.



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Sam Tazumal, CRB Field Staff

Suzanne Callahan is a Field Manager for Jackson and Josephine Counties. She resides in Medford and is based out of the Jackson County Courthouse. Suzanne has been with OJD since 2004. She has a background in education and child psychology. Prior to joining CRB, Suzanne worked for private mental health agencies. She worked as a middle school counsellor in Ashland, Oregon. Suzanne has worked as a mental health specialist in residential treatment, has facilitated sex abuse trauma groups for children and was a director of a local children's program. Suzanne has been a member of several CRB committees and most recently served on the CRB policy and procedural workgroup.

Suzanne Callahan, CRB Field Staff

Sam has several years of experience in the Child Welfare and Adult Protective Services fields, as well as a medical and school social worker. He has degrees from Portland State University in Child and Family Studies and a Master's degree in Social Work. He has been with the CRB for about three years as a Field Manager and as a Review Specialist.

Assessing Parental Progress: An Attorney's Perspective

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Where do we find out what services DHS wants the parent to participate in?

- Bases of jurisdiction
- Action agreements
- Psychological, psychosexual, drug and alcohol, and domestic violence evaluations
- Treatment recommendations from providers
- Requirements of probation/probation officers
- Voluntary services suggested by parent
- 333 or other case planning documents

Bases of Jurisdiction

- Drug abuse
- Mental health
- Physical or sexual abuse
- Dirty house/lack of housing
- Failure to meet child's needs
- Criminal history/incarceration
- No relationship with child
- Previous DHS history



Drug Abuse

- How quickly did the parent set up evaluation?
- What level of treatment was recommended?
- How is the parent's attendance? Participation?
- What kind of feedback does the parent get from treatment providers?
- Is the parent showing up for UAs? Providing valid and negative samples?
- Consider treatment courts (drug court, FATC)



Mental Health/Cognitive Issues

- Psychological evaluation/mental health assessment
- How quickly did the parent engage in counseling, if deemed necessary?
- Attendance is a huge factor, but so is insurance coverage; DHS will sometimes assist
- What is the feedback from the counselor?
- Are services being offered in a manner that best suits the parent's cognitive abilities and learning style?



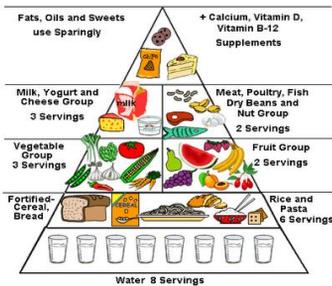
Physical or Sexual Abuse

- Can be against the child or another person
- Has the parent done a psychological or psychosexual evaluation or a DV assessment?
- Can the parent afford to pay for treatment?
- Is the parent participating in treatment and internalizing change?
- Parenting classes (in cases of inappropriate discipline)



Dirty House/Lack of Housing

- How quickly did the parent clean the house?
- Can the parent maintain cleanliness?
- Are unannounced home visits being done?
- If a parent can't keep the house clean without the kids, it's unlikely that will improve once the kids are returned.
- Work on finding housing should begin early in the case, but timing is important





No Relationship with Child

- What, if any, has been the relationship between the child and the absent parent?
- Has the absent parent paid child support?
- Has the absent parent had ways to contact the child over the years, but neglected to do so?
- Sibling considerations are often at play – Kinship House-type assessments are valuable
- Does the child want contact with the absent parent? How does the child react to the parent?



Previous DHS History

- How long ago was the DHS history?
- What services did the parent complete or participate in previously?
- What has happened since the earlier case?
- If other case is currently open, is the parent participating in the case plan and making progress?
- What is the relationship between parent and other children?



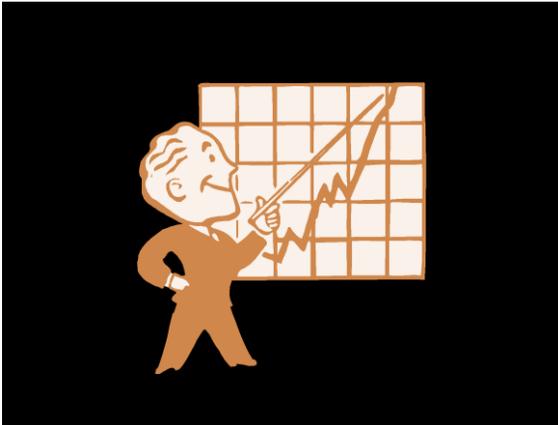
Final Considerations

- Does the parent have work obligations that prevent him/her from fully participating in required services?
- Does the parent have financial limitations that prevent him/her from fully participating in required services?
- Lack of transportation (unless far out of area where services are located) is seldom a legitimate issue – it's usually just poor planning that causes problems

ASSESSING PARENTAL PROGRESS WHEN IS SUFFICIENT ENOUGH?



Suzanne Callahan and Sam Tazumal



“The parents have made **SUFFICIENT** progress to make it possible for the child to safely return home.”

This finding applies ONLY when the plan is RETURN TO PARENT

The finding is made separately for EACH PARENT.

COMPLIANCE vs. Sufficient Progress

Sufficient Progress:

Sufficient progress does not mean the child can *immediately* return home. It is determined by parental improvement in areas necessary for the child to safely return home.

LEGAL CONSIDERATIONS:

- RATE OF PROGRESS
 - Progress is measured by ASFA timelines/ 15 of 22 months
- BASIS OF JURISDICTION
 - Founded Allegations
 - Confirmed Safety Threats
 - Action Agreements/Letters of Expectation
- MINIMAL CONDITIONS for return
- THE CHILD'S NEEDS
 - age , vulnerability, special needs



ASFA requires measurement

SEC. 475. [42 U.S.C. 675] (4) (B): ASFA requires the status of each child to be reviewed periodically but no less frequently than once every six months by either a court or by administrative review...in order to determine the safety of the child, the continuing necessity for and appropriateness of the placement, the extent of compliance with the case plan, and the extent of progress which has been made toward alleviating or mitigating the causes necessitating the placement...

Oregon Safety Model Terminology:

Safety Threats: (16) determined at time of assessment
Conditions for Return: a written statement of the specific behaviors, conditions, or circumstances that must exist within a child's home before a child can safely return and remain in the home with an in-home ongoing safety plan.
Protective Capacities: behavioral, cognitive, and emotional characteristics that can specifically and directly be associated with a person's ability and willingness to care for and keep a child safe.
Expected Outcomes: an observable, sustained change in behavior, condition, or circumstance that, when accomplished, will increase a parent's protective capacity and reduce or eliminate an identified safety threat. (no longer requiring Child Welfare intervention)

Progress is measured by behavioral changes.
 The goal is to return the child(ren) with an in-home ongoing safety plan as soon as safely possible.

The family situation is such that an adult in the home routinely performing parenting and responsibilities that assure child safety. YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>	One or both parents' or caregivers' attitudes, emotions and behavior are such that they are acting (behaving) dangerously. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>	One or both parents' or caregivers' attitudes or emotions are such that they will not/ cannot control their behavior. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>	Parents' or Caregivers' perceptions of a child are distorted . <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>
A family situation or behavior is such that the family does not have or use resources necessary to assure a child's safety. YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>	One or both parents' or caregivers' attitudes, emotions and behavior are such that they are scared or fearful they will abuse or neglect the child and/or request placement. YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>	One or both parents' or caregivers' attitudes or emotions are such that they over (ed) react to the child. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>	A situation, attitudes and/or behavior is such that one or both parents or caregivers lack protective capacities, skills, and motivation necessary to assure a child's safety. YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>
Parents' or Caregivers' attitudes and behavior result in overtly refusing CPS intervention refusing access to a child, and/or there is some indication that the caregivers will flee. YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>	Parents' or Caregivers' attitude, behavior, perception result in the child's and/or caregiver's inability to protect the child from abuse or neglect that affect his/her safety. YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>	The family situation is such that being seriously distorted the child's safety . <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>	The situation is such that a child be seriously physically injured or seriously physically abused or neglected . <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>
The situation is such that a child shows serious emotional symptoms and/or lacks behavioral control that result in severe adverse reactions in parents or caregivers. YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>	The situation is such that a child is fearful of the home situation or people within the home. YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>	Because of perception, attitude or emotion, parents or caregivers will not or do not require a child's return - despite family conditions . <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>	One or both parents or caregivers have a child out of his/her care due to child abuse or neglect or has lost a child due to termination of parental rights. YES <input type="checkbox"/> NO <input type="checkbox"/> PROGRESS <input type="checkbox"/>

OTHER FACTORS TO CONSIDER:

- INFORMATION: Discovery Material and Verbal Input
- TIMELINE: Length of time child has been in substitute care, ASFA timeline, court extensions, previous history.
- TIMELINESS OF SERVICES: When services were ordered, when the service was provided by DHS, and how quickly the parent engaged.
- INTERNALIZATION: Frequency of attendance, level of participation , demonstrated level of benefit
- FEEDBACK: DHS, collateral input from service/treatment providers
- MINIMAL STANDARDS : not our standards, completion of services not necessary

SPECIFIC CRITERIA for measuring progress:

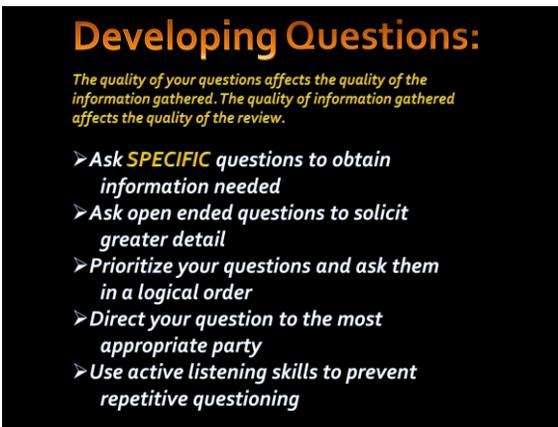
- What was court ordered and/or required of the parent?
- What additional treatment recommendations have been made from service providers?
- When was jurisdiction established? How has the parent addressed the jurisdictional issues that brought the child into care?
- To what level has the parent followed through with court ordered services? What services is the parent current attending? How long have they attended?
- What factual proof or tangible evidence has been obtained as to their involvement and progress in services?
- What collateral input has been received from service providers?
- Are the changes in the parents' motivation, behavior, and/or circumstance observable?

SPECIFIC CRITERIA CON'T:

- How long has the child been in substitute care? (ASFA timeline, court extension)
- What is the parent's relationship and understanding of the child's needs?
- How have the documented safety threats present at time of removal been ameliorated? Gone? New safety threats?
- What are the remaining barriers and safety issues that prevent the child from returning home with an in-home plan?
- At the parent's current rate of progress, is it likely safety issues can be adequately resolved within a reasonable period of time?







Questions:

Parents

<p>When did you complete the D/A assessment and what were the recommendations for treatment?</p> <p>What is your current involvement in D/A services?</p> <p>Terrance and Talisa have previously been in care due to concerns of neglect. What changes have you made since the children's re-entry?</p> <p>What is your clean date? Do you have a sponsor? What healthy supports have you established?</p> <p>What will be your plan after discharge from residential treatment?</p> <p>What have you learned from working the parent coach?</p> <p>What is the status of your criminal charges?</p>	<p>What is your current living situation?</p> <p>How have you addressed the recommendations made in the psychological evaluation about your current relationship?</p> <p>Are you participating in family therapy with Emily? What are your treatment goals?</p> <p>What is your understanding of Elizabeth's medical diagnosis? Are you attending her doctor appointments?</p> <p>How will you protect Maria from Mr. Mahar if she were to return home to your care?</p> <p>What are the barriers to your participation in individual counseling services?</p> <p>Are there any additional services you feel would be of benefit?</p>
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Questions:

Other Parties

<p>What is the agency's position with respect to the parents' current rate of progress?</p> <p>What additional expectations do you have of the parent(s) before reunification can take place?</p> <p>How is Mr. Jones progressing in anger management?</p> <p>What additional recommendations were made in the mother's psychological evaluation?</p> <p>What feedback have you received from the father's mental health counselor?</p> <p>What has been the level of contact between the parents and the agency?</p>	<p>What would you like to add on behalf of your client?</p> <p>What is Ms. Jones' level of involvement in D/A treatment?</p> <p>What is your client's position about the proposed reunification plan with the father?</p> <p>Do you have any concerns about the parents' current living environment?</p> <p>What is the current visitation plan? What observations has the visitation supervisor made?</p> <p>What is preventing Tyler from being placed with Ms. Jones in the residential treatment program?</p>
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MAKE THE FINDING

Is the parent making sufficient progress toward reunification? (Make for each parent separately)

Briefly summarize rationale for YES/ NO

Make recommendations to address any NO findings

Board Demeanor:

The demeanor of the board affects the level and quality of participation by the parties.

- Be aware of your perspectives and perceptions and how they influence you
- Be sensitive of your audience
- Ask appropriate and relevant questions
- Avoid lecturing, counseling, and story telling
- Be aware of body language and tone of voice
- Address parties by name and not their role
- Be conscious of time allocated for review



"Progress is the activity of today and the assurance of tomorrow."
-Ralph Waldo Emerson

"The permanency plan is the most appropriate plan for the child."

- When the plan is no longer return to parent, Parental Progress is addressed under Finding #9 (appropriateness of the permanency plan).
- Permanency Hierarchy:
 - Return to Parent
 - Adoption
 - Guardianship
 - APPLA: PFC, Independence, Other

Parental Progress Scenario 1:

The case involves Victor, an 11 year old special needs child who is currently receiving community based wraparound services due to his behavioral and emotional needs. He has been in the same foster home since 6/10. He disrupted from his first foster home due to aggressive behaviors. Jurisdiction was based on the mother's substance abuse issues, the mother's history of mental health problems, the father's substance abuse issues and the father's involvement in criminal activities. The mother has completed outpatient drug and alcohol treatment and is currently involved in parenting classes and individual mental health counseling. Treatment reports are positive as to her attendance and level of progress in services. She has physical custody of her older daughter. The mother is anxious to have Victor return home. Visitation reports indicate that the mother is attending visits regularly but she has difficulty managing Victor's behaviors without support of the visitation supervisor and the relationship between Victor and his mother remains strained. Family counseling sessions between Victor and his mother have not been productive. The father has repeatedly been incarcerated on drug related probation violations since Victor's entry but he recently enrolled in D/A treatment through community corrections. This is the second CRB review.

WHAT IS YOUR FINDING?

Parental Progress Scenario 2:

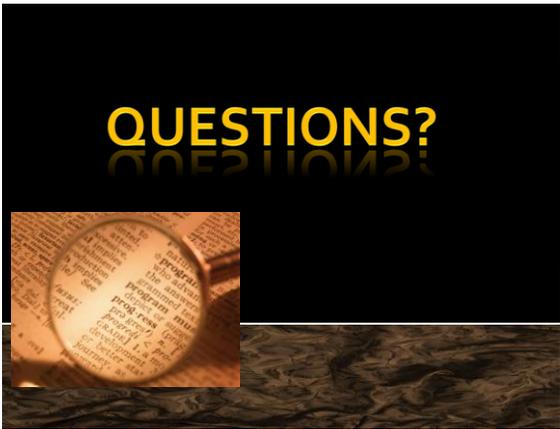
The case involves Cassandra and Colton, four year old twins. The mother has had her parental rights terminated to three older children. The twins were brought into care due to the mother's substance abuse, domestic violence and the mother's inability to protect the children from unsafe situations. Jurisdiction against the father was established due to the father's history of alcohol use, lack of custody and failure to maintain a relationship. The father is now visiting regularly. He previously completed alcohol diversion classes related to his DUII. He is in support of the children remaining in the home of their maternal aunt, where the children's older half-siblings also reside. He doesn't feel he could be a primary custodial resource for the twins due to his employment as a long haul truck driver. The mother has been in two treatment facilities since the children's entry into care. She is attending NA meetings and states she has been clean for 63 days. She is currently residing at the Women's Shelter. This is the first CRB review.

WHAT IS YOUR FINDING?

Test Your Skills: Small Group Activity







**2011 CRB Annual Conference
Breakout Session Report**

Title of Breakout Session: _____
 Board Member to report out at closing plenary: _____
 CRB Field Staff: _____

Why is this topic significant for children and/or families involved in the foster care system?
 : _____
 : _____

What are the most important questions to ask in reviews related to this topic?
 : _____
 : _____

What specific recommendations should boards always consider making related to this topic?
 : _____
 : _____

What strategies should CRB implement for Working with Community Partners (Court, DHS, Attorneys, CASAs, etc.) related to this topic?
 : _____
 : _____

"If all boards _____, then children and/or families involved in the foster care system will _____."





Key Concept: “*The Protective Capacity Assessment*”

The **Protective Capacity Assessment** is a collaborative process between the caseworker and the parent to examine and understand the behaviors, conditions or circumstances that resulted in a child being unsafe. The collaborative process identifies enhanced protective capacities that can be employed to promote and reinforce change, and diminished protective capacities that must change in order for the parent to regain full responsibility for the safety of the child.

The Initial Protective Capacity Assessment

- Builds on the information gathered during the initial CPS assessment
- Is the first intervention after the completion of the CPS assessment
- Allows for the development of a case plan focused on addressing the changes that must occur for the family to assure child safety.

The Ongoing Protective Capacity Assessment

- Is the process of continually observing and measuring change
 - Is the focus of face-to-face contacts with the family throughout the life of a case
- Provides the caseworker with information to document observable, measurable change.

The purpose of developing a case plan based on a Protective Capacity Assessment is:

- The parents and child welfare staff mutually understand(or agree on) the protective capacities that must change; and
- To provide a written case plan identifying the observable, sustained changes that, when accomplished, will increase protective capacity, and reduce or eliminate a safety threat.

There are four stages involved in an Initial Protective Capacity Assessment:

1. Preparation – This is the caseworker’s time to review the case history and to plan for how to conduct a focused protective capacity assessment. The planning process will include the following:

- Ensure you have the information needed to begin the assessment
- Consider what more you need to understand
- Decide how best to approach the family

2. Introduction

- Introduce yourself
- Introduce the **Protective Capacity Assessment** process with parents
- Discuss roles, responsibilities, expectations, issues and concerns



- Explain child welfare involvement, authority and obligations
- Review and explain court processes, and parents' rights
- Discuss self-determination, latitude, boundaries and consequences of parents' choices.
- Listen and understand a parent's point of view

3. Discovery

- Jointly identify specific enhanced and diminished protective capacities directly related to child safety
- Jointly discover what must change for a parent to regain and sustain responsibility for the child's safety
- Determine what the parents are willing to work on
- It is important to include discussion about what is working well
- Keep it simple – aim to come to agreements on contents of a case plan.

4. Case Planning

- Decide “what are we going to do”
- The plan grows out of the process of the **Protective Capacity Assessment**.
- It brings the caseworker and the parents to agreement on:
 - **What is going on now**
 - **What must change**
 - **What must eventually exist**

It is important to remember client self-determination in the Protective Capacity Assessment process.

- Personal choice is fundamental to change regardless of circumstances
- Keep in mind that personal change is an internal matter

For more information about the **Protective Capacity Assessment**, you are encouraged to reference the Child Welfare Procedure Manual, Chapter 3, Section 5 and Chapter 3, Appendixes, 3.1, 3.2, 3.3, 3.4, and 3.5. The Procedure Manual can be found at http://www.dhs.state.or.us/caf/safety_model/index.html#pm

Two definitions from Oregon Child Welfare Administrative Rule that are closely linked to the **Protective Capacity Assessment** are:

"Safety threat" means family behavior, conditions or circumstances that could result in harm to a child.

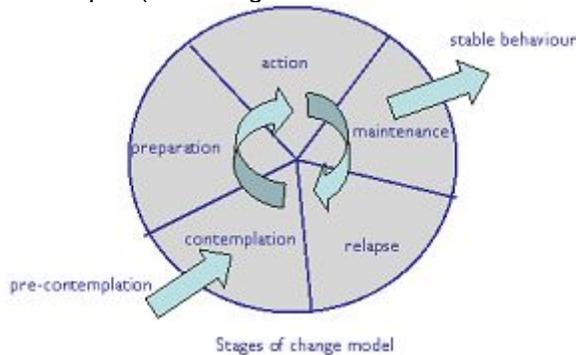


"Protective capacity" means behavioral, cognitive, and emotional characteristics that can specifically and directly be associated with a person's ability to care for and keep a child safe.

The Stages of Change

The stages of change are:

- Precontemplation (Not yet acknowledging that there is a problem behavior that needs to be changed)
- Contemplation (Acknowledging that there is a problem but not yet ready or sure of wanting to make a change)
- Preparation/Determination (Getting ready to change)
- Action/Willpower (Changing behavior)
- Maintenance (Maintaining the behavior change) and
- Relapse (Returning to older behaviors and abandoning the new changes)



Stage One: Precontemplation

In the precontemplation stage, people are not thinking seriously about changing and are not interested in any kind of help. People in this stage tend to defend their current bad habit(s) and do not feel it is a problem. They may be defensive in the face of other people's efforts to pressure them to quit.

They do not focus their attention on quitting and tend not to discuss their bad habit with others. In AA, this stage is called "denial," but at Addiction Alternatives, we do not like to use that term. Rather, we like to think that in this stage people just do not yet see themselves as having a problem.

Are you in the precontemplation stage? No, because the fact that you are reading this shows that you are already ready to consider that you may have a problem with one or more bad habits.

(Of course, you may be reading this because you have a loved one who is still in the pre-contemplation stage. If this is the case, keep reading for suggestions about how you can help others progress through their stages of change)

Stage Two: Contemplation

In the contemplation stage people are more aware of the personal consequences of their bad habit and they spend time thinking about their problem. Although they are able to consider the possibility of changing, they tend to be ambivalent about it.

In this stage, people are on a teeter-totter, weighing the pros and cons of quitting or modifying their behavior. Although they think about the negative aspects of their bad habit and the positives associated with giving it up (or reducing), they may doubt that the long-term benefits associated with quitting will outweigh the short-term costs.

It might take as little as a couple weeks or as long as a lifetime to get through the contemplation stage. (In fact, some people think and think and think about giving up their bad habit and may die never having gotten beyond this stage)

On the plus side, people are more open to receiving information about their bad habit, and more likely to actually use educational interventions and reflect on their own feelings and thoughts concerning their bad habit.

Stage Three: Preparation/Determination

In the preparation/determination stage, people have made a commitment to make a change. Their motivation for changing is reflected by statements such as: "I've got to do something about this — this is serious. Something has to change. What can I do?"

This is sort of a research phase: people are now taking small steps toward cessation. They are trying to gather information (sometimes by reading things like this) about what they will need to do to change their behavior.

Or they will call a lot of clinics, trying to find out what strategies and resources are available to help them in their attempt. Too often, people skip this stage: they try to move directly from contemplation into action and fall flat on their faces because they haven't adequately researched or accepted what it is going to take to make this major lifestyle change.

Stage Four: Action/Willpower

This is the stage where people believe they have the ability to change their behavior and are actively involved in taking steps to change their bad behavior by using a variety of different techniques.

This is the shortest of all the stages. The amount of time people spend in action varies. It generally lasts about 6 months, but it can literally be as short as one hour! This is a stage when people most depend on their own willpower. They are making overt efforts to quit or change the behavior and are at greatest risk for relapse.

Mentally, they review their commitment to themselves and develop plans to deal with both personal and external pressures that may lead to slips. They may use short-term rewards to sustain their motivation, and analyze their behavior change efforts in a way that enhances their self-confidence. People in this stage also tend to be open to receiving help and are also likely to seek support from others (a very important element).

Hopefully, people will then move to:

Stage Five: Maintenance

Maintenance involves being able to successfully avoid any temptations to return to the bad habit. The goal of the maintenance stage is to maintain the new status quo. People in this stage tend to remind themselves of how much progress they have made.

People in maintenance constantly reformulate the rules of their lives and are acquiring new skills to deal with life and avoid relapse. They are able to anticipate the situations in which a relapse could occur and prepare coping strategies in advance.

They remain aware that what they are striving for is personally worthwhile and meaningful. They are patient with themselves and recognize that it often takes a while to let go of old behavior patterns and practice new ones until they are second nature to them. Even though they may have thoughts of returning to their old bad habits, they resist the temptation and stay on track.

As you progress through your own stages of change, it can be helpful to re-evaluate your progress in moving up and down through these stages.

(Even in the course of one day, you may go through several different stages of change).

And remember: it is normal and natural to regress, to attain one stage only to fall back to a previous stage. This is just a normal part of making changes in your behavior.

Stage of Change	Characteristics	Techniques
Pre-contemplation	Not currently considering change: "Ignorance is bliss"	Validate lack of readiness. Clarify: decision is theirs Encourage re-evaluation of current behavior Encourage self-exploration, not action Explain and personalize the risk
Contemplation	Ambivalent about change: "Sitting on the fence" Not considering change within the next month	Validate lack of readiness Clarify: decision is theirs Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations
Preparation	Some experience with change and are trying to change: "Testing the waters" Planning to act within 1 month	Identify and assist in problem solving re: obstacles Help patient identify social support Verify that patient has underlying skills for behavior change Encourage small initial steps
Action	Practicing new behavior for 3-6 months	Focus on restructuring cues and social support Bolster self-efficacy for dealing with obstacles Combat feelings of loss and reiterate long-term benefits
Maintenance	Continued commitment to sustaining new behavior Post-6 months to 5 years	Plan for follow-up support Reinforce internal rewards Discuss coping with relapse
Relapse	Resumption of old behaviors: "Fall from grace"	Evaluate trigger for relapse Reassess motivation and barriers Plan stronger coping strategies

The **transtheoretical model (TTM) of change** in health psychology explains or predicts a person's success or failure in achieving a proposed behavior change, such as developing different habits. It attempts to answer why the change "stuck" or alternatively why the change was not made.

The transtheoretical model (TTM) — currently, the most popular stage model in health psychology (Horwath, 1999) — has proven successful with a wide variety of simple and complex health behaviors, including smoking cessation, weight control, sunscreen use, reduction of dietary fat, exercise acquisition, quitting cocaine, mammography screening, and condom use (Prochaska, et al., 1994). Based on more than 15 years of research, the TTM has found that individuals move through a series of five stages (precontemplation, contemplation, preparation, action, maintenance) in the adoption of healthy behaviors or cessation of unhealthy ones. TTM research on a variety of different problem behaviors has also shown that there are certain predictors of progression through the stages of change (e.g., Prochaska & DiClemente, 1983), including decisional balance (Prochaska, 1994); self-efficacy (e.g., DiClemente, Prochaska, & Gibertini, 1985); and the processes of change (Prochaska & DiClemente, 1983).

The Stages of Change

The TTM (for review, see Prochaska & Velicer, 1997) explains intentional behavior change along a temporal dimension that utilizes both cognitive and performance-based components. Based on more than two decades of research, the TTM has found that individuals move through a series of stages—precontemplation (PC), contemplation (C), preparation (PR), action (A), and maintenance (M)—in the adoption of healthy behaviors or cessation of unhealthy ones (Prochaska & Velicer, 1997).

Pre-Contemplation is the stage in which an individual has no intent to change behavior in the near future, usually measured as the next 6 months. Precontemplators are often characterized as resistant or unmotivated and tend to avoid information, discussion, or thought with regard to the targeted health behavior (Prochaska et al., 1992).

Contemplation stage. Individuals in this stage openly state their intent to change within the next 6 months. They are more aware of the benefits of changing, but remain keenly aware of the costs (Prochaska, Redding, & Evers, 1997). Contemplators are often seen as ambivalent to change or as procrastinators (Prochaska & DiClemente, 1984).

Preparation is the stage in which individuals intend to take steps to change, usually within the next month (DiClemente et al., 1991). PR is viewed as a transition rather than stable stage, with individuals intending progress to A in the next 30 days (Grimley, Prochaska, Velicer, Blais, & DiClemente, 1994).

Action stage is one in which an individual has made overt, perceptible lifestyle modifications for fewer than 6 months (Prochaska et al., 1997).

Maintenance: these are working to prevent relapse and consolidate gains secured during A (Prochaska et al., 1992). Maintainers are distinguishable from those in the A stage in that they report the highest levels of self-efficacy and are less frequently tempted to relapse (Prochaska & DiClemente, 1984).

The TTM uses the stages of change to integrate cognitive and behavioral processes and principles of change, including 10 processes of change (i.e., how one changes; Prochaska, 1979; Prochaska, Velicer, DiClemente, & Fava, 1988), pros and cons (i.e., the benefits and costs of changing; Janis & Mann, 1977; Prochaska, Redding, Harlow, Rossi, & Velicer, 1994; Prochaska, Velicer, et al., 1994), and self-efficacy (i.e., confidence in one's ability to change; Bandura, 1977; DiClemente, Prochaska, & Gibertini, 1985)—all of which have demonstrated reliability and consistency in describing and predicting movement through the stages (Prochaska & Velicer, 1997).

Prochaska's Model stipulates six stages:

1. Precontemplation - lack of awareness that life can be improved by a change in behavior;
2. Contemplation - recognition of the problem, initial consideration of behavior change, and information gathering about possible solutions and actions;
3. Preparation - introspection about the decision, reaffirmation of the need and desire to change behavior, and completion of final pre-action steps;
4. Action - implementation of the practices needed for successful behavior change (e.g. exercise class attendance);
5. Maintenance - consolidation of the behaviors initiated during the action stage;
6. Termination - former problem behaviors are no longer perceived as desirable (e.g. skipping a run results in frustration rather than pleasure).

Processes of Change are the covert and overt activities that people use to progress through the stages. Processes of change provide important guides for intervention programs, since the processes are the independent variables that people need to apply, or be engaged in, to move from stage to stage. Ten processes (Prochaska & DiClemente, 1983; Prochaska, Velicer, DiClemente, & Fava, 1988) have received the most empirical support in our research to date. The first five are classified as Experiential Processes and are used primarily for the early stage transitions. The last five are labeled Behavioral Processes and are used primarily for later stage transitions. Table 1 provides a list of the processes with a sample item for each process from smoking cessation as well as alternative labels.

I. Processes of Change: Experiential

1. **Consciousness Raising [Increasing awareness]**

I recall information people had given me on how to stop smoking

2. **Dramatic Relief [Emotional arousal]**

I react emotionally to warnings about smoking cigarettes

3. **Environmental Reevaluation [Social reappraisal]**

I consider the view that smoking can be harmful to the environment

4. Social Liberation [Environmental opportunities]

I find society changing in ways that make it easier for the nonsmoker

5. Self Reevaluation [Self reappraisal]

My dependency on cigarettes makes me feel disappointed in myself

II. Processes of Change: Behavioral

6. Stimulus Control [Re-engineering]

I remove things from my home that remind me of smoking

7. Helping Relationship [Supporting]

I have someone who listens when I need to talk about my smoking

8. Counter Conditioning [Substituting]

I find that doing other things with my hands is a good substitute for smoking

9. Reinforcement Management [Rewarding]

I reward myself when I don't smoke

10. Self Liberation [Committing]

I make commitments not to smoke

Consciousness Raising involves increased awareness about the causes, consequences and cures for a particular problem behavior. Interventions that can increase awareness include feedback, education, confrontation, interpretation, bibliotherapy and media campaigns.

Dramatic Relief initially produces increased emotional experiences followed by reduced affect if appropriate action can be taken. Psychodrama, role playing, grieving, personal testimonies and media campaigns are examples of techniques that can move people emotionally.

Environmental Reevaluation combines both affective and cognitive assessments of how the presence or absence of a personal habit affects one's social environment. It can also include the awareness that one can serve as a positive or negative role model for others. Empathy training, documentaries, and family interventions can lead to such re-assessments.

Social Liberation requires an increase in social opportunities or alternatives especially for people who are relatively deprived or oppressed. Advocacy, empowerment procedures, and appropriate policies can produce increased opportunities for minority health promotion, gay health promotion, and health promotion for impoverished people. These same procedures can also be used to help all people change such as smoke-free zones, salad bars in school lunches, and easy access to condoms and other contraceptives.

Self-reevaluation combines both cognitive and affective assessments of one's self-image with and without a particular unhealthy habit, such as one's image as a couch potato or an active person. Value clarification, healthy role models, and imagery are techniques that can move people evaluatively.

Stimulus Control removes cues for unhealthy habits and adds prompts for healthier alternatives. Avoidance, environmental re-engineering, and self-help groups can provide stimuli that support change and reduce risks for relapse. Planning parking lots with a two-minute walk to the office and putting art displays in stairwells are examples of reengineering that can encourage more exercise.

Helping Relationships combine caring, trust, openness and acceptance as well as support for the healthy behavior change. Rapport building, a therapeutic alliance, counselor calls and buddy systems can be sources of social support.

Counter Conditioning requires the learning of healthier behaviors that can substitute for problem behaviors. Relaxation can counter stress; assertion can counter peer pressure; nicotine replacement can substitute for cigarettes, and fat free foods can be safer substitutes.

Reinforcement Management provides consequences for taking steps in a particular direction. While reinforcement management can include the use of punishments, we found that self-changers rely on rewards much more than punishments. So reinforcements are emphasized, since a philosophy of the stage model is to work in harmony with how people change naturally. Contingency contracts, overt and covert reinforcements, positive self-statements and group recognition are procedures for increasing reinforcement and the probability that healthier responses will be repeated.

Self-liberation is both the belief that one can change and the commitment and recommitment to act on that belief. New Year's resolutions, public testimonies, and multiple rather than single choices can enhance self-liberation or what the public calls willpower. Motivation research indicates that people with two choices have greater commitment than people with one choice; those with three choices have even greater commitment; four choices do not further enhance will power. So with smokers, for example, three excellent action choices they can be given are cold turkey, nicotine fading and nicotine replacement.



Case Synopsis

INSTRUCTIONS:

- *Read the case information provided below.*
- *Note any additional questions you would ask at the review.*
- *Discuss the finding with your group to determine how you would find for each parent and why.*

Date of review: 4/9/11

Permanency Plan: Return to Parent

Concurrent Plan: Guardianship

Date entered care: 11/16/10

Date of Jurisdiction: 12/13/09

Date of Birth: 3/1/96; 1/29/99; 8/17/01

Basis for Jurisdiction: Katy, age 15, Brooklyn, age 12, and Dylan, age 9 ½, are under court jurisdiction based on the following allegations: the mother, Catherine Bogle, having a substance abuse problem which threatens her ability to care for the child; the father, Jose Romero, having a substance abuse problem which threatens his ability to care for the children; and the father having been a perpetrator of domestic violence against the mother; therefore, the child's welfare is endangered.

ICWA Status: ICWA does not apply.

Case Summary:

DHS has been providing services to the family since 2009. There had been six prior referrals between 2008 and 2009, including three founded referrals due to concerns of alcohol/ substance abuse and Mr. Romero's assaultive behavior toward the mother. Petitions were initially filed on 10/23/09 when Mr. Romero was arrested on Assault charges. An in-home safety plan was developed allowing the children to remain with their mother. A restraining order was filed but was later dismissed per the mother's request. Ms. Bogle relapsed on alcohol and narcotic pain medication in 3/10. The children reported erratic behavior and inappropriate discipline by their mother. The safety plan was modified and the children were placed with their father. The children were removed from their father's care and placed in substitute care on 11/16/10 when Mr. Romero was transported to the hospital by police for making suicidal threats. His BAC was .17 at the time.

A Permanency Hearing was held on 10/16/10 and the parents were granted a 120 day extension based on the in-home safety plan. A review hearing was held on 2/13/11 and the parents were granted an additional 120 day extension. **A Permanency Review Hearing is scheduled for 6/12/11.**

Updated Action Agreements were provided for the parents on 2/2/11. Mr. Romero was required to: attend and successfully complete a D/A program; attend and successfully complete a domestic violence alternative program; maintain a clean/sober lifestyle; and regularly attend visitation with the children. Ms. Bogle was required to: attend and successfully complete a D/A program; maintain a clean/sober lifestyle; attend and successfully complete parenting classes; participate in intensive family counseling services; and regularly attend visitation with the children.

Information Reported at the Review:

Parties present: DHS, foster parent, mother, mother's D/A counselor, Dylan's therapist, father's attorney.

Ms. Bogle completed a D/A assessment on 4/5/10 following her relapse on narcotic pain medications. She was assessed as needing intensive outpatient treatment. Due to lack of progress in groups, the program recommended she participate in individual sessions with a D/A counselor twice per week. Ms. Bogle was unsuccessfully discharged on 8/6/10 for lack of attendance and failure to acknowledge the severity of her addiction. Ms. Bogle was arrested for a DUUI on 10/31/10. She received diversion and was court ordered to complete a D/A program. Ms. Bogle re-enrolled in D/A treatment on 11/27/10. The evaluator recommended a Dual Diagnosis group (for co-occurring mental health and D/A disorders). The evaluator indicated prognosis was poor without Ms. Bogle's willingness to embrace recovery.

Ms. Bogle is currently attending D/A treatment two days per week and participating in a Dual Diagnosis group once per week. She states she has been clean from prescription pain medication since 11/4/10 but admits to a relapse on alcohol on New Year's Eve. Ms. Bogle states she is attending AA/NA meetings 2 times per week but does not have a sponsor.

Ms. Bogle's D/A counselor reports Ms. Bogle is an active participant in D/A groups and her attendance has been more consistent since 1/11. Ms. Bogle has taken greater accountability for the impact of her substance abuse on the children and she self-reported the relapse on alcohol on New Year's Eve. There have been 5 random UA's administered since Ms. Bogle's enrollment in treatment; all have been clean.

Ms. Bogle has twice weekly visitation with all three children. She is involved in family therapy with Katy and Dylan every other week. Dylan's counselor reports Ms. Bogle has attended 2 family sessions to date. Dylan is diagnosed with ADHD and Oppositional Defiance Disorder. Additional work needs to be done to repair the relationship dynamic between Dylan and his mother. The foster parent reports Dylan is still very angry with his mother and has stated he wants to live with his father.

Ms. Bogle has part-time employment and is renting a room from a member of her church. She states she does not intend to reunite with Mr. Romero. She states she is on the HUD wait list for a 3 bedroom apartment. Ms. Bogle began parenting classes on 1/4/11. She is scheduled to graduate from parenting classes on 4/12/11. DHS reports the initial referral for parenting classes was closed in 5/10 for lack of follow through.

Mr. Romero successfully completed a 90 day outpatient D/A treatment program on 2/3/11 but he has been unable to maintain sobriety since graduation. He verbally admitted at the Permanency Review Hearing on 2/13/11 to daily consumption of beer. Mr. Romero is now on the wait list for residential D/A treatment. He is calling the program weekly to remain on the wait list. He has been enrolled in a domestic violence program since 12/09 but attendance has been inconsistent and he has not completed the course. The counselor is recommending Mr. Romero re-start the course from the beginning. His attorney reports Mr. Romero's work schedule prevents him from consistently attending domestic violence groups but notes the DV counselor gave a very favorable report as to Mr. Romero's level of participation when he does attend. The attorney reports Mr. Romero is willing to complete the services required in order to regain custody of the children.

Mr. Romero has full-time employment and stable housing. Mr. Romero is visiting with the children once per week and has nightly phone contact. Visitation reports indicate he has a loving and supportive relationship with his children.

FINDING:

The parents have made sufficient progress to make it possible for the child to safely return home.

MOTHER -

FATHER -