*Service Standards*

# Child and Family Development and Support Services

**Purpose**

Child and Family Development and Support Services promote positive parenting; support children's health and safety; strengthen parent-child relationships; improve family functioning and self-sufficiency; and enhance parental health, well-being, and life course development.

## Definition

Child and Family Development and Support Services (CFD) is designed to accommodate a variety of supportive programs that may be provided to families who need help promoting positive development, meeting challenges, and preventing adverse outcomes. Many programs will serve the family as a whole and involve both parents and children in services, but CFD can also accommodate programs that work only with parents, as long as the focus of the program is on supporting the whole family. The section can also accommodate programs for families who seek services voluntarily as well as programs for families mandated to participate in services (e.g., because they have been reported for child maltreatment). While CFD is geared towards services provided to biological parents and their children, the section can also accommodate programs provided to kinship, foster, and adoptive families.

Programs may be designed to provide different types of services, such as home visiting services, early intervention services, family-centered peer support services, and/or parent education groups. Programs may also be designed to target families with different needs, characteristics, and risk factors. For example, some programs may be specifically designed to serve expectant or new parents, while other programs may be designed to serve families with school-aged children or adolescents. Similarly, while one program might provide services to any interested family as a means of primary prevention, another might offer services only to families with certain risk factors (e.g., families experiencing or at risk for child maltreatment, families who need help addressing a child's emotional or behavioral issues, or families impacted by substance use).

**Note:** *Organizations providing only parent education groups will complete: CFD 1, CFD 2, CFD 3, and CFD 6.*

*Organizations providing only family-centered peer support services will complete: CFD 1, CFD 2, CFD 3, CFD 5, and CFD 10. If peer support workers are also responsible for delivering the services addressed in other core concept standards (e.g., parent education), those additional core concepts should be completed, as applicable.*

*All other organizations will complete the following core concept standards relating to general service delivery: CFD 1-CFD 5, and CFD 11. They will also complete one or more of the following core concept standards, based on the services their programs provide: CFD 6, CFD 7, CFD 8, CFD 9, and CFD 10. For example, a home visiting program that provides education services would complete CFD 6, whereas a home visiting program that provides education and health services would complete CFD 6 and CFD 8.*

**Note:** *In cases where a program is designed to serve only one or both parents and does not include the children in services, standards that reference collaboration with families or family members can be implemented by collaborating with parents to address the needs of the family.*

**Note:** *Please see CFD Reference List and CFD – Peer Support Services Reference List for the research that informed the development of these standards.*

# Table of Evidence

## Self Study Evidence

*No Self Study Evidence*

Child and Family Development and Support Services

# CFD 1: Person-Centered Logic Model

**Purpose**

Child and Family Development and Support Services promote positive parenting; support children's health and safety; strengthen parent-child relationships; improve family functioning and self-sufficiency; and enhance parental health, well-being, and life course development.

The organization implements a program logic model that describes how resources and program activities will support the achievement of positive outcomes.

**Note:** *Please see the Logic Model Template for additional guidance on this standard.*

**Rating Indicators:**

**1** All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

Logic models have been implemented for all programs and the organization has identified at least two outcomes for all its programs.

**2**

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Logic models need improvement or clarification; or
- Logic models are still under development for some of its programs, but are completed for all high-risk programs such as protective services, foster care, residential treatment, etc.; or
- At least one desired outcome has been identified for all of its programs.

**3**

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Logic models need significant improvement; or
- Logic models are still under development for a majority of programs; or
- A logic model has not been developed for one or more high-risk programs; or
- Outcomes have not been identified for one or more programs.

**4**

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- Logic models have not been developed or implemented; or
- Outcomes have not been identified for any programs.

## Table of Evidence

### Self Study Evidence

| | | |
|---|---|---|
| * | • Program logic model that includes a list of outcomes being measured | |
| | • See program description completed during intake | |

### Site Visit Evidence

*No Site Visit Evidence*

### On-Site Activities

*

- Interviews may include:

1. Program director
2. Relevant personnel

## CFD 1.01

A program logic model, or equivalent framework, identifies:

a. needs the program will address;
b. available human, financial, organizational, and community resources (i.e. inputs);
c. program activities intended to bring about desired results;
d. program outputs (i.e. the size and scope of services delivered);
e. desired outcomes (i.e. the changes you expect to see in persons served); and
f. expected long-term impact on the organization, community, and/or system.

**Examples:** *Please see the W.K. Kellogg Foundation Logic Model Development Guide and COA Accreditation's PQI Guide for more information on developing and using program logic models.*

**Examples:** *Information that may be used to inform the development of the program logic model includes, but is not limited to: (a) characteristics of the service population; (b) needs assessments and periodic reassessments; (c) risks assessments conducted for specific interventions; and (d) the best available evidence of service effectiveness.*

## CFD 1.02

The logic model identifies desired outcomes in at least two of the following areas:

a. change in clinical status;
b. change in functional status;
c. health, welfare, and safety;
d. permanency of life situation;
e. quality of life;
f. achievement of individual or family goals; and
g. other outcomes as appropriate to the program or service population.

**Interpretation:** *Outcomes data should be disaggregated to identify patterns of disparity or inequity that can be masked by aggregate data reporting. See PQI 5.02 for more information on disaggregating data to track and monitor identified outcomes.*

Child and Family Development and Support Services

# CFD 2: Personnel

**Purpose**

Child and Family Development and Support Services promote positive parenting; support children's health and safety; strengthen parent-child relationships; improve family functioning and self-sufficiency; and enhance parental health, well-being, and life course development.

Program personnel have the competency and support needed to provide services and meet the needs of families.

**Interpretation:** *Competency can be demonstrated through education, training, or experience, including lived experience when applicable. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas.*

**Rating Indicators:**

**1** All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

**2**

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, but the integrity of the service is not compromised; or
- Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
- Most staff who do not meet educational requirements are seeking to obtain them; or
- With few exceptions, staff have received required training, including applicable specialized training; or
- Training curricula are not fully developed or lack depth; or
- Training documentation is consistently maintained and kept up-to-date with some exceptions; or
- A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
- With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
- Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
- Specialized services are obtained as required by the standards.

**3**

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- A significant number of staff (direct service providers, supervisors, and program managers) do not possess the required qualifications, and, as a result, the integrity of the service may be compromised; or
- Job descriptions typically do not reflect the requirements of the standards, and/or hiring practices do not document efforts to hire staff with required qualifications when vacancies occur; or
- Supervisors do not typically provide additional support and oversight to staff without the listed qualifications; or
- A significant number of staff have not received required training, including applicable specialized training; or
- Training documentation is poorly maintained; or
- A significant number of supervisors do not meet the requirements of the standard, and the organization makes little effort to provide training and/or consultation to improve competencies; or
- There are numerous instances where caseload sizes exceed the standards' requirements or the requirements of internal policy when a caseload size is not set by the standard; or
- Workloads are excessive, and the integrity of the service may be compromised; or
- Specialized staff are typically not retained as required and/or many do not possess the required qualifications; or
- Specialized services are infrequently obtained as required by the standards.

**4** Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards.

## Table of Evidence

### Self Study Evidence

| | | |
|---|---|---|
| * | • Table of contents of training curricula | |
| * | • Procedures or other documentation relevant to continuity of care and case assignment | |
| * | • List of program personnel that includes:<br><br>1. Title<br>2. Name<br>3. Employee, volunteer, or independent contractor<br>4. Degree or other qualifications<br>5. Time in current position<br><br>• See organizational chart submitted during application | |
| * | • Procedures or other documentation specific to peer support workers, if applicable | |

### Site Visit Evidence

| | |
|---|---|
| * | • Sample job descriptions from across relevant job categories<br>• Documentation tracking staff completion of required trainings and/or competencies<br>• Training curricula<br>• Caseload size requirements set by policy, program model, regulation, or contract, when applicable<br>• Documentation of current caseload size per worker, when applicable |

### On-Site Activities

| | |
|---|---|
| * | • Interviews may include:<br><br>1. Program director<br>2. Relevant personnel<br><br>• Review personnel files |

## CFD 2.01

Direct service personnel are qualified by:

a. a bachelor's degree in a health or human service field;
b. a high school degree or equivalent and at least two years' experience working with children and families; or
c. certification in accordance with an evidence-based program model.

**NA:** The organization provides only peer support services.

## CFD 2.02

Supervisors are qualified by:

a. an advanced degree in a health or human service field; or
b. a bachelor's degree in a health or human service field and at least two years' experience working with children and families.

**NA:** The organization provides only peer support services.

**Examples:** *When supervisors are qualified by element (b), prior experience with supervision may also be desirable.*

## CFD 2.03

When individuals with lived experience provide peer support services, their supervisors are qualified by a bachelor's degree in a health or human service field, relevant experience, and appropriate training.

**NA:** The organization does not provide peer support services.

**Interpretation:** *Appropriate experience and training can compensate for a lack of a bachelor's degree. For example, lived experience, time spent providing peer support, and specialized training may be more critical than level of academic degree.*

*Specialized training specific to the peer support role will also be critical if supervisors have not provided peer support themselves. Appropriate training should address: (a) concepts and philosophies related to peer support and recovery; (b) the role of a peer support worker; (c) ethical guidelines, including potential ethical dilemmas; and (d) recognizing and responding to relapse triggers and signs of trauma among peer support workers.*

## CFD 2.04

All direct service personnel are trained on, or demonstrate competency in:

a. establishing professional boundaries and employing appropriate methods of support;
b. encouraging independence;
c. understanding child development and individual and family functioning;
d. identifying and building on strengths and protective factors;
e. assessing needs, risks, and safety;
f. helping family members develop skills relevant to positive parenting, child development, caregiving, health and safety, and/or positive personal development, as appropriate to the services provided;
g. understanding, recognizing and responding to problems related to child abuse and neglect, domestic violence, substance use, and mental health, including signs of prenatal and postpartum depression; and
h. implementing the specific program model used to deliver services, if applicable.

**NA:**

- The organization provides only parent education groups.
- The organization provides only peer support services.

## CFD 2.05

All direct service personnel providing early intervention services are trained on, or demonstrate competency in:

a. administering early intervention techniques;
b. understanding issues of particular relevance to the families of children with developmental delays or disabilities; and
c. helping families learn how to support and promote their children's healthy development.

**NA:** The organization does not provide early intervention services.

## CFD 2.06

All direct service personnel providing parent education services in a group setting are trained on, or demonstrate competency in:

a. providing a supportive, nonjudgmental environment that promotes respectful interactions;
b. engaging and motivating group members;
c. understanding group dynamics;
d. leading discussions;
e. facilitating group activities;
f. helping family members develop skills relevant to the class's areas of focus, including positive parenting, child development, caregiving, health and safety, and/or positive personal development, as appropriate to the services provided; and

g. implementing the specific program model used to deliver services, if applicable.

**NA:** The organization does not provide parent education groups.

## CFD 2.07

When individuals with lived experience provide peer support to families, the organization:

a. determines how appropriate candidates will be recruited and selected, including how much time must pass before an individual with lived experience is eligible to serve as a peer support worker;
b. provides ongoing support and supervision to address any issues that may arise on the job, including helping peer support workers navigate complex situations and manage personal triggers and challenges; and
c. facilitates opportunities for peer support workers to connect and consult with others performing similar roles.

**NA:** The organization does not provide peer support services.

**Note:** *The organization should make sure that it follows all applicable laws and regulations when recruiting and selecting candidates with lived experience, as addressed in HR 2.02 and RPM 1.*

## CFD 2.08

Personnel who provide peer support receive pre- and in-service training on:

a. their roles and responsibilities;
b. concepts and philosophies related to peer support and recovery;
c. establishing healthy and appropriate boundaries, including balancing self-disclosure with professionalism;
d. handling ethical dilemmas, including those related to privacy, confidentiality, conflicts of interest, and the mandatory disclosure of information;
e. ways to engage, motivate, and collaborate with family members;
f. child development and individual and family functioning, including how a family may be impacted by the needs and challenges the program is designed to address;
g. strategies for supporting family members, and building on their strengths, to address the needs and challenges the program is designed to address;
h. processes and requirements of the agencies and systems working with children and families, including the child welfare, behavioral health, and/or justice systems, as appropriate; and
i. managing personal triggers that may occur during the course of their role as a peer support worker.

**NA:** The organization does not provide peer support services.

**Interpretation:** *Peer support workers will draw upon their own knowledge and perspectives when working with families, but can still benefit from training that helps them use their own personal experience to support others. For example, although peer recovery coaches working with families in the child welfare system will have experience with both substance use and child welfare, they may still benefit from a strengthened understanding of both child welfare processes and the ways substance use may impact child development and family functioning.*

## CFD 2.09

The organization maintains service continuity by:

a. assigning a worker at intake or early in the contact;
b. avoiding the arbitrary or indiscriminate reassignment of direct service personnel; and
c. using a team approach to ensure a comprehensive and integrated approach to service delivery, when multiple providers are involved.

**Note:** *See CFD 10.04 for additional expectations regarding teams and partnerships when peer support services are provided.*

## CFD 2.10

Employee workloads support the achievement of positive outcomes and are regularly reviewed.

**Interpretation:** *When an organization implements a specific evidence-based program model, caseloads/workloads should be based on the model guidelines and reflected in policy/procedures and practice.*

**Examples:** *Factors that may be considered when determining employee workloads include, but are not limited to: (a) the program model being implemented; (b) the qualifications, competencies, and experience of the worker, including the level of supervision needed; (c) case complexity and circumstances, including the intensity of child and family needs, the frequency of services provided, the size of the family, travel time, and the goal of the case; (d) case status, including progress toward achievement of desired outcomes; (e) the work and time required to accomplish assigned tasks and job responsibilities; (f) whether services are provided by multiple professionals or team members; (g) whether workers providing peer support services will have sufficient time to focus on self-care and their own recovery; and (h) service volume.*

*Different program models recommend different caseloads/workloads. For example, SafeCare recommends a caseload of 10 to 12 families, Healthy Families America recommends 14 to 16 families, and the Nurse Family Partnership recommends no more than 25 families. Parents as Teachers focuses on the number of visits per month rather than the number of families served, and recommends a maximum of 40 to 50 visits per month.*

## CFD 2.11

The organization prevents and counters the development of work-related stress, including burnout and secondary traumatic stress, by:

a. helping personnel understand how they can be impacted by stress, distress, and trauma;
b. helping personnel develop the skills and behaviors needed to manage and cope with work-related stressors;
c. encouraging respectful collaboration and support among co-workers;
d. examining how the organization's culture and policies contribute to or prevent burnout and secondary traumatic stress; and
e. informing personnel about treatment services and other available supports, as needed.

**NA:** The organization provides only parent education groups.

**Interpretation:** *Implementation of this standard will be especially important when individuals with lived experience provide peer support services. Organizations operating peer support programs should ensure that peer support workers receive the training, supervision, and support they need to manage challenges and maintain their own recovery, as referenced in CFD 2.03, CFD 2.07, and CFD 2.08.*

**Examples:** *Regarding element (b), organizations can help personnel develop the skills and behaviors that will enable them to, for example: (a) engage in positive thinking;(b) increase their self-awareness;(c) know their limits and needs;(d) practice self-compassion;(e) establish healthy boundaries with co-workers and persons served;(f) effectively communicate about unrealistic and unspoken expectations;(g) monitor and regulate their emotions and behaviors;(h) identify and manage emotional triggers;(i) have difficult conversations with co-workers and supervisors;(j) practice brain-aware activities to stay regulated;(k) take time for self-care; and (l) obtain help if needed.*

*Regarding element (d), areas to consider include, but are not limited to: (a) supervision;(b) workload;(c) scheduling, including options for flexibility; (d) paid time off; (e) trainings;(f) crisis response;(g) psychological safety; and (h) healthy and realistic staff expectations and boundaries.*

Child and Family Development and Support Services

# CFD 3: Intake and Assessment

**Purpose**

Child and Family Development and Support Services promote positive parenting; support children's health and safety; strengthen parent-child relationships; improve family functioning and self-sufficiency; and enhance parental health, well-being, and life course development.

The organization's outreach, intake, and assessment practices ensure that families receive prompt and responsive access to appropriate services.

**Rating Indicators:**

**1** All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

**2**

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- In a few rare instances, urgent needs were not prioritized; or
- For the most part, established timeframes are met; or
- Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

**3**

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Urgent needs are often not prioritized; or
- Services are frequently not initiated in a timely manner; or
- Applicants are not receiving referrals, as appropriate; or
- Assessment and reassessment timeframes are often missed; or
- Assessments are sometimes not sufficiently individualized; or
- Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

**4** Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- There are no written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

## Table of Evidence

### Self Study Evidence

| | |
|---|---|

| | | |
|---|---|---|
| * | • Screening and intake procedures | |
| * | • Assessment procedures | |
| * | • Copy of assessment tool(s) | |

**Site Visit Evidence**

| | |
|---|---|
| * | • Outreach materials, if applicable<br>• Documentation of collaboration with other providers, if applicable<br>• Eligibility criteria, if applicable<br>• Community resource and referral list |

**On-Site Activities**

| | |
|---|---|
| * | • Interviews may include:<br><br>1. Program director<br>2. Relevant personnel<br>3. Persons served<br><br>• Review case records |

## CFD 3.01

The organization conducts community outreach, or collaborates with other providers who may come in contact with the program's target population, to identify and engage families who may benefit from the organization's services.

**Interpretation:** *Programs designed to provide services to expectant parents or parents with very young children should strive to identify and engage families as early as possible, to ensure families receive services at critical points in pregnancy and early childhood.*

**Examples:** *When the organization provides outreach directly to families, outreach strategies may include, but are not limited to: (a) telephone calls; (b) mailings; (c) announcements at community programs and events; (d) distributing information packets in places where families naturally congregate (e.g., schools, libraries, and faith-based institutions); and (e) drop-in visits to the home.*

**Examples:** *Other providers that may come in contact with individuals or families in need of services include, but are not limited to: (a) hospitals; (b) prenatal clinics; (c) health departments and providers; (d) schools; (e) departments of social and human services, including child welfare agencies; (f) mental health and substance use service providers; (g) family courts, and (h) drug courts.*

## CFD 3.02

Families are screened and informed about:

a. how well their needs match the organization's services; and
b. what services will be available and when.

**NA:** Another organization is responsible for screening, as defined in a contract.

## CFD 3.03 (FP)

Prompt, responsive intake practices:

a. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;
b. give priority to urgent needs and emergency situations;
c. support timely initiation of services; and
d. provide placement on a waiting list or referral to appropriate resources when individuals cannot be served or cannot be served promptly.

**Interpretation:** *When individuals cannot be served promptly and services should not be delayed (e.g., when individuals are seeking time-sensitive services during pregnancy or for very young children), they should be referred to alternate resources rather than placed on a waiting list.*

***Examples:*** *Some organizations that provide only parent education groups, and thus are not required to conduct more thorough assessments as per CFD 3.04 and CFD 3.05, may strive to promote service responsiveness by also seeking information regarding needs, goals, and potential barriers to service participation.*

## CFD 3.04

Family members participate in an individualized, culturally and linguistically responsive assessment that is:

a. completed within established timeframes;
b. updated as needed based on the needs of the family and the design of the program; and
c. focused on information pertinent for meeting service requests and objectives.

**NA:**

- The organization provides only parent education groups.
- The organization provides only peer support services.

**Examples:** *Timeframes for reassessment may vary based on program design. For example, a program designed to monitor child health and development may require reassessments at specific intervals, e.g., annually or in accordance with specific child development milestones.*

## CFD 3.05

Standardized assessment tools are used to identify:

a. strengths and protective factors upon which the family can build; and
b. needs and risk factors associated with poor child, individual, and family outcomes.

**NA:**

- The organization provides only parent education groups.
- The organization provides only peer support services.

**Interpretation:** *The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA Accreditation's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design.*

**Interpretation:** *Programs that conduct assessments of child development should work with families to better understand a child's strengths and needs, and informed clinical opinion can be used when standardized measures will not accurately reflect a child's developmental status.*

**Examples:** *Programs may concentrate their assessments on different areas, depending on the program model and area of focus. For example, while one program might limit its assessment to observation of a parent's skills and functioning in specific areas, another might take a broader approach and include a more in-depth evaluation of areas such as parent-child attachment and/or child health and development.*

Child and Family Development and Support Services

# CFD 4: Service Planning and Monitoring

**Purpose**

Child and Family Development and Support Services promote positive parenting; support children's health and safety; strengthen parent-child relationships; improve family functioning and self-sufficiency; and enhance parental health, well-being, and life course development.

Family members participate in the development and ongoing review of a service plan that is the basis for delivery of appropriate services and support.

**NA:**

- The organization provides only parent education groups.
- The organization provides only peer support services.

**Rating Indicators:**

**1** All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

**2**

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- With few exceptions, staff work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc.; or
- Active participation of persons served occurs to a considerable extent.

**3**

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Case reviews are not being done consistently; or
- Level of care for some people is clearly inappropriate; or
- Service planning is often done without the full participation of persons served; or
- Appropriate family involvement is not documented; or
- Documentation is routinely incomplete and/or missing; or
- Individual staff members work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc., but this is the exception.

**4** Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

## Table of Evidence

### Self Study Evidence

| | |
|---|---|
| • Service planning and monitoring procedures | |

### Site Visit Evidence

*No Site Visit Evidence*

### On-Site Activities

- Interviews may include:

1. Program director
2. Relevant personnel
3. Persons served

- Review case records

## CFD 4.01

An assessment-based, family-centered service plan is developed in a timely manner with the full participation of family members, and includes:

a. agreed-upon goals, desired outcomes, and timeframes for achieving them;
b. services and supports to be provided, and by whom;
c. procedures for expedited service planning when crisis or urgent need is identified; and
d. documentation of the family's participation in service planning.

**Interpretation:** *Generally children age six and over should be included in service planning, unless there are clinical justifications for not doing so.*

**Examples:** *Planning often focuses on determining the supports and services needed to reduce the risks, and build on the strengths, identified in the assessment. Some programs may break goals into intermediary steps, and develop plans for each meeting with the family, to facilitate progress toward the overarching goals specified in the service plan. The process of developing and achieving goals, and reflecting and building upon those successes, can also support family members' sense of agency and self-efficacy.*

## CFD 4.02

The organization works in active partnership with family members and other community providers to:

a. help family members access needed services the organization does not provide;
b. promote a comprehensive, coordinated approach to serving family members;
c. ensure that family members receive appropriate advocacy support; and
d. mediate barriers to services within the service delivery system.

**Examples:** *Some programs may place special emphasis on working with family members to promote service coordination in a specific area, such as early intervention and/or child and maternal health.*

## CFD 4.03

The worker and a supervisor, or a clinical, service, or peer team, review the case quarterly, or more frequently depending on the needs of the family, to assess:

a. service plan implementation;
b. progress toward achieving goals and desired outcomes, as well as any factors that may be impeding that progress; and
c. the continuing appropriateness of planned services and agreed upon service goals.

**Interpretation:** *When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard.*

## CFD 4.04

The worker and family:

a. review progress toward achievement of agreed upon service goals;
b. review factors impeding progress; and
c. document revisions to service goals and plans.

# CFD 5: Family-Focused Approach to Service

**Purpose**

Child and Family Development and Support Services promote positive parenting; support children's health and safety; strengthen parent-child relationships; improve family functioning and self-sufficiency; and enhance parental health, well-being, and life course development.

Families receive services that are flexible, accessible, and responsive to their needs and circumstances.
**NA:** The organization provides only parent education groups.

**Rating Indicators:**

**1** All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

**2**

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

**3**

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

**4** Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

## Table of Evidence

### Self Study Evidence

*No Self Study Evidence*

### Site Visit Evidence

*No Site Visit Evidence*

### On-Site Activities

*

- Interviews may include:

1. Program director
2. Relevant personnel
3. Persons served

- Review case records
- Observe sites, as appropriate

## CFD 5.01

Workers partner with families to establish respectful, trust-based relationships that facilitate engagement and productive service delivery.

**Examples:** *Examples of ways personnel can build trust and promote the development of positive relationships include: (a) adopting a trauma-informed approach to engagement; (b) interacting with family members in a respectful, non-threatening, non-stigmatizing, and non-judgmental manner; (c) using person/family-centered language; (d) demonstrating sensitivity to the willingness of an individual to be engaged; (e) interacting with family members in a culturally and linguistically responsive manner; (f) being honest, transparent, and authentic; (g) listening actively and empathetically; (h) recognizing and responding to individuals' goals and concerns; (i) being consistent, reliable, and accessible; (j) identifying and building on strengths; (k) offering encouragement and emotional support; (l) expressing compassion; (m) respecting individuals' autonomy, confidentiality, boundaries, and choices; (n) celebrating successes; and (o) remaining persistent over time. When peer support services are provided, workers can also build trust and promote the development of positive relationships by sharing their personal stories and experiences.*

*One way that a relationship can help facilitate engagement and productive service delivery is by helping family members increase their motivation to make positive choices and changes. Strategies for accomplishing this can include, for example: (a) helping family members develop a vision of what they want; (b) encouraging family members to explore their own reasons for making positive choices and changes; (c) helping family members consider the pros and cons of different choices, including any discrepancies between their current situation and their hopes for the future; (d) helping family members see how services can help them; (e) highlighting past successes and strengths family members can draw upon when trying to change; and (f) avoiding argumentative or blaming strategies that might prompt family members to withdraw or become defensive.*

## CFD 5.02

In an effort to encourage engagement and promote long-term change, services are, to the extent possible and appropriate:

a. provided at times acceptable to the family, including times that accommodate the family's schedule and needs;
b. provided in natural environments and comfortable places, including home and/or community settings of the family's choosing; and
c. designed to support and meet the needs of the whole family.

**Examples:** *Times that accommodate the family's schedule and needs may include, for example, evenings and weekends, as well as specific times relevant to the educational content addressed (e.g., nap time, bath time) or the needs of the family (e.g., situations the family finds challenging). Other factors that can be considered when deciding the times services will be offered include, for example, staff availability and safety.*

**Examples:** *Different programs may take different approaches to supporting and meeting the needs of the whole family. For example, while one program may be designed to include all family members in each scheduled contact, another program may be designed to include different parties at different times (e.g., involving children in some sessions, but having some sessions focus only on the parent(s)). In some cases, a program may be designed to support and meet the needs of the family as a whole, but only work with parents rather than also including children in services.*

**Examples:** *Providing services in the home can be helpful because it can: (a) eliminate some logistical barriers to the family's participation; (b) enable workers to gain a better understanding of the family's environment; (c) allow workers to address issues in the home; and (d) promote skill acquisition and generalization.*

## CFD 5.03

The content, frequency, intensity, and duration of services are tailored to reflect each family's strengths, needs, and circumstances, to the extent possible and appropriate based on the type of services offered.

**Interpretation:** *When service provision is guided by a structured curriculum, the organization may implement this standard by adjusting delivery of the curriculum based on families' unique strengths and needs.*

**Examples:** *Different programs may implement this standard in different ways. Peer support programs are often specifically designed to provide flexible services that support engagement and recovery by responding to the needs, progress, and setbacks of families served. Some programs, such as home visiting programs for expectant parents and/or parents of very young children, may establish a visit schedule that varies based on the stage of pregnancy and the age of the child, and then adjust that schedule further based on the needs and/or progress of individual families. Other programs may have a standard schedule with less built-in variation (e.g., 90-minute visits, once a week, for 10 weeks), but still adjust visit length, frequency, or duration based on the needs and progress of the families served.*

*Strategies for tailoring content may also vary based on program model and type. For example, while some programs may determine what topics to cover based on their assessment of the family, other programs may be guided by a structured curriculum, but have flexibility in how to deliver that curriculum (e.g., individualizing the time spent on different topics, and/or the order in which topics are addressed, based on a family's needs).*

# CFD 6: Parent Education Services

**Purpose**

Child and Family Development and Support Services promote positive parenting; support children's health and safety; strengthen parent-child relationships; improve family functioning and self-sufficiency; and enhance parental health, well-being, and life course development.

Educational and skill-building activities empower parents, promote positive child development, and improve adult functioning.
**NA:** The organization does not provide parent education services.

**Rating Indicators:**

**1** All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

**2**

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

**3**

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

**4** Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

## Table of Evidence

### Self Study Evidence

| | | |
|---|---|---|
| * | • Table of contents of educational curricula | |

### Site Visit Evidence

| | |
|---|---|
| * | • Educational curricula and materials |

- Parent education group schedule for the previous 12 months, if applicable

**On-Site Activities**

*

- Interviews may include:

1. Program director
2. Relevant personnel
3. Persons served

- Review case records
- Observe sites, as appropriate

## CFD 6.01

Parents are helped to build skills in areas that include the following, as appropriate to the ages and developmental levels of their children and the goals of the program:

a. understanding child/youth development, including what is appropriate at different ages and stages;
b. parenting in a sensitive and responsive manner designed to promote positive interactions, relationships, and bonding;
c. supporting and protecting their children's physical, cognitive, emotional, and/or social development and functioning; and
d. implementing appropriate techniques for providing supervision, setting limits, and managing behavior, including challenging behaviors.

**Interpretation:** *When a program is designed to serve expectant parents and/or parents with very young children, the topics addressed should include: (a) appropriate caregiving, including physical care of the child, feeding and nutrition, and obtaining preventive healthcare; (b) environmental safety and injury prevention, including childproofing, child supervision, and safe practices for sleeping and bathing; and (c) recognizing and responding to symptoms of illness and injury.*

## CFD 6.02

Expectant parents are educated about the following prenatal health topics:

a. fetal growth and development;
b. the importance of prenatal care;
c. nutrition and proper weight gain;
d. appropriate exercise;
e. medication use during pregnancy;
f. effects of tobacco and substance use on fetal development;
g. prenatal and postpartum depression;
h. warning signs of possible pregnancy complications, and when to call the doctor;
i. what to expect during labor and delivery, and after childbirth; and
j. benefits of breastfeeding.

**NA:** The organization does not serve expectant parents.

**Interpretation:** *Some of these topics may be addressed by qualified medical personnel in the context of the prenatal health care referenced in CFD 8.03.*

## CFD 6.03

Parent education services promote self-sufficiency and self-efficacy by addressing topics related to positive personal functioning and development, as appropriate to the needs of the service population and the goals of the program.

**Examples:** *Relevant topics may include, but are not limited to: (a) problem solving and conflict management; (b) stress management and self-care; (c) managing and coping with anger and other emotions; (d) time, budget, and household management; (e) healthy and effective communication; (f) interpersonal relationships and supportive networks; (g) life transitions, including integrating parenthood with other responsibilities and aspects of life; (h) personal growth and future aspirations; and (i) accessing and utilizing needed services and resources.*

*Some programs may tailor the way content is covered to target the needs of a specific population. For example, a program serving expectant parents may focus on changes to expect when the baby arrives, including how the baby's arrival may impact*

*the parents' other relationships and responsibilities associated with school or work. Similarly, a program serving individuals in recovery may focus on preventing and coping with relapse.*

## CFD 6.04

Parent education services:

a. include instruction and discussion about the topics and practices being addressed, and why they are important;
b. model the practices and skills being targeted;
c. include opportunities for practice;
d. provide coaching, positive reinforcement, and corrective feedback, as needed;
e. help parents personalize and generalize the information they are taught; and
f. are provided in a safe environment that does not punish mistakes.

**Examples:** *Opportunities for practice may include, but are not limited to: (a) role play with personnel; (b) practice in the family's natural environment; (c) within-session practice with the child; and (d) homework assignments.*

*When a program provides services in a group setting and does not include opportunities for live practice with the child, it may be helpful if personnel put increased effort into helping parents personalize and generalize the information they are taught.*

## CFD 6.05

When parent education is provided in a group setting, participants have opportunities to:

a. contribute by asking questions and sharing their experiences;
b. listen to and learn from those who are similar to and different from themselves;
c. build connections and develop positive relationships; and
d. participate in activities of interest.

**NA:** The organization does not provide parent education groups.

## CFD 6.06

When parent education is provided in a group setting, the organization:

a. groups parents with others who have children of similar ages;
b. provides classes in a welcoming environment;
c. includes opportunities for participants to consult individually with personnel, as needed;
d. responds flexibly to the changing needs of group members; and
e. schedules services with participants' time commitments in mind, to the extent possible and appropriate.

**NA:** The organization does not provide parent education groups.

# CFD 7: Family Support Services

**Purpose**

Child and Family Development and Support Services promote positive parenting; support children's health and safety; strengthen parent-child relationships; improve family functioning and self-sufficiency; and enhance parental health, well-being, and life course development.

Families are linked to formal and informal services and supports that can help them address needs and attain goals.
**NA:** The organization does not provide family support services.

**Rating Indicators:**

**1** All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

**2**

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

**3**

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

**4** Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

## Table of Evidence

### Self Study Evidence

| | | |
|---|---|---|
| * | • Procedures for referring individuals to services | |

### Site Visit Evidence

| | |
|---|---|
| * | • Community resource and referral list |

- Contracts or service agreements with community providers, if applicable

**On-Site Activities**

*

- Interviews may include:

1. Program director
2. Relevant personnel
3. Persons served

- Review case records

## CFD 7.01

Families are linked to community services and supports that help them meet basic needs, care for their children, and promote positive child/youth development, including, as appropriate:

a. food and nutrition services;
b. health services;
c. housing services, including transitional living arrangements;
d. transportation services;
e. financial assistance;
f. child care;
g. respite care;
h. education services for children, including early intervention and/or special education; and
i. recreational services and activities for children.

## CFD 7.02

Families are helped to access community services that promote parents' self-sufficiency and positive life course development, including, as appropriate:

a. education and literacy services;
b. vocational and employment services, including career development and job placement; and
c. parent education services and support groups.

## CFD 7.03 (FP)

Families are helped to access community services needed to support effective child, adult, and family functioning, including, as appropriate:

a. counseling services;
b. mental health services;
c. substance use services; and
d. domestic violence services.

## CFD 7.04

In an effort to promote positive connections and reduce social isolation, the organization helps family members strengthen and expand their social relationships and informal networks.

**Examples:** *Social relationships and informal networks can include connections with, for example: (a) others within the family, including the extended family; (b) friends; (c) neighbors; (d) community members; and (e) community institutions.*

Child and Family Development and Support Services

# CFD 8: Health Services

**Purpose**

Child and Family Development and Support Services promote positive parenting; support children's health and safety; strengthen parent-child relationships; improve family functioning and self-sufficiency; and enhance parental health, well-being, and life course development.

Families are educated about health-related topics, and linked to health services that promote positive child development and the health of all family members.
**NA:** The organization does not provide health services.

**Rating Indicators:**

**1** All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

**2**

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

**3**

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

**4** Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

## Table of Evidence

### Self Study Evidence

| | |
|---|---|
| • Procedures for referring individuals to services | |

### Site Visit Evidence

* 
- Educational/informational materials
- Community resource and referral list
- Contracts or service agreements with community providers, if applicable

**On-Site Activities**

* 
- Interviews may include:

1. Program director
2. Relevant personnel
3. Persons served

- Review case records

## CFD 8.01

Families are helped to understand issues and factors relevant to child and parent health.

**Examples:** *Topics relevant to parent health may include, but are not limited to: (a) the importance of obtaining preventive medical and dental care; (b) good preventive health practices, such as eating healthfully, exercising, reducing substance use, and preventing disease; and (c) family planning.*

*Topics relevant to child health may include, but are not limited to: (a) physical care of the child; (b) nutrition and feeding, including the benefits of breastfeeding; (c) the importance of well-child visits, including immunizations; (d) environmental safety and injury prevention, including childproofing, child supervision, and safe practices for sleeping and bathing; and (e) child development milestones.*

*Some programs may also work with parents to track, review, and support children's progress toward achieving developmental milestones.*

## CFD 8.02 (FP)

Families are linked to the following health services, as needed:

a. ongoing health care for adults and children, including routine medical checkups, immunizations, and specialty care;
b. diagnosis and treatment of health problems;
c. dental care;
d. mental health care, including information, screening, and treatment for postpartum depression;
e. early intervention services;
f. information and education about pregnancy planning and prevention, including linkages to family planning services; and
g. substance use services.

**Note:** *Organizations that provide early intervention services directly will also demonstrate implementation of CFD 9: Early Intervention Services.*

## CFD 8.03 (FP)

Expectant parents are linked to the following healthcare services, as needed:

a. prenatal care;
b. genetic risk identification and counseling services;
c. labor and delivery services;
d. nutrition services;
e. information, screening, and treatment for prenatal depression; and
f. postpartum care.

**NA:** The organization does not serve expectant parents.

CFD 8.04

Personnel collaborate with families to explore:

a. whether they have adequate health insurance coverage; and
b. how they can obtain appropriate coverage, when necessary.

Child and Family Development and Support Services

# CFD 9: Early Intervention Services

**Purpose**

Child and Family Development and Support Services promote positive parenting; support children's health and safety; strengthen parent-child relationships; improve family functioning and self-sufficiency; and enhance parental health, well-being, and life course development.

Early intervention services promote the health and well-being of children who have or are at risk for developmental delays.
**NA:** The organization does not provide early intervention services.

**Rating Indicators:**

**1** All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

**2**

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

**3**

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

**4** Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

## Table of Evidence

### Self Study Evidence

| | | |
|---|---|---|
| * | • Procedures for referring individuals to services | |

### Site Visit Evidence

| | |
|---|---|
| * | • Intervention curricula and/or materials |

- Community resource and referral list
- Contracts or service agreements with community providers, if applicable

**On-Site Activities**

*

- Interviews may include:

1. Program director
2. Relevant personnel
3. Persons served

- Review case records

## CFD 9.01 (FP)

Children receive, either directly or by referral to other qualified professionals, all specialized services needed to promote their physical, cognitive, emotional, social, communicative, and adaptive development.

**Examples:** *Needed services may include, but are not limited to: (a) medical services; (b) nursing services; (c) visual services; (d) audiological services; (e) speech and language services; (f) orientation and mobility services; (g) psychological services; (h) nutrition services; (i) family therapy; (j) occupational and physical therapy; (k) assistive technology; and (l) special education.*

## CFD 9.02

Children receive services that:

a. take into account their ages, developmental levels, strengths, challenges, functional status, and social competence; and
b. facilitate their ability to complete essential, age-appropriate daily tasks.

## CFD 9.03

Children receive early intervention services in inclusive settings where they can interact in a positive way with other children, to the extent possible.

## CFD 9.04

Families are involved in services and provided with information and education about:

a. developmental delays and disabilities;
b. the best strategies for lessening the effects of developmental delays and disabilities;
c. meeting their children's needs; and
d. their children's progress.

## CFD 9.05

Early intervention services:

a. include family members' ideas;
b. use the family's informal resources, such as toys, household materials, and family members;
c. take advantage of learning opportunities that occur naturally during activities in which the family participates; and
d. can be incorporated into everyday routines and activities.

## CFD 9.06

Families are linked to needed support services, including, as appropriate:

a. individual counseling or parent-to-parent support groups; and
b. financial assistance for specialized services that meet their children's needs.

Child and Family Development and Support Services

# CFD 10: Family-Centered Peer Support Services

**Purpose**

Child and Family Development and Support Services promote positive parenting; support children's health and safety; strengthen parent-child relationships; improve family functioning and self-sufficiency; and enhance parental health, well-being, and life course development.

Individuals with lived experience help to engage, empower, and support families that are navigating challenges.

**NA:** The organization does not provide peer support services.

**Examples:** *Individuals providing peer support services can have many different job titles that can include, but are not limited to: (a) peer support worker; (b) peer recovery coach; (c) peer support specialist; (d) recovery support specialist; (e) peer navigator; (f) parent peer specialist; (g) family mentor; (h) family partner; (i) family liaison; and (j) family peer recovery support specialist.*

**Rating Indicators:**

## 1

All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

## 2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

## 3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

## 4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

## Table of Evidence

### Self Study Evidence

| | |
|---|---|
| * • Informational materials describing the peer support program | |
| * • Matching procedures | |
| * • Procedures for onboarding peer support workers | |
| * • Match closing procedures | |

### Site Visit Evidence

| |
|---|
| * • See training curricula (submitted in CFD 2 On-Site Evidence)<br>• Procedures, interagency agreements, and/or training documents addressing partnerships with other program personnel, agencies, and/or systems, if applicable |

### On-Site Activities

| |
|---|
| * • Interviews may include:<br><br>1. Programdirector<br>2. Relevant personnel<br>3. Persons served<br><br>• Review case records |

## CFD 10.01

The organization:

a. clearly defines the role and responsibilities of a peer support worker, including what workers should and should not do when delivering services; and
b. helps families understand the role and responsibilities of a peer support worker.

**Note:** *Peer support workers should receive pre- and in-service training on their role and responsibilities, as addressed in CFD 2.08.*

## CFD 10.02

To the extent possible and appropriate, the organization considers families' needs, backgrounds, and experiences when matching them with peer support workers.

## CFD 10.03

Peer support workers provide relational, informational, and practical support that is designed to:

a. foster motivation and engagement;
b. build on families' strengths;

c. respond to families' needs, priorities, circumstances, and goals;
d. help families build supports, access services, and navigate systems; and
e. encourage healing, recovery, and wellness.

**Examples:** *Peer support workers may help families in a variety of ways that include, for example: (a) serving as models of recovery and hope; (b) offering encouragement and empathy; (c) helping family members develop their social support networks, including connections with self-help/mutual aid groups or other recovery communities; (d) helping family members overcome barriers to accessing treatment and/or other needed services (e.g., by helping them find transportation or child care); (e) explaining the logistics and requirements of the different agencies and systems families may need to navigate (e.g., child welfare, behavioral health, and/or justice systems); (f) showing family members how to work productively with other service providers; (g) accompanying family members to appointments and meetings with other providers; (h) helping family members learn how to advocate appropriately for themselves; (i) providing information about healthy behaviors and strategies related to coping, self-awareness, self-care, and/or parenting; and (j) helping family members define their personal recovery and wellness goals and develop plans to attain them.*

**Note:** *See CFD 5.01 for more information regarding the positive, trusting relationships that are the foundation of effective peer support.*

## CFD 10.04

When peer support workers provide services in partnership with other program personnel, agencies, and/or systems, the organization strives to ensure that:

a. other partners are helped to understand the purpose, value, role, and responsibilities of a peer support worker;
b. peer support workers are welcomed and integrated into the larger team; and
c. all parties understand how they are expected to work together.

**NA:** Peer support workers do not provide services in partnership with other program personnel, agencies, and/or systems.

**Examples:** *Regarding element (c), all parties may benefit from support that helps them understand expectations regarding: (a) communication; (b) confidentiality and information sharing; (c) decision making; (d) how work will be divided, including the role each party will play in achieving overall goals; and (e) how conflicts will be handled.*

**Examples:** *When peer support workers collaborate with other program personnel, agencies, and/or systems they can play an important role in: (a) helping others better understand families' needs, perspectives, and circumstances; (b) reducing negative attitudes and stigma towards parents; and (c) fostering the development of a culture that respects and prioritizes the experiences and involvement of families served.*

## CFD 10.05

Procedures clarify:

a. when and how matches will be closed; and
b. whether ongoing contact following match closure is permitted or discouraged.

**Interpretation:** *Procedures for closing matches should address both: (a) routine match closure (i.e., following a successful match); and (b) how to proceed if either a family or peer support worker feels the match is not working or inappropriate.*

**Examples:** *While some programs may allow or even encourage relationships to continue following match closure to bolster families' social support networks, other programs may be more concerned with boundaries and thus discourage contact once the official match is closed.*

Child and Family Development and Support Services

# CFD 11: Case Closing and Aftercare

**Purpose**

Child and Family Development and Support Services promote positive parenting; support children's health and safety; strengthen parent-child relationships; improve family functioning and self-sufficiency; and enhance parental health, well-being, and life course development.

The organization works with families to plan for case closing and, when possible, to develop aftercare plans.

**NA:**

- The organization provides only parent education groups.
- The organization provides only peer support services.

**Rating Indicators:**

**1** All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

**2**

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- In a few instances, the organization terminated services inappropriately; or
- Active participation of persons served occurs to a considerable extent; or
- A formal case closing evaluation is not consistently provided to the public authority per the requirements of the standard.

**3**

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Services are frequently terminated inappropriately; or
- Aftercare planning is not initiated early enough to ensure orderly transitions; or
- A formal case closing summary and assessment is seldom provided to the public authority per the requirements of the standard; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

**4** Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

## Table of Evidence

### Self Study Evidence

| | | |
|---|---|---|
| * | • Case closing procedures | |

| | |
|---|---|
| * • Aftercare planning and follow-up procedures | |

**Site Visit Evidence**

| |
|---|
| * • Relevant portions of contract with public authority, as applicable |

**On-Site Activities**

| |
|---|
| * • Interviews may include:<br><br>1. Program director<br>2. Relevant personnel<br>3. Persons served<br><br>• Review case records |

## CFD 11.01

Planning for case closing:

a. is a clearly defined process that includes assignment of staff responsibility;
b. begins at intake; and
c. involves the worker, the family, and others, as appropriate to the needs and wishes of family members.

## CFD 11.02

Upon case closing, the organization notifies any collaborating service providers, as appropriate.

## CFD 11.03

If a family has to leave the program unexpectedly, the organization makes every effort to identify other service options and link family members with appropriate services.

**Interpretation:** *The organization must determine on a case-by-case basis its responsibility to continue providing services to families whose third-party benefits are denied or have ended and who are in critical situations.*

## CFD 11.04

When appropriate, the organization works with the family to:

a. develop an aftercare plan, sufficiently in advance of case closing, that identifies short- and long-term needs and goals and facilitates the initiation or continuation of needed supports and services; or
b. conduct a formal case closing evaluation, including an assessment of unmet needs, when the organization has a contract with a public authority that does not include aftercare planning or follow-up.

## CFD 11.05

The organization follows up on the aftercare plan, as appropriate, when possible, and with the permission of family members.

**NA:** The organization has a contract with a public authority that prohibits or does not include aftercare planning or follow-up.