STEP UP PARENTING TIME PLANS TO ACCOMPANY FAMILY THERAPY & REPORTING IN PARENT CHILD CONTACT CASES [1,2]

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Children are often dealing with multiple issues regarding their feelings toward an resisted rejected parent. Difficulty adjusting to contact with a parent, or a lack of interest in a relationship with a parent, is not a reason, in and of itself, to delay reunification. Indeed, often the stepped resumption of contact with a parent, combined with appropriate mental health interventions, is needed to address the child contact problems.

Challenges are encountered if the therapist is put in the position of either recommending or determining the parenting time or related adjustments. These challenges are likely especially likely if the therapist is expected to determine the pacing of implementing the court ordered parenting time schedule that may not be realistic or possible when the parents commence therapy.

Assigning this responsibility to the therapist puts them in an improper dual role. Further, it contradicts the premise upon which the family therapy is proceeding, namely that the court has determined or the parents have agreed it IS in the child's best interests to have contact with the rejected parent irrespective of the nature and intensity of the contact problem. The therapy process is NOT to determine if it is in the child's best interests to have contact with a parent, but rather to implement contact and restore family relationships, including that between parents and children, and between parents as co-parents. When it cannot be stipulated that it is in the child's best interest to resume and/or repair contact with a parent, a different process be it legal or clinical, must occur before therapy can proceed.

Accordingly, in parent-child contact problem cases, a court order for family therapy needs to specify a **clear** plan to move a parent from whatever level of parent time they are currently having to whatever level of contact the court sets, or the parents can agree to in a consent order. In addition to the need for a detailed and unambiguous court order for the therapy, a specific and unambiguous parenting time schedule needs to be inserted into the treatment agreement (see 5b of separate handout, Family Therapy Agreement).

In some cases, the current status quo or court ordered parenting time schedule will suffice, with the expectation that it is to be implemented as ordered while the family

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[1] See separate handouts: Checklist for court order and sample Family Therapy Agreement.

[2] With permission, this handout has been adapted from material prepared by Dr. Aaron Robb April 18, 2014 for: 2014 Innovations - Breaking Boundaries in Custody Litigation A Systematic Approach to Reunification Therapy June 12-13, Dallas/Addison, Texas, University of Texas School of Law.

therapy is ongoing. At the very least, the intention would be for the therapist to work towards implementing the court ordered parenting time. To address this problem, "stepped plans", a term used by Texas psychologist Dr. Aaron Robb, may be indicated.

Although the therapist does not have the authority or responsibility to determine the parenting time, in accordance with their mandatory reporting obligation, the therapist would be obliged to report any reasonable suspicions of child abuse or neglect (sexual, physical, emotional harm), which would in effect introduce potential concerns about the advisability of the current parenting time continuing until the CAS has investigate.

Different types of contact may be included in stepped plans:

1. Supervised Contact: Supervision provided by a professional or nonprofessional (family member, friend, other).

2. Monitored Contact: Provided by a third party who remains nearby in the same location. However, when there are concerns about possible emotional or physical abuse of the children, the sharing of inappropriate adult information with the children, or other interactions where a closer level of scrutiny is needed (i.e., supervision), monitored contact is not appropriate.

3. Therapeutically Facilitated Contact: There may be cases where starting unsupervised, supervised or monitored contact may not be advisable as a starting point and a therapy-oriented approach is more appropriate. In these cases, all parent-child contact occurs during the therapy as part of the therapy. This could occur in the therapist's office, a parent's home, or in the community with the therapist.

4. Parent-Child Contact Without 1, 2, or 3 as above: This would be as per the court order and terms in 5b of the Family Therapy Agreement.

A. Examples of Step Up Plans From Supervised to the Court Ordered Parenting Time

The following are fairly standard stair steps plans:

Plan #1

Level 1: Supervised contact for 2 hours every Saturday
Level 2: Supervised contact for 4 hours every Saturday
Level 3: Monitored contact from 9:00 a.m. to 6:00 p.m. on the first, third, and fifth Saturdays
Level 4: Remove monitor, continue with Level 3 schedule

Level 5: First, third, and fifth weekends from Saturdays at 9:00 a.m. to Sundays at 6:00 p.m.
Level 6: First, third, and fifth weekends from Fridays after school to Sundays at 6:00 p.m.
Level 7: Interim or final endpoint court ordered parenting time schedule

A variation on this plan when supervised or monitored contact might not be needed would be to start with Level 2 (without supervisor), progressing to Level 3 (without monitor), and then progressing through levels 5, 6, and 7.

Plan #2

Level 1: 8 hours total supervised contact on the first, third and fifth weekends
Level 2: Add an unsupervised 3-hour meal parenting time (lunch/dinner) on the second and fourth weekends
Level 3: Change to 4 hours supervised and 4 hours unsupervised contact on the first, third, and fifth weekends
Level 4: Unsupervised parenting time 9:00 a.m. to 5:00 p.m. Saturdays and Sundays on the first, third, and fifth weekends. End meal parenting times on second and fourth weekends.
Level 5: Unsupervised parenting time from 9:00 a.m. Saturdays to 5:00 p.m. Sundays on the first, third, and fifth weekends. Add weeknight unsupervised dinner parenting time on Thursdays.
Level 6: Interim or final endpoint Court-ordered parenting time

A variation on this plan when supervised contact might not be needed would be to start with Level 4 and move forward from there.

Plan #3 - Contact with therapist only initially

Level 1: Therapeutically-facilitated contact of child and parent. Following initial intake and assessment, the family therapist will schedule [# of sessions] weekly joint sessions with the RP and the child, to which the FP parent will transport the child. Individual sessions with each parent or the child at the discretion of the therapist should be included at each level of this plan.
Level 2: The RP and the child will have a 3 hour unsupervised meal time parenting time following a parent-child therapy session where they will discuss plans for the parenting time. The RP and the child will return to the therapist's office at the end of the parenting time to meet with the FP to process how their contact with the RP went. The child will leave with the FP at the end of the session.
Level 3: RP will have 8 hours of unsupervised contact, with contact starting and ending at the therapist's office.
Level 4: RP will have 6 hours unsupervised contact, with FP dropping the child

off at the home of RP or another location identified by the therapist at the start of the parenting time and the parenting time ending at the therapist's office to process how interaction went. FP will pick the child up at the end of the session.

Level 5: While continuing weekly family therapy, RP will have unsupervised parenting time from 9:00 a.m. Saturdays to 5:00 p.m. Sundays on the first, third, and fifth weekends.

Level 6: Interim or final endpoint Court ordered parenting time

Various iterations of this plan, adjusting the number of steps and the rate of increased time per step, should be obvious. The initial goals are to allow monitoring of interactions and a safe space to process any interactions. Debriefing with all family members, including the FP is essential. Individual contact can also be used to process outside of the joint sessions.

Plan #4

Level 1: While the child and parent are participating in individual sessions with the family therapist or a separate individual therapist for each, parenting time occurs under therapeutic supervision with a neutral/unaffiliated provider. This avoids both dual-role violations for therapists and preserves the neutrality of the therapeutic supervisor.

Level 2: Convert therapeutic supervision to standard supervised contact. Continue individual therapy throughout remaining levels as needed.

Level 3: Remove supervision constraints under one of the previously noted plans.

This plan focuses on more intensive services at the beginning of contact and may be suitable where concerns are less about parent-child relationships and more about parenting competency and/or safety. Feedback from therapists after Level 1 may be less interaction focused and more in regards to each person's individual issues.

Additional provisions can be tied to the various levels, such as holiday parenting time if a parent is on a particular level (i.e. an overnight near Christmas on Example 2, Level 5, or a few days over spring break on Example 1, Level 6) if those are viewed as appropriate to the case. Additionally parents always have the option, however unlikely, to agree to such arrangements on their own as the case progresses. As a caution, any such variations should be agreed between the parents in writing (hardcopy, e-mail, Our Family Wizard, etc.), and copies should be provided to the treatment team.

B. Moving Between Steps

As noted, the predetermined court order or agreement specifies that the therapist managing the reunification process is not to make decisions about parenting time or custody. The therapist, is however, expected to report back on behavioral progress of the parents and child, which then serve as "trigger conditions". It cannot be overstated that the therapist job is to assess and implement, not determine or even recommend parenting time.
Requirements to move up to next step can identify any or all:

1. # of weeks at each level
2. #of weeks in individual and/or family therapy
3. participation and/or completion in other interventions (e.g., parenting education such as individual, group or on-line, with a specification as to what needs to be included in the curriculum such as: the impact on children of parental conflict, information about the differentiation of various parent-child contact problems and the impact on children, reducing parental alienating behaviours, basic parenting skill development, etc.)
4. period of time having abstained from drugs or alcohol

Steps may also go down to decrease the amount of parenting time, again pursuant to the court ordered plan.

In the case of noncompliance, relapse, or other behavioural problems, one possible consequence is that instead of plateauing at the current parenting time plan, the rejected parent returns to an earlier level. This might mean returning to the step immediately previous to the current step, starting over from the beginning, or somewhere in between

Example: Should the treatment team determine the RP is not in compliance, this parent will return to the prior parenting time level for [# of weeks]. At the end of this time, compliance shall be reassessed and the RP either advances to the next level if compliant, or again moves to the next lower parenting time level if noncompliant and reassessed again in [# of weeks], repeating this process until the RP returns to compliance. (*This is a broad judgment call, but acknowledges that some parents may simply not engage as needed in order to meet the best interests of their children.*)

Example: Should the RP test positive for illegal drugs at any drug screen, they shall return to Level 1 of the previously outlined parenting plan. (*This is an automatic trigger needing no judgment at all, just a report from the drug testing agency.*)

C. Reporting: Frequency, What to Include & to Whom

Reporting is intended to promote accountability and compliance; while the report may be used in Court, these reports may not end up in court. The reports must provide the information needed by the court and lawyers, while remaining sensitive to preserving some confidentiality.

Frequency of Reports

1. *Time based* – Every X weeks, monthly, or quarterly. Reporting does not have to be on a fixed basis, but as parents progress through various levels, the need for reports may be lessened. The case that may need weekly summaries in the beginning, and might transition to monthly reports as time progresses. It is important to check with the reporting professional to insure they are able to make reports on the schedule the case requires.

2. *Condition based* – Reports may be limited to when critical milestones are reached. Once a parent completes a particular task the mental health professional certifies that to the lawyers and/or court.

3. *Combinations* – It is highly recommended that there be some form of routine reporting so that contemporaneous assessments of progress are documented. Setting a maximum period that will pass before a report is needed may allow several condition-based reports to be generated, but prevents total silence if there is a lull in services or plateau in progress for some reason.

Options of What to Include in the Report:

1. *Therapy*

    - summary of education and interventions completed
    - summary of homework completed
    - frequency of attendance
    - assessments of compliance with treatment plans
    - willingness and responsiveness to behaving differently, examples of specific behavioural changes
    - whether shortcomings are a reflection of a need to build additional abilities or a lack of willingness to use the skills they are being taught,
    - level of insight
    - ability to express healthy insight to the child in question, etc.

2. *Psychiatric care*

    - compliance with medication checks
    - assessment of client understanding of the importance of medication management
    - client willingness to adhere to a medication regimen
    - participation in Intensive Outpatient or Partial Hospitalization Programs

3. *Substance Abuse*

    - results of physiological testing (clean, positive for particular substances, or not responded to and treated as a failed test)
    - feedback from sponsors, attendance at community support groups or Supportive Outpatient Programs, behaviours indicative of increased relapse risk, etc.

4. *Pain management* - viewed as a subset of substance abuse, therapy, or psychiatric issues. Untreated or undertreated pain can manifest negatively in many ways. Additionally parents may also develop tolerance and drug-seeking behaviors. In addition to 3. Above:

    - results of monitoring that the parent has alerted their various treatment provider (such as their primary care provider) to the pain management plan
    - has advised regarding treatment issues
    - is (or is not) complying with that plan

5. *Basic parenting skills* – this entails parents demonstrating anything from the ability to change a diaper to more complex skills such as offering choices and consequences.

    - summarizing observed parenting, improvements, set backs, no change

6. *Additional Group or Individualized Educational Programs or Courses*

    - Inclusion of list of parenting education parent obtained outside of the therapy (e.g., books read, videos watched, on line or in person course, etc.). Parent can be asked to keep a homework log summarizing all of the material provided that they completed outside the therapy sessions that were then discussed in the therapy.
    - obtaining certificates of completion
    - records of homework

7. *Participation in supervised/monitored contact* (addresses self-sabotaging approach)

    - obtaining record of participation of resisted/rejected parent (RP)
    - has the favoured parent (FP) brought the child and on time
    - obtaining observations notes, positives and negatives, taken by supervisor (summarizing problems/issues, if any, are occurring during supervised parenting times)

Reporting To Whom

Regular exchange of information between members of the treatment team, including informal reports status updates will be a requirement and noted in the court order and family therapy agreement. The following represent more formal reports:

1. *Status reports to the court*. See above. Copies should be sent to parents and counsel.

2. *Letters to the counsel*. While there is a minimal additional expense in keeping the lawyer involved, depending on the nature of the case and level of involvement of the lawyers, reports are an easy way to routinely document progress. Any formal communications by or between the treatment team (treatment plans, billing statements, etc.) should also normally be copied to all lawyers to insure transparency is maintained.

3. *Directly to the parents.* This is the most direct way of documenting progress, and may be done via formal written communication, or more informal methods such as e-mail or using a communication software platform, such as Our Family Wizard. They should normally receive copies of letters to the court and counsel.