Oklahoma Department of Human Services Child Welfare Practice Model Guide

Revised July 2018

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Oklahoma Department of Human Services (DHS)
Child Welfare Practice Model Guide
Condensed Version July 2018

FORWARD

In 2008, Oklahoma made a decision to create practice standards and an accompanying practice model that would guide the work of the child welfare system—from case opening to case closure. Over the past decade there has been a "push" to think differently about how to provide child welfare services. The urgency grows to become more evidence-based and able to produce outcomes demonstrating as a result of DHS' work that children are safer and DHS is really helping children and families succeed. The state of Oklahoma embarked on two processes intended to improve practice and ultimately to improve outcomes.

Following the development of the Practice Standards, the state began to develop a Practice Model that embeds the practice standards and specifically describes the "what" of the day-to- day work. Oklahoma made a decision to create practice standards and an accompanying practice model that guide the child welfare system - from case opening to case closure.

The Practice Standards and Practice Model challenge every child welfare staff member to work to varying degrees, differently than they may have in the past. DHS believes that this Practice Model will safely reduce the number of children entering the system as well as improve the care of those that do. It requires strong teamwork and communication between the various units of the agency, and a willingness to look at biases, and personal values that may get in the way of effectively serving families.

This version of the updated Practice Model was created in June 2018 to include the most current safety practices that specialists utilize to positively impact outcomes for families served in Oklahoma. The original Practice Model created in 2008 is still available and can be referenced when needed.

STANDARDIZED INTAKE AND SCREENING

The "front-end" or intake portion of child protective services (CPS) process involves:

- Receiving reports of abuse or neglect
- Screening the reports
- Cross-reporting to law enforcement

The standardized intake component of the Practice Model seeks to ensure that the state minimizes inconsistencies in how Child Welfare Services (CWS) brings families into the system and the priority in which those families are served.

However, prescribing the process in considerable detail has certain disadvantages.

- Overly prescribing details makes it more difficult for child welfare (CW) specialists to weigh which aspects of what they do are the most important, and thus devote sufficient attention to these aspects of their jobs.

- Also, a prescriptive process tends to become labor intensive for CW specialists and supervisors – an important factor when staff resources are limited – and further constrains their ability to deal effectively with workloads. For instance, preventing staff to ramp up to meet unexpectedly high volumes of referrals.

In Oklahoma, a balanced model must:

- Recognize that the most critical resource is experienced professionals on the front-line: CW specialists and supervisors. These individuals must be capable of making accurate and timely decisions.
- Provide more structure and support for less experienced specialists than for proven professionals.
- Recognize screening as a "clinical practice" that requires interviewing/listening skills, sound judgment, and clinical oversight and guidance.
- Assist specialists in devoting proper attention and effort to those children whose safety is most at risk.
- Provide supervisors the tools needed to effectively review the quality of specialist performance.
- Provide managers the tools needed to effectively review overall program performance.
- Recognize the importance of both clinical quality control and management oversight.

The criteria applied at intake when determining whether or not a CPS specialist must conduct a safety assessment of the family are described in CPS policy, Oklahoma Administrative Code (OAC) 340:75-3-130 and require that the caller's description of the issues meet the definition of abuse and neglect.

If the initial criteria for acceptance are met, then the response is prioritized based on:

1. the child's age;
2. the child's physical and mental abilities;
3. the perpetrator's access to and attitude toward the child; and
4. any allegations of injury to the child

A Priority I report indicates the child is in present danger and at risk of serious harm or injury. Allegations of abuse and neglect may be severe and conditions extreme. The situation is responded to immediately the same day the report is received.

A Priority II report indicates there is no present danger or risk of serious harm or injury. Priority II investigation or assessment is initiated within two to ten-calendar days from the date the report is accepted for investigation or assessment.
When a report is received that is not appropriate for CPS, but it is clear from the caller's description of the family that services are needed, the CW specialist may make a referral within the Oklahoma Department of Human Services (DHS), to outside resources, or both, for emergency food, shelter, medical services, or counseling. In situations that indicate the child and family are in need of services, referrals to community agencies or DHS contract providers may be offered to the family and are in keeping with the DHS goal to partner with community providers to create a community safety net for children and families.

ASSESSMENT OF SAFETY AND DECISION MAKING

Information is the foundation of the safety evaluation process. To understand child safety, Child Welfare Services (CWS) staff must assess the pertinent areas of family life that contribute to a child(ren) being safe.

Family Engagement

To collect accurate information, a specialist must have the ability to rapidly engage with families.

- Communicate through actions and words to the family that what they say matters.
- Listen to their story and effectively communicate to the family that their perspective and voice help CWS best serve them.
- Fully disclose to the family why CWS is in their home, what information is being gathered, the steps of the process, and the rationale for any decisions that are made.
- Honor the family's culture and recognize the need to understand how the family's culture impacts decision making, parenting, and family functioning. Don't presume to have an instant understanding of the family's culture and dynamics.
- Leave personal views, biases, and cultural perspectives out of interactions with the family.
- Learn who matters to the family or who might be able to support the family, such as kin and friends, in the problem-solving process.
- Ask questions that engage the family and make certain to use terms that are familiar to the family or take the time to explain a term's meaning.
- Avoid, when possible, actions that minimize or undermine a parent's power. Invoking authority is easier and requires less skill than engaging families, but is less productive.
- Look for opportunities to put the family in a position of authority--for example, by asking for permission, when appropriate. People are more disclosing, open, and cooperative if they don't feel threatened and judged.

In the CWS approach to safety assessment, the following definitions guide decision making:

Safe: "Safe" means a child is in an environment where there is no identifiable safety threat or a person responsible for the child (PRFC) has sufficient protective capacities to prevent the child from being harmed.

Unsafe: "Unsafe" means an identifiable safety threat to a child is present within his or her environment and the caregiver's protective capacities are insufficient to prevent the child from being harmed and requires outside intervention.
Note: Children three years of age or younger and/or children with diminished mental or physical capacity should be considered more vulnerable.

- Present Danger: An immediate, significant, and clearly observable family condition occurring in the present tense (occurring now), already endangering, or threatening to endanger a child.
- Impending Danger: The presence of a threatening family condition that is specific and observable, is out-of-control, is certain to happen in the near future, meaning the next several days, and is likely to have severe effects. Impending danger to child safety or this state of danger is not always obvious or occurring at the onset of CPS intervention or in a present context.Impending danger includes several specific features:

1. Impending danger refers to threats to a child's safety that exist and are insidious, but are not immediate, obvious, or active at the onset of CPS intervention like present danger is understood or identified.
2. Impending danger refers to threats that eventually are identified and understood upon more fully evaluating and understanding individual and family conditions and functioning.
3. Impending danger refers to threats that will result in severe harm if safety intervention does not occur and is not sustained.

Steps to Take When Present Danger Exists

Initial safety plans are used when a specific present danger to a child is identified. Safety plans are:

- Designed to control and manage the present danger threats so that the child is safe while the full assessment of safety is completed.
- Short-term in nature, thus making them distinctly different than ongoing safety plans and case plans.
- Replaced with an ongoing safety plan when the evaluation of safety is completed and the child(ren) is found to be unsafe.

Address the following areas when considering an initial safety plan.

- Parents' willingness to co-operate.
- Description of person(s) responsible for the protective action and check of home for obvious safety threats.
- Confirmation of the PRF(s)'s trustworthiness, reliability, commitment, availability, and adherence to the safety plan by the person responsible for protective action. Most importantly, does this person believe that the safety threats are real and may result in serious harm to the child? Can the specialist justify that this person can and will protect the child?
- Description of protective action, what it is, and the details of how it will work, including communication between specialist and provider of protective plan and time frames of protective action and oversight.

SAFETY ASSESSMENT

Research indicates six general areas of family life provide pertinent and sufficient information to complete an effective assessment of threats to child safety. Assessment in these six areas provides the foundation from which to identify the presence of threats to child safety.

1. Assessment of the extent of the maltreatment. This area is concerned with the extent of the alleged maltreatment to determine if the child has been abused or neglected. It considers what is occurring or has occurred, such as hitting, and what the results are, such as injuries. Information gathered in this phase of the safety assessment provides evidence to support or rule out the allegations regarding child maltreatment and includes:

- Type of maltreatment
- Severity of the maltreatment
- History or duration of the maltreatment
- Description of specific events
- Description of emotional and physical symptoms

- Identification of the child and maltreating caregiver
- Victim's explanation of the maltreatment
- Collateral knowledge of the maltreatment

2. Assessment of the circumstances surrounding the maltreatment. This area is concerned with the nature of what accompanies or surrounds the maltreatment. It addresses what is going on at the time that the maltreatment occurs or has occurred. It serves to qualify the nature of the maltreatment. Information gathered in this phase of the safety assessment includes:

- Person responsible for the child's (PRFC's) intent concerning the maltreatment
- PRFC's explanation for the maltreatment and family conditions
- PRFC's acknowledgement and attitude about the maltreatment
- History or pattern of maltreatment of the victim or others by the PRFC
- PRFC's criminal history
- Other problems occurring in association with the maltreatment, such as substance abuse
- PRFC's and the victim's sibling's explanation of the maltreatment
- Collateral information related to the circumstances and history

3. Assessment of how the child functions/behaves on a daily basis. This area is concerned with a child's general behavior, emotions, temperament and physical capacity. When conducting an assessment of the child (AOCS), the child welfare (CW) specialist seeks to determine if a child's special needs are being met, if there are any unusual child behaviors, and considers the child's sense of security, physical health, the child's vulnerability, and signs of positive interaction with PRFC. This assessment focuses on how a child is from day-to-day rather than focusing on points in time, such as a child protective services (CPS) contact or time of the maltreatment event. Information gathered in this phase of the safety assessment includes:

- Individual needs of each child and if they are being met
- General mood and temperament
- Intellectual functioning
- Communication and social skills
- Expressions of emotions/feelings
- Child's behavior
- Peer relations
- School performance
- Motor skills
- Physical and mental health
- Signs of positive interaction with PRFC(s)
- Functioning within cultural norms
- Developmental functioning
- Gender identity and sexual orientation
- Collateral information related to child functioning

4. Assessment of the disciplinary approaches. This area is concerned with the manner in which a PRFC approaches discipline and child guidance. Discipline is considered in the broader context of socialization – teaching and guiding the child. When conducting an assessment of the disciplinary practices, CW specialists assess the type and nature or methods of disciplinary practices, the purposes of discipline in the home, awareness of effective disciplinary practices, and emotional state while disciplining the child. Information to be gathered in this phase of the safety assessment includes:

- Disciplinary methods

- Concept and purpose of discipline, such as providing direction or managing behavior
- Context in which discipline occurs
- PRFC's perception of the effectiveness of the discipline methods utilized
- If the discipline is based on reasonable expectations of the child
- How discipline is informed by culture
- Child's perception of the discipline methods and effectiveness
- Collateral information obtained related to family discipline

5. Assessment of parenting practices used by the PRFC. When looking at the pervasive parenting practices, a CW specialist assesses if the:

- PRFC's expectations of the child are developmentally appropriate;
- PRFC expresses concern or empathy for the child;
- manner of responding and interacting with the child is supportive and helpful;
- PRFC ensures the child is supervised; and
- PRFC is able to recognize danger or threats of danger to the child.

Information gathered in this phase of the safety assessment includes:

- Reasons for being a parent
- Satisfaction in being a parent
- Knowledge and skill in parenting and child development
- Expectations and empathy for a child
- General parenting style
- Protectiveness
- Collateral information related to parenting

6. Assessment of Adult Functioning. This area is concerned with how the PRFC(s) or adults in the family feel, think and act on a daily basis. The question here focuses on adult functioning separate from parenting. When conducting ongoing assessment for adult functioning, the CW specialist looks to see if the caregiver continues to be committed to the child's safety and is willing to do what is necessary and required within the safety plan. The specialist needs to see if the caregiver is growing in understanding why the child was unsafe and the family needed a safety plan. Part of this assessment is the determination of whether or not substance abuse or behavioral health issues are impeding an adult's functioning and his or her ability to offer protection to the child. In this area, the concern is with how adults in the family behave regardless of whether they are parents or not.

Information gathered in this phase of the safety assessment includes:

- Coping and stress management
- Self-control in relationships and discipline
- Problem-solving abilities
- Judgment and decision making
- Home and financial management
- Employment history
- Domestic violence or substance use histories
- Behavioral health
- Physical health and capacity
- Collateral information related to adult functioning

Experience has confirmed repeatedly that the information related to these six areas can be effectively gathered by CPS staff during the initial assessment of safety. While CW specialists know there is certainly variation in the ease of getting information from families, through engaging families and seeking to understand their perspectives and views, specialists can gather pertinent and sufficient information related to these six questions in one to two family contacts.

As is evident, assessing the safety of a child is NOT merely determining if something occurred, often referred to as incident-based child protection, but identifying safety threats and working with families to identify ways to control and manage those threats.

Consideration of Protective Capacities
A protective capacity points to an inherent family skill and/or resource that can be identified and contribute to the child's ongoing protection. Consideration of the PRFC(s)'s protective capacities is important to in determining if a child(ren) is safe or the PRFC can control and manage identified safety threats.

It is important to note that the assessment of protective capacities is not simply a listing of the positive qualities and resources; the protective capacities must be relevant and dynamically involved in offsetting the safety threats or risks related to abuse and/or neglect. The protective capacities must be able to be identified and clearly articulated within the safety assessment and the service plan.

Individual factors contributing to protection: good cognitive and social skills, a positive self-perception, motivation to change, a willingness to seek support, an awareness of the threats to safety, ability to take action to protect children, self-discipline, and a focus on acquiring knowledge and skills.

Environmental factors contributing to protection: support from family and friends, stability of the living environment, positive interactions with others, and a connection to the community.

Identification of Potential Safety Threats during the Evaluation Process
At times, CW specialists may conduct a safety evaluation and determine that a child is safe, meaning there is no present or impending danger, but be concerned by conditions they observed within the family. Families can experience elevated stress and circumstances that may place them in crisis, but the child(ren) are not unsafe.

When a CW specialist determines that a child is safe but may be at risk of future harm, the specialist makes a referral to a community agency to assist the family in making changes. Critical thinking and analysis are essential in understanding the differences between conditions in a family that create a risk of maltreatment and conditions that cause the child to be in present or impending danger.

Supervisors, during the intake and safety assessment phase, did you:

- ☞ Talk to a specialist about power imbalance--if the specialist is to really engage families, he or she must first admit that there is a power imbalance--admitting that families have legitimate reasons to feel scared intimidated by the "system."
- ☞ Notice if the specialist's language, written and verbal, reflects an understanding of the family. Is the language without judgment? Does it reflect the family's ideas about what might work? Does the language depict collaboration between the specialist and the family?

- ☞ Ensure the specialist reviewed all history in order to make an educated decision regarding current circumstances?
- ☞ Ensure that the specialist identified kin during the intake and/or safety assessment so that these kin might support the family?
- ☞ Assist the specialist in identifying collaterals that will provide quality information regarding the family and safety concerns?
- ☞ Ensure the specialist can clearly articulate how the child is safe or unsafe through describing the caretaker's protective capacities or lack of and any unsafe behaviors?
- ☞ Assist the specialist in analyzing information compiled during the safety assessment? Did he or she use critical thinking skills when coming to their conclusions regarding child safety?

Joint Investigations

In a rare number of instances during the intake call, information is collected from collateral sources or during the safety evaluation phase indicates that the allegations could result in criminal prosecution. In those instances, it is critical that CW specialists partner effectively with the Multi-disciplinary Team (MDT) in the completion of a joint investigation.

The MDT approach is:

- used whenever feasible for investigations and treatment planning involving cases of child sexual abuse, serious physical abuse, and serious neglect;
- used to enhance the investigative process and maximize services provided to the affected children and families; and
- not required when there is reasonable cause to believe that a delay in investigation or interview of a child victim could place the child at risk of harm or threatened harm.

The MDT members include, but are not limited to:

- Mental health professionals
- Law enforcement
- Medical personnel
- Child Welfare Services staff
- MDT coordinators or child advocacy centers personnel
- tThe county district attorney or assistant district attorney

The forensic interview, a technique used to obtain a statement from a child in an objective, developmentally sensitive, and legally defensible manner, often plays a key role in child maltreatment investigations. Properly conducted forensic interviews are legally sound in part because they ensure the interviewer's objectivity, employ non-leading techniques, and emphasize careful documentation of the interview.

In a forensic interview, a caseworker or trained professional of the MDT interviews a child to find out whether he or she has been maltreated. The approach is used to produce evidence that will stand up in court if the investigation leads to criminal prosecution. Forensic interviewing is designed to reduce child trauma by minimizing the number of times a child is asked to relate an abusive event.

Although CWS and other MDT members may differ on their particular short-term objectives, both hope to:

- stop future abuse by the same perpetrator;
- intervene with the child and family to reduce the probability of re-victimization of the child by other perpetrators;

- prevent "secondary victimization" of the child by the system;
- reduce chances the perpetrator will victimize other children in the future;
- promote healthy ways for families to interact and healthy ways for children to form relationships with others; and
- prevent other future behavioral/emotional/lifestyle problems associated with a child sexual abuse history, such as substance abuse, joining in exploitative adult relationships, criminal lifestyles, mental health problems, or raising children who become abused.

These overall goals could be expressed in even simpler terms--all agencies involved in MDTs wish to foster healthier and safer relationships for children and to prevent further exploitation and harm.

Forensic Interviews
The goal of the forensic interview is to obtain a statement from a child in an objective, developmentally-sensitive, and legally-defensible manner. To ensure facts are gathered in a way that will stand up in court, forensic interviews are carefully controlled: the interviewer's statements and body language must be neutral; alternative explanations for a child's statements are thoroughly explored; and the results of the interview are documented in such a way that they can bear judicial scrutiny.

One of the objectives of forensic interviewing is to reduce the number of times a child(ren) is interviewed. The concern is contamination of the child's memory of the incident(s) being investigated. Research and clinical experience indicate that the more times a child--especially a young child--is interviewed about alleged abuse, the less reliable and legally defensible the child's testimony may become.

The MDT approach enables these professionals to see that, despite differences in their missions, human services and law enforcement agencies share two common goals: fostering healthier, safer relationships for children, and preventing further exploitation and harm.

Family-Centered Practice in Forensic Interviewing
When thinking about the use of forensic interviewing and partnerships with the MDT, it is important to keep in mind family-centered practice is expected in both the family assessment AND the investigative assessment approach. Some people initially have difficulty with this notion. They ask, "*How can we be family-centered when a technique such as the forensic interview is used? Isn't it too adversarial?"* Some parts of forensic interviewing and the overall investigative approach can appear to go against family-centered practice--for example, it is recommended when the circumstance may result in criminal prosecution, that CPS interview a child(ren) before speaking with the parent(s). At face value, this approach may appear to alienate families. Yet even with these constraints, when family-centered principles are embraced, families can almost always be treated in a way that makes it clear they are valued and respected. Family-centered suggestions, that fully reflect the Practice Standards are suggested below and may help inspire family cooperation, even during investigations of reports of serious child abuse and neglect.

- Take time to engage families. A relationship with the family is at the heart of an investigation and everything that follows. Investing the time needed to build a rapport with the family obtains more and better information, which provides a solid foundation for working with the family. Here the ability to listen empathically is key--when listening respectfully, with an open mind, and withholding judgment, a parent feels heard and

understood while defensiveness is reduced, and solutions can be sought. *Practice Standard: We respect and honor the families we serve.*

- Look for family strengths. Point out positives to the family when learning about them. Use strengths-based language in documentation. *Practice Standard: Continually Examine Our Use of Power, Use of Self, and Personal Biases.*
- Help families with transitions. Be clear, informative, and supportive when explaining things to the family, and whenever it is time to move to the next step in the process. *Practice Standard: Nothing About Me Without Me.*
- Give families empowering choices. Research indicates when clients feel they have been given a say and presented with options, they respond favorably. *Practice Standard: Nothing About Me Without Me.*
- Pay attention word usage. The CW specialist must seek to present information in as non-threatening a way as possible. For example, come up with alternatives to phrases such as, "I'm not at liberty to say", or "My agency requires…." *Practice Standard: Continually Examine Our Use of Power, Use of Self, and Personal Biases.*

IN HOME AND OUT OF HOME SAFETY PLANNING

The state of Oklahoma believes alternate interventions to removal are available when children are found to be unsafe in their own home. The safety plan is a temporary intervention concept, which is dynamic and fluid, developed using a least to most intrusive mentality. Several options exist within the continuum of leaving children in their home and removing them. Safety plans may occur within the home, out of the home, or some combination of the two. Safety plans control safety threats and focus on enhancing caregiver protective capacities. They do not seek to change general family functioning but provide a temporary set of interventions to keep children safe until the parenting behavior that caused children to be unsafe has changed.

The safety plan is a written arrangement between a family and Child Welfare Services (CWS) that establishes how safety threats are managed. The safety plan is a temporary plan. The safety plan must be implemented and active as long as threats to child safety exist and caregiver protective capacities are insufficient to assure a child is protected. Out-of-home safety plans can exist for 60-90 calendar days and co-exist with the ongoing Individual Service plan. In-home safety plans follow an out-of-home safety plan and remain in place until the identified safety threats are ameliorated. The intervention may also begin with an in-home safety plan involving the children and the person responsible for the child residing with or being closely monitored by the identified safety plan monitor.

The DHS Safety Plan must include the following:

- Specify what safety threats exist. Moving beyond the identified safety threats checked in the assessment of child safety (AOCS), the safety plan contains an elaboration of the threat in terms that describe how it exists uniquely within the given family. This elaboration is critical because it establishes what must be controlled.
- Identify how the safety threat will be managed including by whom, under what circumstances and agreements, and in accordance with specification of time requirements, availability, accessibility and suitability of those involved.
- Include how Child Protective Services (CPS) and the identified monitors will monitor and oversee the plan.

A safety plan must control or manage identified threats, have an immediate effect, be immediately accessible and available and contain safety actions only, not services designed to effect long-term change. It must be sufficient to ensure safety.

Safety management is dynamic, meaning that the work is always be subject to change and adjustment based on what is happening with caregivers and families. Safety management is characterized by a flexibility that results in safety activities, actions and tasks being increased or decreased according to the family's status and changes in caregiver protective capacities.

Safety plans must make sense and actually control or manage safety threats. When a child is determined unsafe and that caregiver protective capacities are diminished, it makes little sense to expect those same caregivers to be responsible to protect the child. For example, safety plans that expect parents to quit drinking, not to hit their child, or not to leave their child alone when they have repeatedly demonstrated that they are incapable of making these behavior changes, are dangerous and a direct contradiction to the judgment that the child is not safe.

Difference between a Safety Plan and an Individualized Service Plan (ISP)

One of the ways to ensure that the safety plan controls or manages the identified safety threat is to make a clear distinction between the safety plan and the ISP. Safety plans can be constructed and implemented along the life of a case. They can be developed early in the case as a way to prevent placement, implemented immediately following placement as a way to return children home rapidly once the identification of family supports occurs, and implemented as part of the reunification plan when children have been in care for some time. The safety plan and ISP can co-exist. The case review process must attend to both the efficacy of the safety plan in controlling and managing safety threats and the success of the services/interventions in supporting caregiver behavior change.

Examples of safety activities may include:

- in-home to out-of-home placement, partial to total out;
- evaluation of protective role of non-offending caregiver;
- evaluation of protective role of others, such as friends, relatives, and others;
- in-home involvement of kin to move into home; and
- child care during critical hours.

Safety arrangements can be very limited or quite extensive. Types of providers may vary from relatives to neighbors, church members, para-professionals, or professionals.

Once the safety plan is constructed, it is critical that a child welfare (CW) specialist reviews the plan with his or her supervisor. The key is to make certain the plan is sufficient to assure safety, that is, the degree of intrusiveness and level of effort represented in the safety plan will be reasonably effective in protecting a child.

Need for Engaging Kin in Safety Planning

When seeking to find ways to safely keep a child in the home the following Family Finding Work of Kevin Campbell provides a direction that CW specialists should pursue:

Step One - Discovery Goal:

Create more options for support and safety planning. The goal is to identify as many kin as possible to support the family. Success is achieved when the family is extensively known.

Step Two: - Engagement Goal:
Engage those who know the child best and have an historic and/or inherent connection to the child by sharing information and helping. Enlist the support of as many family members and others important to the child or family to participate in providing important information beneficial for the child.

Step Three: - Planning Goal:
Hold a Child Safety Meeting (CSM) with the participation of parents, family members and others important to the child focused on planning for the successful future of the child or young person. Encourage the identified family members and others who care about the child to learn together more about the young person's essential, lifelong need for support and affection. Participants must have a voice in the process. Challenges will be identified and solutions created. Planning is done on a "Plan's fail, our children do not" basis.

Step Four: - Decision-Making Goal:
A CWS team, comprised of the case's participating CW specialists, makes timely decisions that provide the child with appropriate levels of affection and belonging that are expected to be enduring. The CWS team involved in planning works with a sense of urgency, fully and candidly informed about the child's needs and the expected consequences of not having a safe forever family. The CWS team must be prepared to make key, informed decisions about the child's future, including safety, physical, and emotional well-being and belonging in a life-time family. The team meets with an understanding that long-term placement(s) without legal permanency are not considered a successful decision.

Throughout the time when a safety plan is in place, the team of people who care about the child including the child's parents, temporary caregiver, CW specialist, and others who are providing services to the family must ensure that the safety plan continues to manage and control the safety threats.

Supervisors, during the safety planning phase, did you:

- ☞ Help CW specialists focus on the entire family as an entity that needs support to stay together safely?
- ☞ Ensure the CW specialist is clear about the specific behaviors or conditions that caused the children to be unsafe?
- ☞ Assist the CW specialist in articulating how the current behaviors are impacting the caretaker's ability to meet the child's needs?
- ☞ Help the CW specialist to consider the feasibility of a safety plan that controlled and managed for safety threats PRIOR to consideration of removal?
- ☞ Ensure if a safety plan is used that the CW specialist thoroughly assesses the safety plan monitors ability to safely care for the children and meet their needs?
- ☞ Help the CW specialist prepare for the CSM and make certain that the specialist has all the information available to make a joint decision with the family to ensure the child's safety?

FAMILY MEETINGs

Family meetings (FMs) are planning and decision-making processes that include parents, caregivers, children, social workers, and other service providers. FMs also include extended family, friends, members of community groups and other community partners. Although FMs occur at different times throughout the life of a case, for example, child safety meetings (CSMs),

initial meetings (IMs), transfer meetings, and FMS for reunification, the purpose of the meeting is the same. An FM assists the child welfare (CW) specialist in engaging the family as the experts to determine what the best course of action should be in regards to child safety, permanency, and well-being.

An FM is intended to:

- Engage the family in working together.
- Prevent removal, if possible, by identifying the natural supports that the family has available, or services that can be utilized and wrapped around the family to create safety.
- Identify roles and responsibilities for each member of the team.
- Learn about the family's existing strengths, resources, and protective capacities.
- Ensure a common definition of success--making certain that the issues identified in the safety assessment are clear and the family understands the behaviors or conditions that need to change in order for the child to return home or for the case to close.
- Explore appropriate services that would be effective in supporting the behavior changes required.
- Learn about any family progress since completion of the most recent safety assessment: and consider whether or not concurrent planning should be initiated, based on a lack of family progress and poor prognosis indicators for reunification.

FMs are expected to be held throughout the process of serving a family--case opening to case closure. While an FM can be held at any time throughout the case process, they are required to be held:

- Following the identification of a safety threat when the child's current safety condition warrants consideration of a safety intervention by moving a child, having a parent leave the home, or having a monitor move into the home.
- When discussing what the child needs to be safely cared for and what additional supports the resource family will need to meet those needs.
- Whenever the case progress is being reviewed or the case is being transferred to a new specialist.
- Whenever the decision was made to pursue concurrent planning. The family needs to understand the poor prognosis indicators for reunification and the reason to identify an alternate permanent caregiver.
- Whenever the decision has been made to reunify the family. The FM ensures that the extended family fully understands the supports the child and the family will need to be successful and makes sure that everyone understands what needs to happen so that the child remains safe.

Child Safety Meeting (CSM)

A CSM is held any time the child's current safety condition warrants consideration of a safety intervention by moving a child, having a parent leave the home, or having a monitor move in. CSMs improve decision-making regarding responses to child safety concerns, when they rise to the level that out-of-home care must be considered. The CW specialist articulates to the family the safety concerns that warrant consideration of out-of-home placement. The CW specialist, in partnership with the family, identifies the family's natural network of relatives and significant others to participate in safety planning and as placement resources, when necessary. CSM is an avenue for developing specific, individualized interventions that will allow for the child to remain safely in the least intrusive, least restrictive environment. When court intervention is determined to be the safest and least intrusive way to ensure a child's safety, a CSM is held as soon as possible, but no later than **two-business days** from order of emergency custody. A CSM is always held prior

to court hearing unless the hearing is held on the same day or day following emergency custody, then it is held no later than **two-business days**. When the CW specialist is considering or implementing an ongoing safety intervention or opening a Family-Centered Services (FCS) or Court Supervision case, the CSM is held as soon as possible, but no later than **two- business days** from the safety intervention.

Initial Meeting (IM)
The IM is an opportunity for the biological parents to share information with the resource parents related to the child's needs. The IM ensures that the child's needs are met and the resource parents have the supports needed to care for the child. This practice reduces stress and trauma to the child, biological parents, and resource family while building a trusting relationship which impacts safety, permanency, and well-being.

An IM is scheduled by the child protective services (CPS) specialist and completed within **10-business days** from the date the child enters the placement as well as anytime the child changes placement. The meeting's participants include, but are not limited to: the CPS specialist, permanency planning (PP) specialist, and resource specialist, the child, biological family, and resource family. The meeting is set on a date and time that accommodates the schedules of the mandated participants. Every effort is made to ensure that the child, biological family, and resource family attend the IM. The IM is documented in KIDS by the PP specialist within **five-business days** of the date the initial meeting occurred.

IM Discussion Topics
- Parent/Child interactions and relationships
- Family routines
- Child functioning
- Additional supports for the resource family

Transfer Meeting
From intake through case closure, the case may be assigned to more than one CW specialist and may involve more than one county. When these points of transfer occur, a meaningful discussion must happen between the specialists and family about the family's needs and specifically the behaviors that have to change in order to address the identified safety threats. The family is included in transfer meetings to ensure transparency, support, and a continuity of services for the child and family.

Information Shared during the Case Transfer Meeting.
- Discuss the assessment of child safety (AOCS) in detail including specifically describing the behaviors that caused the child to be unsafe.
- Walk through the safety plan ensuring it continues to manage and control safety threats.
- Discuss the strengths and protective capacities of the family.
- Ensure that the PP specialist has all of the information about the foster family.
- Ensure that the parent(s) knows who the current specialist and supervisor are and has all contact information for them.
- Discuss the diligent search efforts to date and emphasize additional ongoing search efforts that need to occur.
- Relate the efforts towards identification of community supports or services that occurred in the AOCS--and if these did or did not support an in-home safety plan.
- Review the visitation schedule and discuss ways that more frequent and intentional visitation can occur between the child and the family.

- Talk about child well-being issues, including educational issues or child care, medical issues including prescribed medications, substance use issues and any concerns about the child's mental health.
- Discussion of referrals made for services.
- Results of last court hearing and the date of the next court hearing.

Additional FMs

Other FMs include meetings to discuss concurrent planning, meetings to discuss reunification planning, as well as any other meeting to discuss circumstances of the case, such as sibling placement and connection reviews, lack of progress within the case, or permanency meeting. When a concurrent permanency plan is decided to be appropriate, the CW specialist schedules a meeting with all family members and any supports involved in the case to obtain input on the most appropriate plan for the child. During the meeting, the team develops activities and establishes time frames in order to progress toward the concurrent plan. Examples of concurrent planning activities include: continued diligent search efforts, identification of relatives or kin willing to be a placement or permanent connection, and ongoing efforts to ensure siblings are placed together.

When planning for reunification, the FM includes daycare planning and notice of removal to the foster parents, as well as planning for school transfer. Reunification is never delayed due to school. Discussion for visitation planning is scheduled and progressive leading up to reunification. Purposeful conversation with the child about reunification and thorough discussion occur about the support needed for reunification to be successful. Keep in mind that the Court can order that an FM be completed at any time and for any reason throughout the life of the case. Any FM's main goal is to plan and make decisions for, involve, and engage the family of a child that is in the custody of the Oklahoma Department of Human Services.

Supervisors, when preparing specialists to facilitate FMs, did you:

- ☞ Ensure that the CW specialist asked the family to define who they think about as “family” and verify that those individuals are invited to the meeting?
- ☞ Help the CW specialist know how to share power during the FMs?
- ☞ Help the CW specialist to identify and work through any value issues that he or she may have about any family member or the family itself? For example, the CW specialist may not like or want to find a way to involve “Dad” because he is incarcerated.
- ☞ Ensure that clear objectives for the meeting are created with the family's input and that timely next steps are identified for the CW specialist and family members?

ONGOING SAFETY ASSESSMENTS

Assessment of Child Safety (AOCS)

Assessment supports service planning and decision making regarding the safety, permanency and well-being of children, youth, and families throughout the life of a case. The assessment process begins from the first contact with a family and continues until the case is closed. Assessment is based on the assumption that for services to be relevant and effective, specialists must systematically gather information and continuously evaluate the needs of children, parents, and caregivers as well as the ability of family members to use their strengths to address their problems and meet the child's ongoing needs. Child Welfare Services (CWS) recognizes and

uses the family as experts on their own lives and partners with them through the assessment process as well as developing an individualized service plan (ISP) to change unsafe behaviors. Family involvement in the assessment process fosters engagement by enhancing communication between CWS and the family about how the family got to this point; what has to change; what services are needed to positively impact unsafe behaviors; the expectations for who will do what by when; and the time frames that are necessary.

Assessment of Protective Capacities
Comprehensive family assessments identify individual and family strengths and protective factors. Protective capacities are personal and caregiving behavioral, cognitive, and emotional characteristics that are specifically and directly associated with the ability to protect a child from harm or threatened harm. The continuous exploration of a family's ability to address their problems is important because recognizing strengths can help families realize their capacity to change. In addition, the identified protective factors can assist in mitigating identified needs and mobilize or expand the resources that the family can use to help meet their needs. The assessment of protective factors is not simply a listing of the positive qualities and resources; the protective factors must be relevant and dynamically involved in offsetting the risks related to abuse/neglect.

Individualization
Although some of the same factors may be present among families who enter the child welfare (CW) system, such as substance abuse, mental illness, or poverty, each family is unique in how these factors affect their ability to safely care for their child and meet daily needs. The CW specialist must have a heightened awareness that each individual's experiences are different, and circumstances and underlying causes must be evaluated to effectively serve families.

This individualization carries through to service planning and creating the ISP. Each family as a unit and their individual members should receive services that address specific areas needing behavioral change in the context of the protective capacities and identified resources. Individualizing CWS' response requires commitment to distinguish between what the family needs to change unsafe behaviors and well-being issues, such as a parent's education, employment, or financial situation. CWS has to work with its community stakeholders to ensure that needed services are developed and made available in all the state's jurisdictions.

Linking AOCS Information to the Behaviorally-Based ISP
Effective service planning is a natural byproduct of a comprehensive assessment. When families have an active role in the assessment process that identifies how the family functions and what their needs are, the result is creating an individualized service plan that effectively addresses unsafe behavior. The purpose of the Ongoing AOCS is to identify additional safety threats, underlying causes, and services that will correct unsafe behaviors. The AOCS' six key questions are used to gather information on how the family functions and tells the family's story throughout the life of the case. Protective capacities are assessed to fully understand how the family functions.

Collecting and organizing comprehensive assessment information is not an end in itself; it must be used in a focused way in the service plan. The CW specialist:

- Ensures family members have an accurate understanding of why their situation was reported to CWS and the specific behaviors or conditions that must change in order to safely care for their children.
- Involves family members in the process of moving from assessment to the development of the service plan. Family member should help guide the process of determining what

interventions could best address their situation within the context of a shared commitment to making necessary changes.

- Ensures the process is transparent by sharing the tools and information used to build the service plan.
- Coordinates and involves other service providers, specialized resources, and the family's resources toward changing unsafe behaviors and building protective capacities which directly impacts timely reunification.

Supervisors, when helping the specialist complete an Ongoing AOCS and ISP, did you:

- ☞ Learn about the strengths and the protective capacities of the family? Ensure that the CW specialist understands the difference between protective capacity and strength?
- ☞ Assist the CW specialist in helping the family use their protective capacities?
- ☞ Ensure that the CW specialist and the family have a common definition of the behaviors that have to change in order to keep children safe?
- ☞ Help the CW specialist build a plan with the family that is directly tied to changing unsafe behaviors and review the plan monthly to ensure effectiveness?
- ☞ Ensure that the Individualized Service Plan only has action steps that directly impacts unsafe behaviors. For example, a To-Do list never includes well-being issues that do not impact safety such as "Client will have reliable transportation, Client will have employment, or Client will obtain a GED."
- ☞ Ask the specialist to describe the ways that the specialist is explicitly seeking to engage the family in thinking about the services that would be most effective in helping to change behaviors or conditions that caused the children to be unsafe or at risk of future harm?
- ☞ Ensure that the children/youth are active participants in planning for their own lives?

Permanency Safety Consultations

PSCs help children achieve their permanency goal through CW specialists focusing specifically on timely reunification. CW specialists continually assess the safety of the parents' home and implement the use of safety plans or services so the child may return home as soon as possible.

PSC Goals:

- Improve the understanding, decision making, and articulation of child safety.
- Increase district group learning and consistent safety decision making.
- Review, develop, or enhance culturally-relevant and individualized interventions or services that allow a child to return home safely in the least restrictive environment possible.
- Explore possible alternative safety threat interventions so the child may return home as quickly as possible, resulting in a shorter out-of-home experience while keeping the child safe and reducing levels of trauma.

Consultations occur monthly for cases with a case plan goal of return to own home with the initial PSC being completed 90-calendar days after removal. Follow-up PSCs are held every 90-calendar days thereafter until the child enters trial reunification or the case plan goal is changed. The case plan goal is evaluated at the 12 month PSC when the child is still not deemed safe to return to the parent's home.

Reunification Planning

In most cases, the initial permanency plan is to reunite the child with the biological family. Federal expectation is that 80 percent of children return home within 12 months of removal. When the permanency plan is identified as reunification, services are implemented until the child is returned home. When the unsafe behaviors were not managed or corrected even though sufficient time and services were provided to the family, CWS pursues the case plan goal that is in the child's best interest. The CW specialist is consistently evaluating the ISP's efficacy throughout the life of the case to ensure that the recommended services are impacting the unsafe behaviors. A key factor of successful reunification is parent-child visitation. Intentional visitation between the parents and child is planned, purposeful, and progressive throughout the life of the case. An updated AOCS is completed before unsupervised visitation, trial reunification, and case closure. The parent's enhanced protective capacities are documented within the AOCS and the CW specialist clearly articulates the parent's changed behaviors and ability to meet the child's ongoing needs.

Concurrent Planning

The Adoption and Safe Families Act (ASFA) of 1997 requires states to establish clear time frames for children in foster care to achieve permanency. The required time frames are in response to concerns that children were remaining in foster care longer than necessary and experiencing multiple placements. ASFA's purpose is to ensure safety is the paramount concern throughout the life of a case, reiterating that foster care is temporary for children and there is a level of accountability for achieving permanency outcomes

Successful permanency outcomes within ASFA could include:

- Children remain safely with the parents or extended families.
- Children are reunified safely with their parents or extended families within 12 months
- Children are safely placed with legal guardians - relatives or other families within 18 months
- Children are safely adopted by relatives or other community families within 24 months

To achieve these permanency outcomes, ASFA encourages the use of concurrent planning, and requires that states make reasonable efforts to find permanency for children who cannot return to their biological parents. States are mandated to concurrently identify, recruit, process, and approve a qualified adoptive family for a child when a petition is filed to terminate parental rights or if there is evidence of Poor Prognosis Indicators.

Poor Prognosis Indicators

Implementing concurrent planning means that CW specialists and supervisors must understand and continually assess Poor Prognosis Indicators a minimum of every 90-calendar days, or whenever family circumstances may dictate the need to initiate a concurrent plan.

Concurrent planning can be initiated at the following junctures throughout the life of a case:

- During the initial safety assessment phase when it is determined that one or more poor prognosis indicators exist for reunification.
- During the ongoing AOCS phases, when more information is compiled and it is determined that one or more poor prognosis indicators exist for reunification.
- At any time during the process of serving a family, when progress review indicates that the parents/caregivers are not making behavioral changes and one or more of poor prognosis indicators for reunification exists.

When a decision is made to pursue the development of a concurrent plan, this is an active process that requires development of action steps, timelines, and responsible parties. Simply identifying that the concurrent plan is either legal guardianship or adoption is not sufficient. The plan must specify the steps the CW specialist and other members of the team are to make to identify the permanent caregiver, engage the permanent caregiver, assess the caregiver's willingness and ability, and involve the individual to prepare for legal guardianship or adoption.

Supervisors, when helping specialists consider initiating concurrent planning activities, did you:

- ☞ Help the CW specialist examine the poor prognosis indicators and ensure that they in fact should initiate a concurrent plan?
- ☞ Assist the CW specialist in initiating specific activities that will lead to the possible decision to pursue termination of parental rights and adoption or legal guardianship?
- ☞ Assist the CW specialist in explaining the initiation of concurrent planning activities to the family?
- ☞ Ensure that the CW specialist held a family meeting to discuss concurrent planning?
- ☞ Assist the CW specialist in exploring parental ambivalence?

QUALITY CONTACTS

Quality contacts are purposeful interactions between child welfare (CW) specialists and children, youth, parents, and resource parents that reflect engagement and contribute to assessment and case planning processes. Quality contacts ensure child safety, support permanency planning, and promote child and family well-being. Core components of quality contacts include: preparation and planning, assessment of safety, and progress towards individual case goals, engagement, follow-up, decision making and problem-solving, and documentation. Research indicates connections exist between the frequency and quality of contacts and outcomes related to safety and permanency. Quality contacts are not just used to assess safety when children are in out-of-home placements, but are completed each month to assess for behavioral change and an understanding of the biological parents current circumstances.

A quality monthly contact with a parent includes discussion of the parent's understanding of the ISP, efficacy of services that the parent is participating in, discussion of current unsafe behaviors and why the child cannot return home, and the parent's input on what is going well and what needs to change. The three key phases of quality contacts are: (1) before the visit-preparation; (2) during the visit-engagement and assessment; and (3) after the visit- documentation and follow-up. CW specialists use the quality contact guides to aide in discussion and assessment each month with children, parents, and resource parents.

Supervisor, during the safety assessment process did you help CW specialists by ensuring that:

- ☞ The services provided to meet the needs of the children, parents, and caregivers are culturally sensitive, responsive to family's needs, and accessible?
- ☞ The CW specialist completed an AOCS in the resource home during the monthly contact? How does the CW specialist know the child is currently safe in out-of-home care?

- ☞ The CW specialist assessed for supports that the resource home needs in order to safely care and meet the child's needs? Did the CW specialist follow up on any requests or referrals made?
- ☞ The CW specialist met with the family and explained what the current safety threat is prohibiting the child from returning home?
- ☞ Documentation is of good quality and it reflects current circumstances?
- ☞ If the determination is that Poor Prognosis Indicators exist, a set of concurrent planning activities are initiated? Did you help the CW specialist in explaining to the family what this means? Timeframes?

Parent/Child Visitation

The frequency and quality of parent-child visitation is the single greatest predictive factor of successful reunification and is associated with a shorter time in out-of-home care and placement stability, and as a result is a foundational component of the Oklahoma Department of Human Services (DHS) Practice Model. As supported by research, Child Welfare Services (CWS) concluded that parents cannot be expected to improve parenting practices, maintain bonds with the child, and be able to improve the quality of their parent-child interaction when they see their child infrequently. Logically, in order for frequent visitation to occur, the CW specialist must make every effort to ensure that a child is placed in close proximity to the birth family. Parent-Child visitation is the child's right and is not reduced or suspended for a parent's non-compliance with services, including relapse or unstable housing, or when reunification is no longer the case plan goal. The CW specialist must be aware that lack of compliance within visitation might be due to problems with money, transportation, and discomfort with the degree of responsibility given to them for the child's care, or simply a misunderstanding of the visitation arrangement. Evaluating and eliminating these barriers or obstacles is always attempted before visitation is modified. Parent-child visitation is planned, purposeful, and progressive and evaluated each month during the worker visit with the parent.

Visitation Plan Development.

The visitation plan serves as an agreement between CWS serving the child in placement and the child's family. It clarifies the expectations of the visit, structure of visiting, logistics, necessary tasks, and the roles and responsibilities of placement caregivers, family members, and agency staff. A written plan reassures a child and their family that the agency is invested in protecting family relationships. Research on parental visiting of children in foster care indicates a strong relationship between the development of a visiting plan and actual visitation by parents. A CW specialist's attitudes and behaviors that express encouragement for visiting also have a positive influence on parent visitation.

PLACEMENT STABILITY

Child Welfare Services is engaged in practices to impact placement stability for children in out-of-home care. Child welfare (CW) specialists working with the family are committed to identifying, locating, engaging, and assessing appropriate relatives for children. The CW specialist makes every effort to locate relatives or kinship relations who are best able to meet the child's long-term interests. Identification of family connections and support systems begins with the report of child abuse or neglect to the Hotline. It is imperative that Hotline staff engage the reporter in identifying family connections and support systems as part of gathering information related to family functioning, strengths, and support systems.

Upon first contact with the family, the assigned CW specialist engages the family in the "First Placement-Best Placement" selection process. The specialist engages biological parents and known family connections and support systems to evaluate appropriate kinship options for the child at risk of entering or who entered out-of-home care. The most effective practice indicates this discussion also occurs during the Child Safety Meeting (CSM) to ensure that all kinship options were explored and the best placement option is selected for the child. The expectation is for the assigned CW specialist to review the Important People in the Child's Life Family Tree form with the family to identify possible kinship placement options for each child. When the family has identified possible placement options for the child, the assigned CW specialist uses the Placement Guidance Tool to assist in determining the child's "First Placement-Best Placement".

A number of practices are in place that impact placement stability for children in out-of-home care including:

- Non-kinship district director approval when a child placed in DHS custody does not have a viable kinship placement option
- Resource parent check-in call occurs within **two-business days** of the child entering placement. The call's purpose is to make sure that a child's needs are met and the resource family feels supported. Additionally, the CW specialist ensures the resource family has the necessary information and is aware of the next steps in the case process.
- Initial meeting (IM) provides an opportunity for the biological parents to share information with the resource parents related to the child's needs.
- Ongoing support includes in-home quarterly visits with the resource family's resource specialist. The resource and permanency planning specialists review the support plan developed in the IM and update it as needed to ensure placement stability.

Actively Seeking Kinnections (ASK)

CWS is committed to practices that help place children with relatives or other people with whom they have a relationship. When children are removed from their home and the Oklahoma Department of Human Services (DHS) determines placement with the noncustodial parent is not in the child's best interests, preference is given to relatives and persons who have a kinship relationship with the child, who are determined suitable, capable, and willing to serve as caretakers for the child. The CW specialist conducts intentional interviews with the parents, child when verbal, and all other known family, friends, and community members to identify additional Kinnections. A set of prompter questions are available to help guide the intentional interview to identify connections among family, friends, and community.

Once identified, notice is provided by DHS to each grandparent, other adult relatives of the child, and parents of the child's siblings. Relatives are not notified when it is not in the child's best interests due to past or current family or domestic violence. The CW specialist contacts Kinnections by phone and using the Letter of Notification to Adult Relatives. The Important People in the Child's Life and Family Tree is an optional guide used to gather family connections that ensure a child stays connected to important people in his or her life. When diligent efforts to actively seek Kinnections are insufficient, further search efforts are made, including case mining, searching the Information Management System (IMS), and searching online. In addition, a limited number of CWS staff in each region can access a paid online search tool.

Partnering with Birth Families

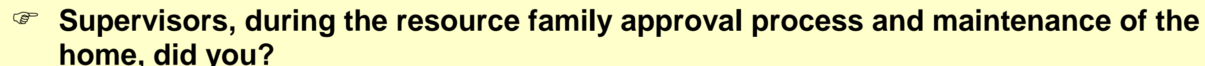
Partnering with birth families is a component of the Practice Model that seeks to view practice through a child's eyes ensuring that a child in care experiences minimal losses in connections to kin, culture, and community while in out-of-home care. Partnering with a birth family begins when a child is placed with the resource family, discussed during the IM, and continues throughout the life of the placement.

Many resource families are strong advocates for maintaining the parent-child connection. They understand and appreciate that many parents are doing the very best they can, under very stressful circumstances, to make a difference in how they parent their children. These resource families understand that safety for a child is more than physical safety, but must also include attending to a child's emotional safety, which is positively impacted by staying connected to family. Through mentoring and role modeling, these enlightened foster families work with birth families to help children return home safely as rapidly as possible.

When the birth family and resource family do not converse about the child's care due to any fear the resource family has of the birth parents, tensions are bound to build the longer the child is in care, with each blaming the other. When the birth family and the resource family are not afforded the opportunity to meet together early after a child was removed from the home and placed in care, the birth family loses the opportunity to help guide the care the child receives from the resource. When CW specialists and resource specialists sense that a resource family is struggling with the idea of partnering with a birth family, they talk the issue through and seek to find willingness for the resource family to at least meet the birth family in a neutral setting. When this first meeting occurs, and the predictable tensions are addressed, a relationship can begin to develop. The first meeting between the birth family and the resource family is the IM, which is organized by the child protective services CW specialist and is conducted within **10-business days** of placement with the resource family.

CW specialists play a crucial role in developing the birth family-resource family relationship. A CW specialist must communicate to a resource family an unwavering conviction that birth parents can grow and safely care for their children. If a specialist does not believe this, then this essential hope and conviction can't be imparted to either the resource family or the birth family. When sharing initial information about the birth family to the resource family, discussions around the birth family's strengths are incorporated. A resource family is often not helped by the specialist to understand a birth family's strengths, or they do not take the time on their own to identify birth family strengths and capacities. Even if they can identify them, many resource families may not know how to build upon those strengths in day-to-day interaction with birth families. This skill set needs to be enhanced for a resource family.

Much has been written about the torn loyalties a child faces when having to choose, or feeling as if forced to choose, between their birth and foster families. Meaningful relationships between birth and resource families minimize the child's perception that he or she must choose. Shared parenting strategies, where a child witnesses birth parents and resource families making decisions together about day-to-day activities communicates to a child that many adults are concerned about him or her and these adults are working together to create an environment of love and support for him/her. Building shared parenting strategies results in a dynamic alliance among those who are important in a child's life--birth parents, resource families, and CWS specialists.


☞ **Supervisors, during the resource family approval process and maintenance of the home, did you?**

- ☞ Ensure the CW specialist was able to identify any potential concerns with the resource family? If concerns were identified, did you confirm the specialist documented the concerns, created a plan to remedy the concerns, and followed-up with the family through resolution?
- ☞ Learn from the CW specialist about the resource family's protective capacities and ability to keep a child safe? How did the specialist gauge the family's protective capacities?
- ☞ Assist the CW specialist in identifying any personal bias while assessing a family for a child's placement?
- ☞ Assess how the CW specialist addressed language barriers? How did the specialist address or resolve this barrier?
- ☞ Ask the CW specialist to identify strengths of the resource family and how those strengths will impact a child placed in the home?
- ☞ Assess the CW specialist's ability to identify any skills, training, or specific needs the resource family may need to care for the child placed in their home?
- ☞ Help the CW specialist understand that his or her role is to continually assess safety in the resource home?
- ☞ Ensure the CW specialist reviewed all information related to the resource family and looked at the overall functioning of the family prior to participating in any screen-out referral consultations and 10-day staffing?
- ☞ Ensure the CW specialist provided specific action steps for both the resource parent and DHS staff when completing a written plan of compliance with the resource family?

Recruitment, Orientation and Training of Resource Families
A resource family is a family who may be asked to:

- provide temporary care, love and nurturance to the child and serve as a mentor actively helping the parent improve their ability to safely care for their children;
- stay connected and assist in the transition to reunification, legal guardianship or adoption to another family;
- serve as the legal guardian for the child while maintaining a child's connection to kin, culture, and community; and/or
- adopt the child while maintaining a child's connection to kin, culture and community.

The recruitment process for resource families begins with messages that seek to make the role of the resource families clear. CWS is looking for families: to care for children coming into care young children, sibling groups, adolescents and children with special medical, developmental or behavioral needs AND willing to partner with birth families and the other members of the team to help children go home safely as quickly as possible.

Individuals interested in becoming a resource family go through an assessment process that includes background checks, training, and a Resource Family Assessment (RFA). This assessment helps the resource specialist understand:

1. If the goals of the prospective resource family are in keeping with the goals of the foster care and adoption program.
2. If the family dynamics within the home are such that children would be safe and well cared for.
3. How to help the prospective resource family be successful in caring for children.

When assessing a prospective family, the resource specialist reviews a variety of information, including criminal and CW history, physical and behavioral health, finances, the condition of the resource home, protective capacities, and the social history of all individuals in the home. The

resource specialist identifies any potential concerns with the family and ensures the concerns are adequately addressed and corrected.

RESOURCE SPECIALIST SAFETY CONSIDERATIONS

The resource specialist's primary roles are to continually assess safety and to support the resource family. The resource specialist has monthly contact with the family to build a relationship, provide support, and address any concerns or needs that may arise. The resource specialist also completes an in-home visit with the family quarterly.

The resource specialist continues to assess safety through contact with the family and information provided by the child's assigned specialist. In addition to phone and in-person contact, the resource specialist participates in referral screen-out consultations, 10-day staffing when an investigation was initiated on the resource home, development of written plans of compliance (WPCs), and yearly reassessments with the resource family.

Referral screen-out consultations and 10-day staffing

When a referral is made on an open resource home and it doesn't rise to the level of an investigation, the referral is screened out. Following a screened-out referral on an open resource home, the resource specialist initiates a screen-out consultation conference call within **10-business days** and includes the resource specialist, the resource supervisor, the assigned specialists and supervisors for all children placed in the home. The conference call includes a review of all previous CW referrals, any identified concerns in the home, and observations by all specialists that were in the home. A determination is made whether a WPC or further evaluation is needed.

When a referral is made on an open resource home and it does rise to the level of an investigation, the assigned CW specialist completing the investigation initiates a 10-day staffing. The 10-day staffing includes a review of all previous CW referrals, the identified concerns in the home, results from interviews with the family and children in the home, and observations by all specialists that were in the home. A determination is made whether a written plan of compliance is needed and/or if the home can continue to be utilized as a resource home.

Written Plans of Compliance

When a concern or non-compliance issue is identified for a resource family, the resource specialist may address it through a WPC. The WPC is developed with the resource family's input and outlines specific action steps that both the resource parent and the resource specialist will complete to correct the identified concern. A WPC is time-limited and also includes skill development for the resource family. If a resource family does not successfully complete the action steps in the WPC, the resource home may be staffed for closure.

Reassessment

All resource families are reassessed each year to ensure they have the skills, abilities, and protective capacities to continue fostering. The reassessment is completed in collaboration with the resource parent and is comprised of interviews with all household members, including DHS custody children, and updating forms. The reassessment identifies strengths of the resource family and any potential training, skills, or development the family may need to continue fostering.

PARTNERSHIP

The bridging component of the Practice Model is predicated upon the belief that the resource family is a critical part of the professional team and is included in every aspect of service planning and service delivery. The resource family is provided as much information as the CW specialist has about the child and their family at placement. Public CW systems have often erred on the side of sharing too little information with resource family for fear that "if they knew everything they would not take the child." The reality is that in the end, the resource family learns all that the CW specialist neglected to share--and more--and because they were not told the truth they were ill-prepared to deal with the child's behaviors or family. Sometimes this lack of preparation results in a placement disruption and it results in a lack of trust between the resource family and the CW agency. Resource families around the country suggest that the lack of honesty on the part of public CW systems about the needs of children coming into their homes is the single most troubling reason they no longer "trust the system." In the bridging component of the Practice Model, resource families are provided with as much information about the child as is known to equip them to care for the child and to work effectively with the child's family.

The resource family is included as an integral part of the team and as such they are they are invited to all case planning and individualized service plan (ISP) review meetings. They receive a copy of the ISP and have active roles in helping children return safely to their family. A resource family cares for the children 24 hours a day, 7 days week. They have a perspective that needs to be heard. When the resource family is not treated as part of the team, not invited to the case planning sessions, and does not receive a copy of the ISP, the effectiveness of their role is minimized.

OUTCOMES/SUMMARY

The Adoption and Safe Families Act of 1997 (AFSA) created a requirement that an annual report be created to assess State performances areas in operating child protection and welfare programs. There are seven outcome categories that all States report on.

- Outcome 1: Reduce reoccurrence of child abuse and/or neglect
- Outcome 2: Reduce the incidence of child abuse and/or neglect in foster care
- Outcome 3: Increase permanency for children in foster care
- Outcome 4: Reduce time in foster care to reunification without increasing reentry
- Outcome 5: Reduce time in foster care to adoption
- Outcome 6: Increase placement stability
- Outcome 7: Reduce placements of young children in group homes or institutions

The federal expectation is that 80 percent of children achieve safe reunification within 12 months. DHS strives to have 90 percent of all children placed in kinship homes. Placement stability is also a key indicator in successful reunification and less trauma and children should have less than two moves a year. The current implementation of safety practices will also reduce incidents of maltreatment of children in foster care.