This guide is the result of hundreds of hours of work over the past two years as the state of 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 we provide child welfare services. There is a growing urgency to become more evidence based, to be able to produce outcomes that demonstrate as a result of our work children are safer and that we are really helping children and families succeed. The state of Oklahoma embarked on two processes intended to improve practice and ultimately to improve outcomes.

In late fall 2006 the state initiated the development of a set of Practice Standards that would guide the “how” of the day to day practice of administrators, supervisors and line staff and their interaction with children, youth and their families, other social workers and the community of caregivers and providers. A cross section of agency leaders, supervisors and line staff came together to explore their beliefs and values about this work, the “evidence” that existed in the field and the experiences of children and families involved in the system. Special thanks go to this work group for their willingness to engage in “courageous conversations” about the work of child welfare. The bi-product of the Practice Standard effort is highlighted in the box below:

**OKDHS Child Welfare Practice Standards**

1. We Continually Examine our Use (Misuse) of Power, Use of Self and Personal Biases
2. We Respect and Honor The Families We Serve
3. We Listen to the Voice of Children
4. We Actively and Continuously Seek to Learn Who Families Are and What They Need
5. We Believe in the Value of “Nothing About Us Without Us”
6. We Maintain A Childs’ Permanent Connection to their Kin, Culture and Community
7. We Conduct Our Work With Integrity At All Levels Of The Agency

The Practice Standards were well received by staff and supervisors and based on the CQI process, have become engrained in the practice of the agency.

Following the development and year long implementation of the Practice Standards, the state embarked on an effort to develop a **Practice Model** that embeds the practice standards and specifically describes the “what” of the day to day work.

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1. See Addendum for complete Practice Standards including all sub-components
The **Practice Model** is the way to operationalize the **Practice Standards**.

The encouragement to develop a Practice Model(s) came both from staff within the agency but also from the Child and Family Service Review (CFSR) process. The results of the CFSR specifically suggested that the state needed to refine the approach to safety assessment, visitation and concurrent planning. Additionally, staff was looking for more direction on how to work with children and their families and community partners to achieve the changes in practice outlined within the Practice Standards. Many staff had been involved in two Casey Family Programs Breakthrough Series Collaboratives (Recruitment and Retention of Resource Families and Supporting Kinship Caregivers) and it was their desire that many of the learnings from these efforts help inform the development of the Practice Model.

**Practice Models are a growing methodology being used by a variety of disciplines to guide the work of the field. Practice Models:**

- prescribes what to do
- can be used in multiple fields of practice
- includes a “style” or a way of approaching the work
- includes sequences
- includes techniques
- are preferably evidence based

Special recognition must go to our 50+ member team of line workers, supervisors, and administrators from throughout the state who came together for six days of development work. They reviewed information from all over the country, engaging in complicated, sometimes tense and highly creative and constructive conversations to design the Practice Model for child welfare services in Oklahoma. These individuals contributed countless hours to this Guide. Their time and suggestions and thoughtful guidance are greatly appreciated.

The Practice Model depicts the flow of the work from case opening to case closure. A flow chart depicting the Practice Model is on the following pages.

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.

**If we want to be accountable professionals, then we can as well develop our practice in a systematic way.**

We believe that the implementation of this Practice Model will over time, safely reduce the number of children entering the system as well as improve the care of those that do. It will require strong teamwork 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.
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OKDHS CW Practice Model Flow Chart

Standardized Intake Process

Information and Referral

Screen Out

Analysis meets criteria
Identified as Priority 1 or 2. Assign as Assessment on KIDS.

Determined to be Safe

Worker completes Assessment of Safety, Critical Thinking, Analysis and Decision Making

Determined to be Unsafe

In rare instances File immediate TPR. Legal finding that reasonable efforts are not required

Subset of Families where there is an Early Identification of Poor Prognosis for Reunification – Initiate Alternate Permanency Plan

BRIDGE Implemented Initial Meetings and Use of Visitation Guidelines

Out of home safety plan

In home Safety plan

Family Team Meeting to Help Define Safety Plan

Transfer Meeting Between CPS and the Permanency Staff (or whenever case is transferred)

Background check, history check, analysis of information following Intake Guide. Begin identification of family members (Diligent Search)

If Serious Maltreatment assign as Investigation on KIDS

Identification of Kin that can support the family.

Will possibly involve criminal prosecution

Forensic interviewing utilized in egregious situations where there is strong possibility that there could be criminal prosecution

If court involved Override Assessment to document as Investigation in KIDS

Hold
Risk and Family FUNCTIONAL ASSESSMENT AND ISP that is focused on changing the behaviors or conditions that caused the child to be unsafe or at high risk of future harm. If In-Home Safety plan is in place, continue to evaluate if the safety plan is controlling and managing safety threats.

In rare instances File TPR. Legal finding that reasonable efforts are not required.

Subset of Families where there is an Early Identification of Poor Prognosis for Reunification

Go Directly To Alternate Permanency Plan

Decision made to initiate CONCURRENT PLANNING Activities

Hold Family Team When Initiating Concurrent Plan

Legal finding that reasonable efforts were not successful. File TPR

Go To Alternate Permanency Plan

Family Reunifies

ISP Review--indicating little to no progress. Poor Prognosis for Reunification

Hold Family Team Meeting Before Reunification OR Moving to Alternate Permanency Plan

Conduct Safety Assessment and implement a Safety Plan as required

Alternate Permanency Plan

When Planned Alternative Permanent Placement is the Permanency Plan initiate Permanency Pact Meeting

ISP Review--indicating progress

Hold Family Team Whenever case progress is reviewed

ONGOING ASSESSMENT that embeds Ongoing Safety Analysis, Risk and Decision Making, assessment of progress and ongoing determination of need for Concurrent Planning

Hold Family Team

Family Reunifies

In rare instances File TPR. Legal finding that reasonable efforts are not required.

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Hold Family Team
The “front-end” (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 the agency brings families into the system and the priority in which those families are served.

However, prescribing the process in considerable detail may have certain disadvantages.
- For example, overly prescribing details may make it more difficult for workers to weigh which aspects of what they do are the most important, and thus to devote sufficient attention to these aspects of their jobs.
- Also, a prescriptive process tends to become labor intensive for workers and supervisors – an important factor when staff resources are limited – and further constrains their ability to deal effectively with workloads (for instance, to ramp up to meet unexpectedly high volumes of calls).

In Oklahoma we believe that a balanced model must:
- Recognize that the most critical resource is experienced professionals on the front-line: workers and supervisors. These individuals must be capable of making accurate and timely decisions.
Provide more structure and support for less experienced workers than for proven professionals.

Recognize screening as a "clinical practice" that requires interviewing/listening skills, sound judgment, and clinical oversight and guidance.

Provide workers improved information tools to make sound decisions.

Assist workers to devote proper attention and effort to those children whose safety is most at risk.

Provide supervisors the tools needed to effectively review the quality of worker 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 child protection worker should conduct a safety assessment of the family are described in CPS Policy OAC 340:75-3-7 and requires that the caller’s description of the issues meet the definition of abuse and neglect. The questions on the following pages assist the intake worker in making decisions about whether or not to screen the family in for the completion of a safety assessment and what priority level should be attached to the safety assessment.

The prompter questions below are designed to assist the CPS Intake social worker in obtaining careful, detailed, and thorough information from the reporter, which lays the foundation for making well-informed screening decisions. These questions are grouped into categories.

The first six categories (What, When, Why, Where, How, Caregiver Strengths/Protective Capacity, and Additional Information) contain general questions that correlate with the current KIDS Referral Screens and should be asked of every reporter.

Categories seven through twenty contain additional questions that are intended as a guide specific to the type of child abuse or neglect alleged by the reporter. (See Addendum B for the table version of the Prompter Document).

1. What

What are the details of abuse/neglect of the child(ren)?

Rephrase: Please explain what makes you believe the child(ren) are abused or neglected?

× What happened to the child(ren), in simple terms?
× Did you see physical evidence of the abuse or neglect? If yes, please describe.
× What did the parent/child(ren) say about how this happened?
× How does this affect the child(ren)?
× Is there anything that makes you believe the child(ren) is in danger right now?

Does the child(ren) have injuries, now? If so, please describe injuries?

Rephrase: Does the child(ren) have any injuries? If so, please describe.

× Is the child(ren) in need of immediate attention?
× Has the child(ren) already received medical treatment for the injuries?
2. When
When was the child(ren) last seen and by whom?
Rephrase: When is the last time you saw the child(ren)? Were they in good condition?
× When did the incident occur?
× Is this an ongoing pattern with the family?

Who else was told or knows of this situation?
× Have these people witnessed the CA/N or incident?

3. Why
Why are you calling today?
Rephrase: Has anything happened recently that prompted you to call today?
× What do you think or hope that OKDHS can do for the family?
× Is there anything you can do to help the family?

4. How
× How did you learn about the incident or situation?
× How long has this been going on?

5. Caregiver Strengths and Protective Capacities
× Are there people or placed the family turns to for help or support?
× What positive interaction have you seen between the parents and child(ren)?
× Can you tell me something good about the family?
× Do the parents seem willing or able to keep their child(ren) safe?
× What strengths do you think the parents have?
× What efforts have the parents made to correct this problem?
× What good things do the parents do for the child(ren)?

6. Worker Safety Factors and Special Circumstances
Are there any issues in the home, such domestic violence, safety hazards, and physically or mentally disabled victim that might cause the worker to be unsafe?
Rephrase: Are you aware of any safety problems with a social worker going to the home?
× To your knowledge, are there guns or other weapons in the home?
× Is anyone in the home likely to be violent or dangerous?
× Are there large dogs or guard dogs in or around the home?
× Are there any gates, codes, fences, isolated locations that prevent entry to the residence?

Are there special circumstances, such as cultural or language barriers?
× Is English the primary language? If not, what is?
× Do the parents or child(ren) have any issues that would make it difficult for the social worker to communicate well with them? (Deafness, mental illness, limited mental capacity, etc.)
× Is there something important about the family’s culture we need to know?

7. Physical Abuse/Inappropriate Discipline
× Does the child(ren) have injuries now? If so, specifically describe the injuries.
× Where was the child(ren) when the abuse occurred?
× Does the child(ren) need immediate medical attention?
• Has the child(ren) already been seen by a physician?
• What led to the child(ren) talking to you about this? or... How did you learn about it?
• When did the injury occur?
• Did anyone witness the abuse?
• Is the child(ren) afraid to go home?
• What is the caregiver’s explanation?
• Are any family members taking protective action?

8. Sexual Abuse/Exploitation/Inappropriate Sexual Acting Out
• Where was the child(ren) when the abuse occurred?
• Does the parent know about the abuse? If so, what steps have they taken to protect the child(ren)?
• Does the person who hurt the child(ren) have access to or contact with the child(ren)?
• Does the person have access to other child(ren)?
• What led to the child(ren) talking about this? or... How did you find out about this?
• What is the age and relationship of the person to the child(ren)? (relative, neighbor, stranger, minor child(ren))
• Does the child(ren) have any injuries from the abuse?
• Has the child(ren) had a medical exam?
• Did the child(ren) disclose where he/she learned these things?

9. Mental Injury/Emotional Abuse/Suicidal Children
• How does the child(ren) function at home and in school?
• What symptoms has the child(ren) exhibited to indicate psychological, emotional, or social, educational impairment?
• Is the child(ren) failing-to-thrive or developmental delayed?
• What has the parent/caregiver done that is harmful?
• How long has the situation been going on, and what changes have been observed?
• Are there any indications of cruel and unusual punishment?
• Does the child(ren) have a therapist or counselor? If so, who?
• Is the child(ren) in need of immediate psychiatric intervention?
• If the child(ren) is suicidal, has the parent been informed? If so, what was their response?

10. Domestic Violence
• Has anyone in the family been hurt? If so, who has been hurt? Describe the injuries specifically.
• Could you describe what “fighting” or “arguing” means?
• Could you explain what “dispute” or “domestic” means?
• Was the child(ren) present during the incident/violence?
• Was the child(ren) hurt during the incident?
• What was the child(ren) doing or where was the child(ren) during the incident?
• Are there any weapons in the home?
• How does the “yelling” affect the child(ren)?
• How does the violence affect the child(ren)?
• Who is caring for and protecting the child(ren) right now?
• What is the battered parent/caretaker’s ability to protect self and the child(ren)?

11. Drug or Alcohol Abuse
• How does the parent’s drug or alcohol use affect the child(ren)?
• Are the child(ren) present during the drug or alcohol use?
× How does this affect the ability of the parent/caregiver to provide for the basic needs of the child(ren)?
× Are the drugs or alcohol kept within the reach of the child(ren)?
× How does this affect their ability to supervise the child(ren)?
× Do you have knowledge that there is selling or manufacturing in the home?

12. Abandonment
× Did the parent arrange with someone else to care for the child(ren)?
× If so, are they willing and able to provide for the child(ren)?
× Does the caretaker know how to contact or the location of the parent?
× Can the child(ren) remain with the caretaker or is immediate intervention needed right now?
× Did the parent say when or if they would return for the child(ren)?

13. Drug or Alcohol Exposed Newborn
× When is the newborn expected to be discharged?
× Are there any known siblings? If so, where are they located?
× Are there any concerns about the mother’s interaction with the newborn?
× Does the newborn have any medical or other special needs that require extra care?
× Are you aware of any other previous drug or alcohol exposed newborns delivered by this mother?
× What was the mother’s explanation for the positive drug or alcohol screen?

14. Lack of Supervision
× Is the child(ren) alone right now?
× Do you know where the parent’s are and/or how to locate them?
× How much longer do you expect the child(ren) to be unsupervised before an adult arrives home?
× Is the child(ren) capable of taking care of him/herself during the time left unsupervised?
× Is the child(ren) responsible for caring for other younger child(ren)?
× Does the child(ren) have access to a phone?
× Is there anything about the home environment that raises the level of concern, i.e. pool, unsecured weapons, dangerous neighborhood, etc.?
× Does the child(ren) have any physical, mental, emotional or psychological limitations that require constant supervision?
× Do the child(ren) have access to another adult?
× What times and how long are the child(ren) left unsupervised?

15. Inadequate and Dangerous Shelter
× Could you describe what “filthy or “dirty” means?
× Does the child(ren) have access to the safety hazards you described?
× What affect does the lack of utility have on the child(ren)?
× What present safety concerns are in the environment?
× When is the last time you were in the home?
× What is it in the environment that makes it unsafe for the child(ren)?

16. Medical/Dental
× Is the child(ren) in need of immediate medical attention?
× Does the child(ren) require ongoing medical supervision, medication, or treatment?
× How are these concerns affecting the child(ren)?
× Is the parent aware of issue, understand the child(ren)’s condition, or the need for treatment?
× Has the parent tried to get medical care for the child(ren)?
What will happen to the child(ren) if they not receive this medical care, medication, intervention, etc?

Does the parent have a mental or physical limitation prohibiting them from seeking treatment for the child(ren)?

17. Inadequate Physical Care
- Is the lack of hygiene affecting the child(ren)’s health?
- Is the child(ren) made fun of because of lack of hygiene?
- Are the untreated head lice resulting in extended absence from school?
- Are the untreated or reoccurring head lice resulting in scabs, sores, or infections?
- Have any resources been provided to the family?
- What steps have the family taken to address these issues?
- How is the delay in changing the baby’s diapers affecting the baby? (severe diaper rash, infection, etc)

18. Inadequate Clothing
- Is the child(ren) exposed to elements that would endanger his/her health?
- Is the child(ren) repeatedly ill due to exposure?
- Does the child(ren)’s clothing generally match the weather conditions?
- What effect does the lack of clothing have on the child(ren)?

19. Educational Neglect
- What reasons has the parent given for the child(ren) missing school?
- How many consecutive days has the child(ren) missed?
- Does the child(ren) want to go to school and the parent will not assist?
- Are the child(ren)’s absences due to illness?
- What steps have been taken to engage the parent to address the problem?
- Has the parent been referred to truancy court?
- What impact will this have on the child(ren)’s academic success?

20. Inadequate Nutrition
- What makes you think the child(ren) is not getting enough food?
- Is there a medical reason why the child(ren) is failure to thrive or malnourished?
- You said the child(ren) only eats junk food. Is the child(ren) fed every day?
- Do you know how often and the last time the child(ren) ate?
- Does the child(ren) attend a child(ren) care or school where they get food?
- Does the child(ren) appear malnourished?
- What food have you observed in the home?

Additionally, the intake worker needs to begin to identify the family’s strengths and supports such as kin or community supports that might be helpful if we end up serving the family.

Intake Decision Making Guide
The purpose of this section of the Practice Model Guide is to help the CPS intake social worker determine whether a report of child abuse and/or neglect is accepted or screened out. Below, in the left column, are listed various types of child abuse and neglect that are frequently reported. The information in the middle and right columns is not all-inclusive, but provides general...
examples of whether the report should be screened out or accepted based on what the CPS Intake social worker has obtained from interviewing the reporter, what history is already known to CPS, Oklahoma State Statute Title 10 Children’s Code, and OKDHS CPS policies [OAC 340:75-3-2, 6 and 7].

**NOTE:** The safety needs of children three years of age or younger and/or children with diminished mental or physical capacity are given the greatest consideration in making screening decisions as these children are most vulnerable to life-threatening consequences of abuse and/or neglect.

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<th>Report</th>
<th>Screen Out</th>
<th>Accept</th>
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</thead>
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<tr>
<td>Abandonment</td>
<td>The parent(s) arranges for a substitute caregiver to provide appropriate care for the child(ren) along with stated or implied plan to resume care or custody of the child.</td>
<td>The parent(s) has made no arrangements for a substitute caregiver and deserts the child; or arrangements were made for a substitute caregiver who is no longer willing to care for the child and the parent(s) cannot be located.</td>
</tr>
<tr>
<td>Children With Special Needs</td>
<td>The school and/or counselors handle children with special educational needs or emotional disturbed behaviors.</td>
<td>There are allegations that the child has current medical or health needs that the caregiver is not addressing.</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>The child(ren)’s welfare must not be at substantial risk of harm.</td>
<td>The domestic violence between adults in the home involves weapons; physical injury requiring medical attention; sinister threats; increase in frequency and/or escalation into serious violence; presence of mental illness &amp; substance abuse; the child(ren) has tried to intervene; and/or the child(ren) has been threatened or injured. Child(ren) who are disabled, medically fragile, or are three years of age or younger are more vulnerable and less able to protect themselves when domestic violence is occurring.</td>
</tr>
<tr>
<td>Drug House Meth Lab</td>
<td>The child(ren)’s welfare must not be at substantial risk of harm. Illegal drug distribution handled by law enforcement.</td>
<td>There are allegations that young child(ren) has easy access to drugs; the caregiver provides drugs to child(ren); child(ren) are employed as part of the operation; child(ren) at risk due to raids and/or drug disputes; child(ren) have access to weapons; child(ren) exposed to a methamphetamine laboratory.</td>
</tr>
<tr>
<td>Educational Neglect</td>
<td>Oklahoma State Statutes allow parents to decide what type of education their child(ren) receives, including public school, private school, or home schooling. There are no statutory regulations or requirements for home schooling, thus CPS does not investigate home schooling issues.</td>
<td>The child(ren) wants to attend school but the caregiver is not providing any type of education to or for the child(ren).</td>
</tr>
<tr>
<td>Emotional Abuse Mental Injury</td>
<td>The parents/caregiver is seeking professional help for their child(ren) who exhibits out-of-control behavioral or emotional problems, suicidal ideation, mental health symptoms, etc.</td>
<td>There are allegations that the parent/caregiver is the direct cause of the child’s inability to function within his/her normal range of performance and behavior, i.e. has unrealistic expectations such as insisting a child carry out extreme tasks that are significantly beyond the</td>
</tr>
<tr>
<td>Report</td>
<td>Screen Out</td>
<td>Accept</td>
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<tr>
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<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Environmental: Clothing Issues</td>
<td>Poverty itself does not constitute abuse/neglect, thus it is not a reason to intervene. Families may be poor but can minimally provide for the child(ren).</td>
<td>The lack of clothing exposes the child(ren) to elements, the child(ren) is inadequately covered, has repeated illness due to exposure.</td>
</tr>
<tr>
<td>Environmental: Dirty House</td>
<td>A dirty house does not automatically mean an unsafe home. Generally, the safety of children is not at a substantial level and family, community agencies, landlords, etc. can handle the issue.</td>
<td>The home is currently a health hazard due to excessive garbage, rotted food, human/animal waste, etc. that threatens the health of the child(ren) who are disabled, medically fragile, or are three years of age or younger.</td>
</tr>
<tr>
<td>Environmental: Head Lice or Scabies</td>
<td>This is a non-threatening health issue handled by the health department, school nurse, etc.</td>
<td>The child(ren) is disabled, medically fragile, or three years of age or younger and the head lice have gone untreated for so long that the scalp is bleeding.</td>
</tr>
<tr>
<td>Environmental: Homelessness</td>
<td>Poverty itself does not constitute child abuse/neglect, thus it is not a reason to intervene. Families may be poor but can minimally provide for the child(ren). Handled by family, shelters, etc.</td>
<td>The current homelessness results in the basic needs of the child(ren) who are disabled, medically fragile, or are three years of age or younger not being met due to lack of adequate nutrition, medical care, etc.</td>
</tr>
<tr>
<td>Environmental: Poor Hygiene</td>
<td>Poor parenting practice that is not an indicator of abuse or neglect.</td>
<td>The child(ren) has become the object of constant ridicule due to the degree or duration of uncleanliness and the parent refuses to address the issue; the child’s health is affected.</td>
</tr>
<tr>
<td>Environmental: Lack of Utilities, i.e. electricity, water, gas, etc.</td>
<td>Poverty itself does not constitute abuse/neglect, thus it is not a reason to intervene. Families may be poor but can minimally provide for the child(ren).</td>
<td>The current lack of utilities directly threatens the health of the child(ren) who is disabled, medically fragile, or is three years of age or younger, i.e. an infant needs an apnea monitor.</td>
</tr>
<tr>
<td>Lack of Immunizations</td>
<td>This is a public health issue handled by the school, child care center, and health department.</td>
<td>There are allegations that the child(ren) is experiencing serious health risks as the result of the absence of immunizations. Generally this type of report would come from medical personnel.</td>
</tr>
<tr>
<td>Lack of Prenatal Care for Unborn Child or Fetus</td>
<td>An unborn child or fetus is not defined as a “child” under Title 10 and thus falls outside the scope of CPS. Handled by health professionals.</td>
<td>There are allegations of child abuse/neglect concerning other children living in the home.</td>
</tr>
<tr>
<td>Lack of Supervision</td>
<td>There are no statutory requirements regarding how old a child must be before he/she is left alone, thus it is a parental decision as to whether the child(ren) is able to care for self.</td>
<td>Generally the child(ren) age six years and younger requires continuous supervision by an adult and current or impending danger exists because of being left alone overnight, alone for extended periods and no resources are available, unsupervised outside of the home or supervised by inappropriate caregiver, playing with dangerous objects, or is in dangerous places without intervention.</td>
</tr>
<tr>
<td>Medical Neglect</td>
<td>A parent choosing not to give their child(ren) ADHD medications or other behavioral-related medications, not</td>
<td>There are allegations that the parent/caregiver is withholding medical treatment or prescription of any type that will significantly harm the child,</td>
</tr>
<tr>
<td>Report</td>
<td>Screen Out</td>
<td>Accept</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>acquiring eye tests or glasses, not taking the child(ren) to the</td>
<td>i.e. not giving prescribed insulin to a diabetic child, refusing to take</td>
<td>There is recent CPS history that the child(ren) has sustained repeated</td>
</tr>
<tr>
<td>doctor or dentist for minor ailments, etc., is not child neglect.</td>
<td>the child to emergency room with broken bones, etc.</td>
<td>non-accidental physical abuse that has placed the child(ren) in grave</td>
</tr>
<tr>
<td>Minor physical abuse of children age 11 years old or older</td>
<td>Injuries are located on the legs, shoulders, arms or buttocks, do not</td>
<td>danger.</td>
</tr>
<tr>
<td>Parent/Child Conflict</td>
<td>require medical attention, and are the result of inappropriate</td>
<td>There are allegations that the conflict includes physical alteration</td>
</tr>
<tr>
<td>Counselors, family, friends or other support systems are available</td>
<td>physical discipline.</td>
<td>resulting in the parent/caregiver injuring a child under age 11-</td>
</tr>
<tr>
<td>Minor physical abuse of children age 11 years old or older</td>
<td>The school and/or counselors handle children with special educational</td>
<td>years-old.</td>
</tr>
<tr>
<td>Children With Special Needs</td>
<td>needs or emotionally disturbed behaviors.</td>
<td>There are allegations that the child has current medical or health</td>
</tr>
<tr>
<td>Spanking or Corporal Punishment</td>
<td>Oklahoma State Statute specifically states that parents are not</td>
<td>needs that the caregiver is not addressing.</td>
</tr>
<tr>
<td>Sexual Activity or Behavior – Age Inappropriate</td>
<td>physically inflicted or</td>
<td>A child under age 11 years old has sustained an injury or injuries.</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>Sexual curiosity is part of normal child development and is generally</td>
<td>There are allegations of sexual activity or behavior that is outside</td>
</tr>
<tr>
<td>Sexual Exploitation</td>
<td>handled by the child’s</td>
<td>the norm. Refer to Understanding Children’s Sexual Behaviors by Toni</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>parents. Refer to Understanding Children’s Sexual Behaviors by Toni</td>
<td></td>
</tr>
<tr>
<td>Truancy Delinquency</td>
<td>Cavanagh Johnson for</td>
<td>Cavanagh Johnson for guidance as to what sexual behaviors are</td>
</tr>
<tr>
<td></td>
<td>guidance as to what sexual behaviors are considered indicators of some</td>
<td></td>
</tr>
<tr>
<td></td>
<td>type of abuse or neglect.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There are allegations of sexual activity, including propositioning or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There are allegations that the parent/caregiver allowed or encourage the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>acts committed or permitted, by the caregiver/parent, i.e. rape, sodomy,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>engaged in sexual acts with others. Prostitution, obscene photographing/</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There are allegations that the parent/caregiver allowed or encourage the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>indicating exposure to adult sexuality.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child(ren) who are disabled, medically fragile, or are three years of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>higher levels of basic care than older children.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oklahoma Law provides schools with compulsory education requirements,</td>
<td></td>
</tr>
</tbody>
</table>

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### Report | Screen Out | Accept
---|---|---
Vehicular Accidents Resulting in Injury & Driver Under the Influence of Drugs or Alcohol | This is an issue handled by law enforcement and the Department of Public Safety. | Reported by law enforcement that the drug or alcohol use directly caused the vehicular accident that resulted in the child's injury. |
Vehicular: Children not placed in car seat/seat belt | This is an issue handled by law enforcement and the Department of Public Safety. |  |

If the initial criteria 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 bruising or injury to the child

Per CPS Policy **75-3-7.1. Priority I reports** indicate the child is in imminent danger of serious physical injury. Allegations of abuse and neglect may be severe and conditions extreme. The situation is responded to immediately, the same day of receipt of the report. If a complete investigation or assessment is not possible, a safety measure is put in place to ensure the child's protection. A safety measure is an action taken that protects the child and controls and manages the safety threats, such as protective child care, perpetrator leaves the home, or other similar protective actions.

Per CPS Policy **75-3-7.1. Priority II reports** indicate there is no imminent danger of severe injury, but without intervention and safety measures it is likely the child will not be safe. Priority II investigations or assessments are initiated within two to 15 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 Child Welfare (CW) worker may make a referral within Oklahoma Department of Human Services (OKDHS), 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 OKDHS contract providers may be offered to the family—and are in keeping with our goal to partner with community providers to create a community safety net for children and families.
Information is the foundation of safety assessment. To understand child safety, OKDHS Child Welfare staff must assess the pertinent areas of family life that contribute to children being safe.

**Rapid Family Engagement**

In order to learn accurate information it is imperative that workers have the ability to rapidly engage families. This occurs through the following:

- **We Communicate To Families (Both Through Our Actions And Our Words) That What They Say Matters.**
  - *During the safety assessment process we hear their story and we effectively communicate to them that their perspective and voice help us best serve their family.*

- **We Practice Full Disclosure**
  - *We let the family know why we are in their homes, what we are learning, the steps of the process and the rationale for any decisions we make.*

- **We Honor The Family’s Culture**
  - *Entering another family’s culture is a process that requires being a student of how culture impacts decision making, parenting and family functioning. We do not assume that we understand and we do not view the family through our own cultural lens.*
  - *We seek to learn who matters to the family—who might be able to support the family such as kin in the problem solving process.*

- **Attend to our Language**
– We ask questions in a way that engages the family and we make certain that we do not use terms that are unfamiliar to the family. If we do so, we explain what we mean.

We seek to avoid, to the extent possible, actions that minimize/undermine parents’ power. Invoking authority is easier and requires less skill than engaging families.

– It is the worker’s responsibility to 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.

“Words are a form of action, capable of influencing change.”

In the OKDHS approach to safety assessment the following definitions guide decision making.

**Safe:** A child is in an environment without any safety threats or if there are immediate and/or impending threats of serious harm, a responsible adult in a caregiver role demonstrates sufficient capacity to protect the child.

**Unsafe:** A condition in which the threat of serious harm is present or imminent and the protective capacities of the family are not sufficient to protect the child. A child is considered unsafe if present danger or impending danger exists. 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, already endangering or threatening to endanger a child (occurring now).

- **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 (i.e., 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, but these can be identified and understood upon more fully evaluating individual and family conditions and functioning.

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).
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

**Immediate Protective Plan**

When Present Danger exists, the worker must put an Immediate Protective Plan into place.

Immediate Protective Plans are used when there is the identification of specific present danger to a child. They are designed to control and manage the present danger threats so that the child is safe while the full assessment of safety is completed. They are short-term in nature, thus making them distinctly different than safety plans and case plans. They are replaced with safety plans when the assessment of safety is completed.

The following areas must be addressed when considering an immediate protective plan.

- Parents’ willingness to co-operate.
- Description of person(s) responsible for the protective action, check of home for obvious safety threats.
- Confirmation of person responsible for protective action: trustworthiness, reliability, commitment, availability, alliance to plan. Most importantly, does this person believe that the safety threats are real and may result in serious harm to the child? Can the worker 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 worker and provider of protective plan and time frames of protective action and oversight.

Assessment of Safety

The research indicates there are six general areas of family life that when assessed provide pertinent and sufficient information to complete an effective assessment of threats to child safety.²

**Six Areas to Include In the Assessment of Child Safety:**

1. Assessment of the extent or severity of the maltreatment.
2. Assessment of the circumstances surrounding the maltreatment.
3. Assessment of how the child functions/behaves on a daily basis.
4. Assessment of the disciplinary approaches.
5. Assessment of the general parenting practices.
6. Assessment of how the caregiver functions in daily life.

Assessment in these six areas provides the foundation from which you will identify the presence of threats to child safety. A further discussion of these six areas is highlighted below:

² Action for Child Protection.
1. Assessment of the extent of the maltreatment. This area is concerned with the maltreating behavior and the immediate physical effects on a child. It considers what is occurring or has occurred and what the results are (e.g. hitting, injuries.) Information to be gathered in this phase of the safety assessment 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

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 to be gathered in this phase of the safety assessment includes:
   - Caregiver intent concerning the maltreatment
   - Caregiver explanation for the maltreatment and family conditions
   - Caregiver acknowledgement and attitude about the maltreatment
   - Other problems occurring in association with the maltreatment

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 we seek to determine if a child’s special needs are being met, if there are any unusual child behaviors, the child’s sense of security, their physical health, the vulnerability of the child, and signs for positive interaction with caregiver. This assessment focuses on how a child is from day to day rather than focusing on points in time (i.e., CPS contact, time of the maltreatment event)

   Information to be gathered in this phase of the safety assessment includes:
   - Capacity for attachment
   - General mood and temperament
   - Intellectual functioning
   - Communication and social skills
   - Expressions of emotions/feelings
   - Behavior
   - Peer relations
   - School performance
   - Independence Motor skills
   - Physical and mental health
   - Functioning within cultural norms
4. **Assessment of the disciplinary approaches.** This area is concerned with the manner in which caregivers approach 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, workers assess the type and nature of disciplinary practices, the purposes of the discipline in the home, awareness of effective disciplinary practices, 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
- Context in which discipline occurs
- How discipline is informed by culture

5. **Assessment of parenting practices used by the caregiver.**
When looking at the pervasive parenting practices workers assess if their expectations of the child are developmentally appropriate, if they express concern or empathy for the child, if their manner of responding and interacting with the child is supportive and helpful, if they are ensuring the child is supervised and if the caregiver is able to recognize danger or threats of danger to the child. Information to be 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

6. **Assessment of Adult Functioning.** This area is concerned with how the adults/caregivers 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 we will look to see if the caregiver continues to be committed to the safety of the child and is willing to do what is necessary and required within the safety plan. We will look to see if the caregiver is growing in their understanding of why their children were unsafe and their family needed a safety plan. Part of this assessment is the determination of whether or not substance abuse or mental health issues are impeding the functioning of the adult and their ability to offer protection to their children. In this area we are concerned with how these adults in the family behave regardless of whether they are parents or not. Information to be gathered in this phase of the safety assessment includes:

- Coping and stress management
- Self control
- Problem solving
- Judgment and decision making
- Home and financial management
- Employment history
- Substance use
Mental health
- Physical health and capacity

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 we know that there is certainly variation in the ease of getting information from families, we also believe that by engaging families and seeking to understand their perspectives and views, workers can gather pertinent and sufficient information related to these six questions in one to two family contacts.

**Relationship of the Six Areas of Assessment to Threats to Safety**
The following table from Action for Child Protection shows the relationship of the six questions to informing about specific threats to child safety. The table shows how the six areas of Assessment of Safety link to safety threats.

<table>
<thead>
<tr>
<th>Safety Assessment Question</th>
<th>Related Safety Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. The Extent of Maltreatment</strong></td>
<td>✗ Caregiver threatened/caused serious physical harm to a child.</td>
</tr>
<tr>
<td></td>
<td>✗ Abuse has been going on for a long period of time.</td>
</tr>
<tr>
<td><strong>2. Circumstances surrounding the maltreatment.</strong></td>
<td>✗ Caregiver cannot/will not explain a child's injuries.</td>
</tr>
<tr>
<td></td>
<td>✗ Caregiver’s intent was to “teach the child a lesson”.</td>
</tr>
<tr>
<td></td>
<td>✗ Caregiver minimizes the harm that occurred to the child.</td>
</tr>
<tr>
<td><strong>3. The child’s daily functioning.</strong></td>
<td>✗ Child is fearful.</td>
</tr>
<tr>
<td></td>
<td>✗ Child behavior places child in danger.</td>
</tr>
<tr>
<td></td>
<td>✗ Child is severely developmentally delayed due to neglect/malnutrition.</td>
</tr>
<tr>
<td><strong>4. Disciplinary practices.</strong></td>
<td>✗ Violent caregivers [or others] in the household.</td>
</tr>
<tr>
<td></td>
<td>✗ Caregiver’s lack of self control.</td>
</tr>
<tr>
<td></td>
<td>✗ Caregiver uses harsh physical discipline as primary means of parenting</td>
</tr>
<tr>
<td><strong>5. General Parenting Practices</strong></td>
<td>✗ Caregiver makes child inaccessible</td>
</tr>
<tr>
<td></td>
<td>✗ Caregiver has distorted negative perception of a child.</td>
</tr>
<tr>
<td></td>
<td>✗ Caregiver fails to protect/supervise.</td>
</tr>
<tr>
<td></td>
<td>✗ Caregiver is unwilling/unable to meet immediate needs of child</td>
</tr>
<tr>
<td><strong>6. Adult Functioning</strong></td>
<td>✗ Violent caregivers or others in the household.</td>
</tr>
<tr>
<td></td>
<td>✗ Caregiver’s lack of self control.</td>
</tr>
<tr>
<td></td>
<td>✗ Caregiver is unwilling/unable to meet immediate needs of child</td>
</tr>
</tbody>
</table>

As is evident, the work when assessing the safety of a child is NOT merely determining whether or not something occurred (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 mobilized* to contribute to the ongoing protection of the child.
– Consideration of the protective capacities of parents/caregivers is relevant for assessment in that these capacities can help us in determining if children area safe or in controlling and managing 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/neglect. The protective capacities must be able to be deliberately mobilized 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 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.

### Protective Capacity
- Presence of a supportive extended family willing and able to help
- Demonstrated ability of parents to accept responsibility for their behavior and willingness to change.
- Clear understanding (and demonstration) of youth and child's developmental needs.
- Willingness (and demonstration) to meet the needs of the child or youth; ability to get child to school, medical appointments, etc.
- Demonstration of ability to adjust discipline to stage of development.
- Ability to control expression of anger.
- Physical and emotional health of parent or caregiver.
- Demonstrated capacity to form and maintain healthy relationships.
- Positive patterns of problem solving in other life areas.
- Parental past experience protecting the child.
- Non-maltreating parent or other adult in the home willing and able to protect the child.

### Decision to Pursue Termination of Parental Rights During the Safety Assessment Process

There are rare instances when the harm to the child is so egregious, or when the situations is such that the situation meets the criteria as outlined under ASFA where reasonable efforts are not required, and a decision is make to file a petition for Termination of Parental Rights. The conditions where ASFA allows for this action include the following:
☐ Parent(s), legal guardian(s), or custodian(s) has inflicted chronic abuse, neglect, or torture on the child(ren), a sibling, or another child(ren) within the household where the child(ren) resides.

☐ Parent(s), legal guardian(s), or custodian(s) has been convicted in the murder or voluntary manslaughter of any child(ren); or aided or abetted, attempted, conspired, or solicited to commit murder or voluntary manslaughter of any child(ren).

☐ Parent(s), legal guardian(s), or custodian(s) has deserted the child(ren) and such desertion continues for a period of at least six months immediately prior to the filing of a petition adjudicating the child(ren) deprived or a petition to terminate parental rights.

☐ Child(ren) has experienced severe physical or sexual abuse in infancy.

☐ Child(ren) was conceived as a result of a rape. This applies only to the parent who committed the rape and whose child(ren) has been placed outside the home.

☐ Parental rights to another child(ren) have been terminated following a period of service delivery to the parent and no significant change has occurred in the interim.

☐ Parent(s), legal guardian(s), or custodian(s) has a recent history of criminal activity and has been incarcerated. The continuation of parental rights would result in harm to the child based on consideration of the following: the duration of the incarceration and its detrimental effect on the parent/child relationship, the age of the child, the current parent/child relationship, and the manner in which the parent(s), legal guardian(s) or custodian(s) has exercised parental rights and duties in the past.

Even in these circumstances it is critical that the worker seek whenever possible to engage the family, helping the family understand the decision making process and determine if the child can have an ongoing relationship with any of the family members.

**Identification of Risk During the Safety Assessment Process**

There are times when workers may conduct an Assessment of Safety and determine that a child is safe (there is no present or impending danger), but be concerned by issues they observed within the family. A child is at risk when the family functioning may result in a child being harmed at some point in the future. As the chart below depicts, when a child is determined to be unsafe immediate action must be taken.

When a worker determines that a child is safe but may be at risk of future harm, the worker should make a referral to a community agency to assist the family in making changes to reduce those risks.

<table>
<thead>
<tr>
<th>Safety</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refers to immediate danger from maltreatment.</td>
<td>Refers to the likelihood that a child will suffer harm in the future.</td>
</tr>
<tr>
<td>Signals a need for immediate Action by the child welfare system.</td>
<td>Identification of risks help focus a change process that may occur over time. Community providers will assist in this preventive change process.</td>
</tr>
</tbody>
</table>
By referring families where children are at risk to our community providers, we are implementing a true community based approach to child welfare. This approach is founded on the belief that no single entity can fully meet the needs of families and that effective partnerships with community providers are vital to enhancing long term family and child health and well being.

Critical Thinking and Analysis supports your understanding of the differences between conditions in a family that create risk of maltreatment and conditions that cause the child to be in present or impending danger.

Supporting Documents:

- New Assessment of Child Safety Tool (Addendum C)
Partnership with MDT and Forensic Interviewing

There are times during the intake call that we learn from collateral sources or during the safety assessment phase that the allegations could result in criminal prosecution. This is the case in a rare number of instances. In those instances it is critical that child welfare workers partner effectively with the Multi-Disciplinary Team (MDT) in the completion of a forensic interview.

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;
- (Oklahoma Department of Human Services (OKDHS) Child Welfare (CW) staff;
- MDT coordinators or child advocacy centers personnel; and
- the 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 Multi Disciplinary Team, 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 child welfare 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
- 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, raising children who become abused, etc.

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

**The Need for Forensic Interviews**

Because many perpetrators of egregious harm deny the abuse and most acts of maltreatment are not witnessed, the child victim’s statement is critical evidence. Yet developmental issues, such as children’s varying abilities to recall events and use language, as well as the trauma they may have experienced, complicate efforts to obtain information about the abuse. The forensic interview is designed to overcome these obstacles.

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 children are 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 that child’s testimony may become.

“If I am the first person to talk to a child about an event, that event is like a design on the bottom of swimming pool filled with clear water—it is easy to read. But each conversation this child has with someone about the alleged abuse clouds the water. If he has talked with his principal, parents, a police officer, etc., it can be very hard or impossible to discern the design at the bottom of the pool.”

Lauren Flick, Psychologist

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Forensic interviewing is important for the way it brings child welfare agencies together with other community and state agencies. Because it is used so often in combination with a multidisciplinary response to child maltreatment, forensic interviewing helps professionals learn about each other’s roles and how the larger system serving families and children operates. It 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 there is an expectation of family-centered practice 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?” It is true that some parts of forensic interviewing and the overall investigative approach appear to go against the family centered practice—for example, it is recommended that when the circumstance may result in criminal prosecution, CPS interview children before speaking with parents. At face value this approach may appear to alienate families. Yet even with these constraints, when we embrace family-centered principles, we can almost always manage to treat families in a way that makes it clear we value and respect them. The following family-centered suggestions, that fully reflect the Practice Standards are suggested below and may help you inspire family cooperation, even during investigations of reports of serious child abuse and neglect.

**Take time to engage families.** Your relationship with the family is at the heart of your investigation and everything that follows. Invest the time needed to build a rapport with the family and you will probably obtain more and better information, and you and others from your agency will have a solid foundation for working with the family. Here your ability to listen empathically is key—when you listen respectfully, with an open mind, and withholding judgment, parents feel heard and understood, 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 you learn about them. Use strengths-based language in your documentation. *Practice Standard: Continually Examine Our Use of Power, Use of Self, and Personal Biases.*

**Help families with transitions.** Be clear, informative, and supportive as you explain 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 tells us that 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 to the words you use. The worker must seek to present information in as non-threatening a way as possible. For example, you may wish to 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.

Supporting Documents:

- Look to Local Protocols for Partnership With Law Enforcement in Criminal Cases.
In Home and Out of Home Safety Planning

The National Resource Center for Child Protective Services suggests in recent articles that Child Protective Services “has been notorious for its diametric view of safety intervention. The point of view that has prevailed in our past is that either kids are safe or not and that if kids are not safe they are removed from their homes”. They go on to suggest that not only is this not very creative thinking; but it is a very troubling way to work with families; and that it is just plain wrong.4

The state of Oklahoma agrees with this perspective and intends for the safety plan to be a temporary intervention concept, which is dynamic and fluid, developed using a least to most intrusive mentality. There are several options that exist within the continuum of leaving children in their home and removing them. Safety plans may occur within the home, out of the home (placement with a Bridge Resource Family) 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 that keep children safe until the parenting behavior that caused children to be unsafe has changed.

A Safety Plan can be constructed when children are in the home, out of the home or a combination of the above.

The safety plan is a written arrangement between a family and the agency that establishes how safety threats will be managed. The safety plan is not necessarily 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. Safety plans likely will remain in place for weeks into months and will co-exist with the ongoing Individual Service plan.

The OKDHS Safety Plan must include the following:
- Specify what safety threats exist. Moving beyond the identified safety threats checked in the safety assessment list, the safety plan should contain an elaboration of the threat in terms that

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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 CPS (and/or others) 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 services and actions only, not services designed to effect long-term change. It must be sufficient to ensure safety.

Safety management is dynamic, meaning that our work must 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 in accordance with the status of the family and changes in caregiver protective capacities.

It is important that safety plans make sense and can actually control or manage safety threats. Once it has been determined that the child is 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 individualized service plan. The chart below makes the distinction between the two kinds of plans. 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, they can be implemented immediately following placement as a way to return children home rapidly once the identification of family supports occurs, and they can be implemented as part of the reunification plan when children have been in care for some time. **It is quite likely that the safety plan and individualized service plan will 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.

<table>
<thead>
<tr>
<th>The Safety Plan</th>
<th>The Individualized Service Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>The purpose is to control.</td>
<td>The purpose is to change.</td>
</tr>
<tr>
<td>The safety plan is limited to impending danger safety threats.</td>
<td>The individualized service plan can address a wide range of family needs.</td>
</tr>
</tbody>
</table>

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5 Action for Child Protection.

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The Safety Plan

The Individualized Service Plan

| The safety plan is put in place immediately upon identifying impending danger. | The individualized service plan can be put in place following further assessment and when the family is ready (or when policy demands.) |
| Activity and services within the safety plan are dense which means there are a lot of things going on frequently. | Activity and services can be spread out occurring intermittently over a long period of time. |
| The safety plan must have an immediate effect. This means it must work the day it is set in place. | The individualized service plan is expected to have long term effects achieved over time. |
| The provider’s role and responsibility in the safety plan is exact and focused on threats. | The provider’s role and responsibility vary according client need. |

**Examples of safety services may include:**

- In-home to out-of-home placement (partial to total);
- Evaluation of protective role of non-offending caregiver;
- Evaluation of protective role of others (friends, relatives, others);
- In home involvement of kin to move into home;
- 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 to professionals.

Once the safety plan is constructed, it is critical that workers view the plan with their supervisor. We want to make certain that 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 children in their homes the following Family Finding Work of Kevin Campbell[6] provides a direction that workers 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 children best and have an historic and/or inherent connection in helping 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 helpful to the child.

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**Step Three: Planning Goal:** Hold a Family Team Meeting meetings 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 together to learn 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:** The team will make timely decisions that provide the young persons with appropriate levels of affection and belonging that are expected to be enduring. **Practice:** The team involved in planning will work with a sense of urgency, fully and candidly informed about the needs of the child or young person and the expected consequences of not having a safe forever family. The team will be prepared to make key, informed decisions about the future of the child(ren), including their safety, physical and emotional well-being and belonging in a life-time family. Teams will meet 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, child welfare worker and others who are providing services to the family must ensure that the safety plan continues to manage and control the safety threats.

**Supporting Documents:**

- Safety Planning Tool
- Away From Home Brochure provided to parents following the Assessment of Safety
Family Team Meetings are planning and decision-making processes that includes parents, caregivers, children, social workers and other service providers. They may also include extended family, friends, members of community groups, and other community partners. There are a variety of models that have been used to bring family members together as part of the planning process including New Zealand’s Family Group Conferencing, Casey Family to Family’s Team Decision Making, John Vandenberg’s Wrap Around, American Humane’s Family Team Meeting. Each has specific guidelines or requirements with varying costs and personnel requirements. Each has its value in bringing families together in the planning and decision making process. After considerable discussion, OKDHS made a decision not to adopt any specific model but to allow the areas of the state to decide how they will approach the Family Team Meeting process.

That said, regardless of the model used, OKDHS Practice Model requires that Family Meetings be held throughout the process of serving a family—case opening to case closure. While a Family Team Meeting can be held at anytime throughout the case process they must be held at the following times:7

- Following the assessment of child safety to identify family supports that can be used to keep children in their home safely, or if that cannot occur, as part of the placement process to identify kin who might be able to provide temporary care to the child(ren);
- As part of the ongoing assessment process and ISP Development;
- When a decision to actively implement concurrent planning is made;
- When alternate permanency plan is indicated; and/or
- Prior to reunification

7 These specific planning/decision making points are highlighted in the Practice Model Flow Chart.
What makes a family-centered team meeting different than a case staffing or traditional approach to planning and decision making is that the Practice Standards are applied to every aspect of planning and implementation.

**Honoring Culture, Race and Ethnicity**

One of the benefits of Family Meetings is the ability they provide to learn about the cultural, racial and ethnic background of the family and how their background impacts parenting decisions.

Culture includes race, religion, ethnicity, family values, lifestyle, family composition, customs, values and beliefs. The family itself is the most important source of information about its unique characteristics, historical roots, and cultural values. Culturally competent workers can help families to have a positive experience in planning and participating in parenting and other family access time by:

- Respecting the client’s perspective.
- Listening well enough to learn about people who are different from themselves.
- Avoiding judgment from bias, stereotypes, or cultural myths.
- Asking the family to explain the significance culture has for them, especially regarding family traditions, child rearing and discipline practices, spiritual beliefs and traditions.

In order to best serve families of diverse backgrounds we believe one needs to possess “cultural humility”. Cultural humility “involves the curiosity and motivation to understand the web of meaning in which children and families live, and the reflective capacity to examine our own cultural values and assumptions. It requires a commitment to appreciating the similarities and differences between one’s own culturally shaped goals and priorities and those of the children and families. It requires as well an obligation to ‘rein in’ our power and authority, so that the voices of children and family members can be fully valued and heard.” The Family Team Meeting is a strong reflection of the Practice Standards “Nothing About Us Without Us”.

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**The cornerstones to effective Family Meetings are as follows:**

- Everyone desires respect
- Everyone needs to be heard
- Everyone has strengths
- Judgments can wait
- Partners share power
- Partnership is a process

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**The Process of Family Team Meetings**

Family Team Meetings are one of the ways that the OKDHS Practice Model strives to fully involve and engage families in the process. The Family Team Meeting process begins by the child welfare worker talking with the key family members about having a meeting. It is essential that this process begins very early in the social worker’s contacts with the family. The Family Team Meeting process may be new to both family and worker, so it can take some time to

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achieve trust in and understanding of the process. In order for the family-centered meeting to be effective, it requires the full support and participation of the family and worker.

Sometimes parents/caregivers are reluctant to include other members of their family/community network in a family meeting. This may be because of the desire for privacy, embarrassment, self-protection, safety, damaged relationships, prior abuse, or any number of reasons. Family Meetings are essentially voluntary processes. Participants, including parents, ultimately decide the level of their participation.

While parental wishes concerning who is invited/not invited should be honored and respected, it is also imperative that the child welfare worker uses diligence in expanding the circle of support for the child and family as widely as possible. *A broad and comprehensive circle of support is more likely to keep the child and family safe.* Widening the circle involves a great deal of skill in working with resistance. When parents/caregivers are reluctant to hold a family meeting, social workers must seek to understand what this reluctance is about and how the safety and comfort of the parents/caregivers can be achieved.

**The Foundational beliefs around holding team meetings include:**
- A group can often be more effective in making good decisions than an individual
- Families are the experts on themselves—we need to engage them as experts.
- When families are included in decision making, they are capable of identifying their own needs and strengths and are much more committed to the successful completion of the plan.
- Members of the family’s own community add value to the process by serving as natural allies to the family and as experts on the community’s resources
- Remember: Nothing About Me Without Me!

**Family Team Meetings Occur:**
- Whenever an in home or out of home safety plan is required. We engage families to identify supports or resources that can help a child stay in the home safely OR we use a family team meeting to identify possible kin caregivers for the child(ren).
- Whenever the case progress is being reviewed. The family has to be part of the case plan review process.
- Whenever the decision has been 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 Family Team Meeting ensures that the extended family fully understands the supports the child and their family will need to be successful and it ensures that everyone understands what needs to happen so that the children remain safe.

**The Intent of the Family Team Meeting Is To:**
- Engage the family and secure an investment 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.
Establish and continue to build the relationship between the worker, the family, the Bridge Resource Family and kin.

Learn about any family progress since the safety assessment:
  - Reinforce and celebrate any steps that the family has taken to mitigate the reasons we are involved in the system
  - Consider whether or not Concurrent Planning should be initiated, based on lack of family progress and poor prognosis indicators for reunification.

Ensure a common definition of success—making certain that the issues identified in the safety assessment are clear and that 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 family existing strengths, resources, and protective capacities.

Identify roles and responsibilities for each member of the team

Provide sample documents so that the families understand what is required by the court.

Identifying a member of the team that will stay connected to the family—and help the team assess progress toward to an agreed upon definition of success.

**If a child is in care the meeting needs to specifically focus on:**

- Establishing/building the relationship between the resource family and the birth family.
- Addressing the predictable tension that can exist between a resource family and a birth family and talk about how to resolve the tension—be very transparent.
- Providing an opportunity for the birth family to share their knowledge about the child’s needs, likes, dislikes, sleeping schedules, napping, favorite food, medical history, etc.
- Discussing ongoing interaction between the child and their family—the role of each in making sure the child stays connected to his kin (this can include teachers, best friends, neighbors and relatives)
- Being very specific about the process—and the timeframes—create a visual aide to show the flow of the case through the system. FULL DISCLOSURE!

It is important to note that when reunification occurs or when an alternate permanency plan is implemented, the Family Team Meeting should include discussion of need for safety planning and ongoing contact with kin.

Some of the considerations in planning Family Team Meetings are highlighted below.

*Is there a clear, open-ended purpose?* The purpose should be written simply, without jargon. It should also be open-ended with many possibilities for planning, decision making, and action. The facilitator may have to help the child welfare worker rewrite the stated purpose of the meeting so that it meets these criteria. If there are any “bottom line” safety issues that must be explored and addressed during the meeting, these should discussed with the family prior to the meeting.
Do the invited participants, especially family members, agree to the purpose? Family Team Meetings are voluntary processes; people can choose to attend. It is critical that the purpose be crafted in such a way that participants can both get their interests met and feel comfortable with the process. In other words, a successful FTM will be one where the participants want to be there and see it as relevant to them and their lives.

Is the worker open and willing to consider the family’s ideas at this time? Sometimes the facts of the case determine decisions and actions that need to be taken. If a decision is already made, it is imperative that the meeting not be held for the purpose of making/justifying that particular decision or simply getting the family to agree with it. Likewise, if there is only one outcome that is potentially acceptable to the agency representative, then it is likely not a good time for a Family Team Meeting. Remember that family-centered practice is all about choice and empowerment. Without choice and the power to make plans and decisions, participants will feel that the meeting is a waste of time—making it a frustrating experience. Family Team Meeting should always be centered on issues where families can participate in the decisions that affect them. For example, if the decision is already made that a child must be placed into foster care, then the focus of the meeting should not be to get the family to go along with this already made decision. Rather, the meeting’s purpose might be to focus on identifying ways to make the transition to foster care go smoothly, how the birth family and extended family can stay connected to the child while the child is in care, and what educational services (for example) the child needs while in care.

Can the right people be there? By definition, a Family Team Meeting is a group process. It requires that the circle of influence and decision involve those most important in the life of the child. This could include numerous family members like parents, siblings, grandparents, cousins, aunts, uncles, etc., but also such people as neighbors, friends, mentors, pastors, godparents, and other like family contacts.

Facilitators need to set the ground rules to ensure a productive meeting:
- Engage the family in setting their own rules.
- No disrespectful language, behavior or negative tones—team members have the right to call one another if they observe these behaviors.
- No talking over another person.
- No cell phones or pagers during the meetings.
- Unless it is an emergency—no one leaves the meeting until the meeting is done.

A Good Facilitator:
- Protects ideas and individuals from attack or being ignored through the provision of a safe, supportive environment to permit communication.
- Models supportive, non-threatening, respectful behavior.

“People tend to support and be successful in directions that they themselves create.”
Understands the difference between effective sharing of self—and telling people what to do.

Finds ways to use humor to diffuse conflict—although we don’t want to be afraid of conflict.

Balances the fine line between being a part of the team—and facilitating the process.

Periodically summarizes, clarifies, reframes and identifies areas of agreement to assist the group.

Ensures that the family’s voice is heard and validates the feelings of all family members. Seeks to find the balance between task and process.

Invites diverse perspectives without taking sides.

Is sensitive and responsive to nonverbal cues. Manages conflict and emotions.

Moves the group through the problem-solving/decision-making process, maintaining reasonable time frames.

Accurately records information and decisions. Provides a copy of the safety/action steps at the completion of the staffing to all participants.

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**Ten Tips For Social Workers For Effective Family Meetings**

1. Be on time. If you are going to be delayed for any reason let the facilitator know so attendees can be informed.
2. Assist parent(s) with transportation if needed.
3. Explain the purpose of the meeting in advance to non-agency attendees.
4. Ensure that every person in the room feels that their perspective is validated.
5. Be sensitive and respectful of the serious nature of the staffing. Parents and others are watching, not just during the meeting but also before the meeting begins and after it ends.
6. Schedule adequate time for yourself. While it is important to adhere to timeframes for the meeting, remember we are dealing with critical and emotional decisions in the lives of families and whatever time is needed to make a quality decision should be expended.
7. Be clear on the goal of developing a decision, with the assistance of the child’s family and others, which keeps the child safe in the least restrictive placement/least intrusive manner.
8. Come organized to present a summary of the situation and prepared with ideas and a recommendation, while receptive to the opinions and ideas of the other participants.
9. Be honest and fair in what you say. Discussion should be strengths-based, direct and straightforward.
10. Assist in keeping the group focused and productive. Invite others to share their perspectives, information and opinions.

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9 This is borrowed in part from Annie E. Casey Family to Family Team Decision Making Model
BRIDGE: Placement and Visitation Practices

The Bridge component of the Practice Model includes all aspects of practice when children are placed in out of home care including recruitment, orientation and training of resource families, child placement practices, visitation between children and the workers and between children and those with whom they have a connection.

Bridge is a component of the Practice Model that seeks to view practice through the eyes of the child ensuring that children in care experience minimal losses in connections to their kin, their culture and their community while in out of home care.

Recruitment, Orientation and Training of Resource Families

The definition of a Bridge 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, and/or
- 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.

By the definition it is clear that Bridge recruits, orients and supports both traditional foster families, kin and adoptive families. There is no distinction in approach.

The recruitment process for Bridge families begins with messages that seek to make the role of the Bridge resource families (as described above) clear. We are 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 we are looking for families willing to partner with birth families and the other members of the team to help children go home safely as rapidly as possible.

The OKDHS Recruitment Message is:

Come Join Us in Building Bridges Together!
As indicated on the chart below, the implementation of Bridge has resulted in an improvement of response to families who call the agency inquiring about becoming a Bridge resource family.

When families call, talking points have been established to ensure that the response to questions and the general messaging on the calls is consistent and reflects our commitment to engaging families to work with birth families and to be willing to care for the kind of children coming into care. When families call, we send them an intake packet that has been revised and reviewed by existing resource families. The packet is sent within 3 working days of the inquiry call.
Within seven days of the mailing of the packet a Bridge Resource Specialist contacts the prospective family to ensure that the received the packet, to answer questions and to link the family up with an existing Bridge family to answer questions and have open and honest discussions about fostering children. Our goal is to have as many families as possible participate in the Orientation process.

During Orientation, the role of Bridge Resource Families is further described. Prospective families are provided with information about the process, about the children who are in need of homes in the specific geographic area of the state, about the application and home study process. A video is shown to prospective families that depict the needs of children and their families and the “heart” of the work of caring for children. Sometimes existing Bridge families present at the Orientation.

All families interested in becoming a BRIDGE resource family attend OKDHS PRIDE training. The training has been modified to discuss in greater detail the role of Bridge families in partnering with birth families, and how the work of Bridge families helps children to maintain connection with their kin, culture and community throughout the period of placement.

The pre-service training for Bridge families includes an assessment of the family. This assessment helps the Bridge Resource Specialist to understand 1) if the goals of the prospective Bridge resource family are in keeping with the goals of the Bridge program 2) if the family dynamics within the home are such that children would be safe and well cared for and 3) how to help the prospective Bridge family be successful in caring for children.

**Partnership Between Child Welfare Workers and Bridge Resource Families**
The Bridge component of the Practice Model is predicated upon the belief that the Bridge family is a critical part of the professional team and that they are included in every aspect of service planning and service delivery. They are provided as much information as the worker has about the child and their family at the point of placement. Public child welfare systems have often erred on the side of sharing too little information with resource families for fear that “if they knew everything they would not take the child.” The reality is that in the end, the resource families learn all that the worker neglected to share—and more—and because they were not told the truth they were ill prepared to deal with the behaviors of the child or the child’s family. Sometimes this lack of preparation results in a placement disruption; always it results in a lack of trust between the resource family and the agency. Resource families around the country suggest that the lack of honesty on the part of public child welfare systems about the needs of children coming into their homes is the single most troubling reason they no longer “trust the system.” In the Bridge component of the Practice Model resource families are provided with as much information about the child as is known in order to equip them in being able to care for the child and to work effectively with the child’s family.

**Bridge resource families are to be included as an integral part of the team and as such they are invited to all case planning and individualized service plan review meetings.** They receive a copy of the individualized service plan and have active roles described in helping children return safely to their family. Bridge resource families are caring
for the children 24 hours a day, 7 days week. They have a perspective and this perspective 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 individualized service plan, the effectiveness of their role is minimized.

The Practice of Partnering with Birth Families
Many resource families across the nation and within the state of Oklahoma are strong advocates for maintaining the parent-child connection and their work reflects this commitment. They understand and appreciate that many parents are doing the very best that 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 results from 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.

In order to ensure that the practice of Bridge resource families supporting birth families occurs, it is critical that Bridge resource families meet birth families shortly after placement (within the first 72 hours).

The purpose of this meeting is to provide an opportunity for birth families to share information with the resource family about their child’s likes and dislikes, needs, medical issues, etc. It also provides an opportunity for the birth family and the Bridge resource family to ask questions of one another and to begin to build a relationship.

When the birth family and resource family do not converse about the care of the child due to the 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 resource families and birth families are not afforded the opportunity to meet together early after a child has been 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.

The University of Illinois Child and Family Research Center published a longitudinal study that showed a strong correlation between birth family-resource family relationship and children achieving permanency outcomes within ASFA timeframes.\(^\text{10}\)

\(^{10}\) University of Illinois Child and Family Research Center. (2003)
Child Welfare workers play a crucial role in developing the birth family-Bridge family relationship. It requires that child welfare workers communicate to Bridge resource families their unwavering conviction that birth parents can grow and safely care for their children. If a worker does not believe this, then they have minimal ability to impart this needed hope and conviction to either the Bridge resource family or the birth family. When sharing initial information about the birth family to the resource family discussions around the strengths of the birth family should be incorporated. The work of Bill O’Hanlon (1999) has helped to further the social work practice of identifying and using strengths as part of the therapeutic process. O’Hanlon suggests that active discussion about strengths with a family, has the effect of intensifying them. A strengths approach assumes that the birth family has what it needs to identify solutions to its own problems. Often resource families are not helped to understand the birth family’s strengths, or they do not take the time to identify birth family strengths and capacities and even if they identify them, many resource families may not know how to build upon strengths in the day to day interaction with birth families. This is a skill set that needs to be enhanced.

When worker’s sense that Bridge families are struggling with the idea of partnering with birth families they talk the issue through and seek to find a willingness for the Bridge family to at least meet the birth family in a neutral setting. Once this first meeting occurs, and the predictable tensions are addressed, relationship can begin to develop.

“It might be easy to judge the birth family as not being good enough, or not trying hard enough…but when I see the kids’ eyes light up when they see their Mom; no matter what she has done to them…I know I have to help them find a way back to each other.”

Child Welfare Worker OKDHS

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

Maintaining Connections Through Visitation
In 2004 the Child Welfare League of America published a paper on parental visitation.11 (Leathers, 2004). This study examines whether parental involvement in the lives of their children

while in placement, is correlated with more frequent visiting and a greater likelihood of reunification. The study examined the relationships between involving parents in planning for visits, in planning where visits are to occur and the goal of the visits with frequency of visiting, chances of reunification while controlling for parental substance abuse and mental illness.

Consistent with the results of other studies, the results of Leather’s study supports the theory that visitation is a stronger predictor of reunification than parental problems, such as substance abuse, mental health issues or even the length of time children spend in care.

The results of this study also suggest that where visits take place is related to how frequently they occur. Visiting in the birthparent’s home or the foster home were both associated with more frequent visiting than visiting at an agency, a fast food restaurant, or another setting. In addition, parental involvement in case reviews and other activities in the child’s life was found to be associated with more frequent visiting. These results suggest that among children who have been placed in foster care inclusive practice is associated with more frequent visiting, which substantially increases a child’s chances for reunification.

Kuehnle and Ellis (2002) make the case for frequent visitation emphatically:

“If an attachment bond is to be maintained between parents and their children in [out-of-home placement], a one-month visitation time frame is not advised. Because physical proximity is a critical requirement in the attachment process for infants and toddlers, and availability is critical for children of other ages, how could children of any age possibly maintain an attachment bond with a parent he or she visits every 30 days....? In family courts [with regard to custody and divorce cases] attorneys and mental health professionals would be outraged if a child were kept from all contact with a parent for weeks, let alone months. In dependency court why is this tolerated? If maltreating parents and their dependent children are going to be reunited, the quality of their relationship needs to be enhanced through stable and nurturing contact, rather than diminished further though absence.”

The frequency and consistency of visitation is a foundational component of the OKDHS Practice Model. As supported by research, we concluded that we cannot expect parents will improve parenting practices, maintain bonds with their children and be able to improve the quality of their parent-child interaction when they see them infrequently. Logically, in order for frequent visitation to occur, children must be placed in close proximity to the birth family and workers must be supported in the visitation process.

Visiting Does Not End When It Is Determined That Reunification Is Not The Goal

Unless visits are prohibited by court order, parents and children have the right to visit. An agency decision against reunification in and of itself does not remove this right. Even if parental rights are terminated, visiting may take place as agreed upon by the child’s new permanent family and the child’s birth family.

Development of the Visitation Plan
Given time constraints child welfare workers may not going to be able to facilitate the number of visits the team feels are necessary. As such workers are going to have to engage all team members in planning for and supporting the visitation process. Various counties tested involvement of Bridge resource in planning for the visitation process and in supporting frequent parent-child visitation. They suggest that Bridge resource families can play an invaluable role as team member, teachers and mentors to birth families.

"Workers found that it enriches the process immeasurably. The Bridge resource parents, birth parents, and extended family were able to work together to come up with an excellent plan including how visitation will occur and the roles that each will play to ensure that visitation occurs frequently. Everyone felt wonderful about the process."

OKDHS Supervisor

The visitation plan serves as an agreement between the agency serving the child in placement and the child’s family. It clarifies the structure of visiting, logistics, necessary tasks, and the roles and responsibilities of placement caregivers, family members, and agency staff. A written plan reassures children and their families that the agency is invested in protecting family relationships. It also identifies possible consequences should the plan not be adhered to. 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. Child welfare worker attitudes and behaviors that express encouragement for visiting also have a positive influence on parent visitation.13

"There is a preferred visiting plan in every case that will best meet individual children’s and parents’ needs and closely parallel the service plan... Reaching for the ideal in a plan does not deny the realities that may affect implementation; but assuming that the preferred or ideal plan can never be implemented guarantees that we will fall short of our standard."14

The extent of the parents’ cooperation with the visiting plan must be considered in visit arrangements. [Limited cooperation] may be examined at two levels: the actual behaviors and the meaning of the behaviors. Depending on the persistence and meaning of the [limited cooperation], a social worker’s response may differ. For example, parents might not cooperate with a plan for weekly visits at home, often not being there or always being late when the child is brought for the visits. This behavior might indicate an inability to keep track of the visit schedule, ambivalence about visits in the home and family reunification, worry about their own ability to care for or protect the child in the home, reaction the pain of being separated from the child, disinterest in the child’s return, and so forth.


Each explanation suggests different actions for child welfare workers to take. The reasons for [limited cooperation] with visit arrangements should always be explored. The lack of compliance might be due to problems with money, transportation, or child care; inability to tell time; changes in parents’ work schedules; discomfort with the degree of responsibility given to them for the child’s care; or simply misunderstanding of the arrangements. Eliminating such obstacles should always be tried before visit arrangements are modified.\footnote{Hess, P. & Proch, K. (1988). Family visiting of children in out-of-care: A practical guide. Washington, D.C.: The Child Welfare League of America.}

**We Do Not Use Visitation as a Punishment**

During the development of the Practice Standards and the Practice Model there was significant energy around withholding of visitation as a punishment to parents or even to children in out of home care. Numerous instances were shared where families were denied visitation due to “lack of compliance” with the individualized service plan, children were denied visitation due to behavior outburst, parents were denied visitation due to a perceived inappropriate interaction with the worker or the resource family. The conclusion the workgroup came to is that 

visitation is a right of children. It is a moral obligation of child welfare agencies to find safe ways that children are able to maintain connections with those they love. Regardless of how much we “like” the birth parents, or their behavior is “annoying” to us, we need to be champions of children and families right/need to see one another.

Regular visitation tells the child:

☞ That the parent(s) care enough to visit, and the child(ren) can see that all adults—Birth Family, Bridge Family and child welfare worker are working together.

☞ How much progress their parent(s) are making toward getting them home.

☞ If the children are allowed to have contact and express all their upset feelings, they are less likely to take out or “displace” these feelings on the Bridge Family.

**Visitation is Not Something that Children Must Earn**

There has been a history in group care settings of making visitation contingent on a child reaching a certain “level” or on a child’s behavior within the facility. A child welfare worker may need supervisory or administrative support to impact “rules” and enforce visiting plans.
Regardless if the visit occurs in the facility or in the child’s home, the setting in which the child is located does not remove the child’s right to visit with parents, siblings or other kin.

Contact with their children is also crucial for birth parents. Contact and frequent parent-child interaction generates hope, allows families to build on existing strengths and supports the development of the child-parent bond. It provides a place where parents can work on behaviors that caused children to be unsafe.

Contact between child(ren) and Birth Family helps the Bridge resource family. By getting to know the birth family, the Bridge resource family can better understand the child(ren’s) behavior and understand the love that exists between child and parent. The Bridge resource family can see first hand the love between the child and the family and it helps them in supporting the reunification process. Further, children who do not see their family often lose hope and do not understand what is happening to them and this often results in children acting out their fear and frustration in the Bridge family’s home—which is difficult for the Bridge family.

Contact between the Birth Family and child(ren) also helps the social worker. Because visits are a primary predictor of family reunification, visits are an effective tool to assess the consistency and efforts of the parents in putting their children’s needs first, the quality of the relationship between the parent and the child(ren) and how much progress is being made toward changing the behaviors that caused the children to be unsafe or at risk of future harm.

OKDHS Five Step Approach To Parent-Child and Sibling Visitation

1. Planning for the Visitation. Whenever possible the visitation plan should be created during the Family Team Meeting. In the beginning the child welfare worker will be actively involved in the visitation process…this may change over time as the Bridge family takes on a larger role. The Bridge Family should (whenever possible) be given approval to arrange for visits (as part of the Family Team Meeting). The Bridge family and the birth family need to discuss how these visits are going with the child welfare worker.

The following issues should be addressed during the planning process:

✓ Ensure transportation needs are met.
✓ Plan for the visit to occur where the parents/child feel most comfortable visiting.
✓ Help the parent to plan a specific activity for the visit posing the question “What are the things that your children like to do…could you bring along a game?” Some times parents are unclear about how to participate in parenting time or are unsure of their ability to do so. Supervisory or other decision-making consultation forums are resources to assist child welfare workers in working through these types of challenges.
✓ Ensure that the visitation plan actually support changes in behaviors or conditions that caused the children to be unsafe or at risk of future harm. Parents need to understand the link between the activities involved in the visitation process and changing behaviors or conditions that caused their children to be unsafe in their care.
Ensure that the environment allows for a natural parent-child interaction, bonding and attachment.

Consider who else should be at the visit. Pose the question “Who is it important for the child to stay connected to?” (Grandparents, friends, pets, teachers, pastors, neighbors…..)

2. Preparing the Birth Family. Child welfare workers have primary responsibility for preparing the Birth Family. The Birth family should have a clear understanding of the visitation arrangement and the plan should be included in the family’s ISP. The birth family should be prepared for possible reactions by the child, according to the circumstance and development of the child. For example,

- An 11 month old baby may cling to the foster parent if he or she has not seen their parents for a period of time. This could be very painful for a parent who has not been prepared for such a reaction, and could potentially cause unnecessary anger toward the Bridge Family.
- A 15 year old feels tremendously guilty and responsible because she feels that her Mother needs her and she is not there to help her. This impacts interaction with Mom.

The Birth family needs to plan activities for the visits and bring required food, clothing, toys and diapers. It is important for the team to remember that visits are NOT natural situations, particularly if they are held in the office and as such, the team needs to work to try to make the visit as nurturing and pleasant for the child as possible. Finally it is critical for the birth family to discuss how they will say good bye to the child(ren).

3. Preparing the Children. The Bridge family has primary responsibility for preparing the child(ren). All members of the team including the child(ren) as age appropriate should have a clear understanding of visitation arrangements. Too often children are picked up and carried to and from visits with little idea of what is going on, or is going to happen. The child should have as much information as possible and appropriate about the visit ahead of time. Both the child welfare worker and the Bridge resource family should help prepare the child(ren) for the parent’s reaction to seeing them.

The child should be also prepared for his or her own feelings and reactions. Seeing the parents may bring an overwhelming sense of guilt in a child who has made a seemingly smooth adjustment into the Bridge Family. A child who has not seemed to miss his or her parents may suddenly be overcome with grief at having to leave them. Emotions are complicated and unpredictable. We need to help children and youth understand that the visit may bring up a range of feelings (rather than to identify one possibility), and they need to be reassured that this is all right. Finally, if the child has safety or protection concerns, he or she needs to be assured that child welfare worker or Bridge resource family will be there to help make sure everybody is safe.

4. Preparing Siblings. Siblings need to see one another even if there is no plan for reunification or if the children have been adopted into separate homes. Research tells us that
depending on the circumstances, siblings have a varying reaction to seeing their brother or sister following placement. Often the events leading to placement have been traumatic. Siblings who remained with the Birth Family may feel angry with the child in placement. They may feel the child has abandoned the family or revealed a family secret(s). Or the sibling in care may feel that he or she has been abandoned. Children placed with different Bridge families may be curious as to the reasons why. The child welfare worker may need to talk with siblings before the visit to help them understand the situation.

5. Preparing Bridge Resource Families. The Bridge Resource Family should have a clear understanding of the visitation arrangements. They may have several children in care, and coordinating activities can be a challenge. This is another reason why it is critical that Bridge Resource Families are part of the planning process. The visitation plan must also take the Bridge family’s schedule into account. If a foster parent is expected to comfort a child following a visit, the plan must assure that he/ she is home when the child returns from a visit, rather than have the child returned by a parent or a volunteer at a time when it is known that a foster parent will not be home and an older child or someone else will be receiving the child. Similarly, visit beginnings and endings should not be scheduled at times that will be highly disruptive for the foster family, such as the family’s regular dinner hour. Visits on holidays or during vacation periods require particularly thoughtful advance planning in order to minimize confusion for the child and disruption to the foster family.”

The Bridge resource family should be prepared for the child(ren’s) reaction both before and after visits. When resource families misunderstand or misinterpret the reactions children have following a visit they may draw conclusions that are not helpful to the child or to the reunification process. Normal feelings of loss and separation may be reactivated by seeing the parent and may be expressed in emotional distress or behavioral acting out.

- The child may be anxious and fearful when with the parent; their time together may be stressful.
- The child may experience loyalty conflicts after having visited with the parent, and may need to reject the foster caregiver upon return to the foster home in order to continue to feel loyal to the parent.
- Following a visit the Child welfare worker should fully assess the reasons for the child’s distress and, if appropriate, revise the visitation schedule accordingly:
  - If the child becomes upset during visits due to feelings of separation and loss, the frequency of visits should be increased rather than decreased.
  - If the child is anxious because the child is not comfortable with the parent, increasing contact, perhaps with child welfare worker involvement to ease the discomfort, is useful.
  - If loyalty conflicts contribute to the child’s distress, they can reassure the child that it is OK to care for both their family and their foster family.

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If the child appears to be fearful and reticent to visit with the parent, the worker should encourage the child to talk about their fears, and reassure the child that the worker will ensure their safety. When this is the case these visits should be supervised and monitored.

The Bridge resource family also needs to be prepared for how they might feel or react during and following the visit.

- When parents don’t show up for visits and children are continually disappointed, Bridge families may feel angry and will need to process these feelings.
- When visits go well—and patterns suggest that the behaviors that caused the child to be unsafe or at risk of future harm may have been resolved, the Bridge Family can be saddened, as it may signal that the time is approaching for the child(ren) to return home.
- Bridge Families need to have somewhere to go to discuss their own grief and loss issues.

**Visits between Worker and Child**  
New federal legislation requires that workers see children in care no less than monthly.

Whenever we see children as part of our face-to-face interaction on a monthly minimum basis, we will assess for child safety and well being using a tool that assists in assessment of a child/youths safety and developmental well being. During this safety assessment, we will look to see if the child’s special needs are being met, if the child is exhibiting any unusual child behaviors, and if they feel secure in the home. By visual observation, we will assess for their physical health and look for signs for positive interaction with caregiver.

📖 **Supporting Documents/Tools:**

- Talking Points used during intake call with prospective Bridge Resource Families
- Information Packets
- Bridge Orientation Video
- Integrated Home Study
- Revised Pride Training
- Tools for Initial Meeting Between Birth Family and Bridge Resource Family
  - All About Me Form
  - Bridge Family Profile Form
  - Agenda for Initial Meeting
CASE TRANSFER MEETINGS

One of the significant issues facing children, families and resource families within the child welfare system is the changing of social workers. Building trust within a team is not an easy task in any situation, but building trust within a team where several members of the team may have been traumatized is even more challenging. Once trust does begin to develop, a change in the team constellation can cause mistrust and withdrawal of team members to occur.

In the OKDHS child welfare system, change in workers is in many counties a planned part of the process. One worker engages the family during the assessment of safety and then the case is transferred to another worker to support the family through the Functional Assessment, ISP development and permanency decisions. When these points of transfer occur, it is imperative that there is a meaningful discussion between the workers about the family, children’s needs and specifically the behaviors or conditions that have to change in order to address the safety threats or risks identified.

The following information should be shared during the Case Transfer Meeting.

- Discuss the Child Safety Assessment in detail including specifically describing the behaviors/conditions that caused the child to be unsafe.
- Walk through the Safety Plan ensuring that if an in home safety plan is in place, it continues to manage and control safety threats.
- Discuss the strengths and protective capacities of the family—so that the Permanency worker really starts the interaction with the family from a place of hope and optimism.
- Ensure that the Permanency worker has all of the information about the Bridge family, the role that the Bridge family has played to date in visitation and information about the Initial Meeting Between the Birth Family and the Bridge Family.
- Discuss the Diligent Search efforts to date and emphasize additional Diligent Search efforts that need to occur.
- Relate the efforts towards identification of community supports that occurred in the Assessment of Safety—and how these either did or did not support an in home safety plan.
- Review the visitation schedule and discuss ways that more frequent visitation can occur between the child and their family.
- Talk about child well being issues—including educational issues (or child care) medical issues, substance use issues and any concerns about child mental health.
- Results of Family Team Meeting and the scheduled date for next Family Team Meeting
- Discussion of referrals made for services

A planful and intentional approach to the case transfer process will directly impact child safety and well-being.
Results of last court hearing and the date of the next court hearing

Whenever possible, the family should be included in the Transfer Meeting. This allows for the introduction of the family to the new worker and transparency in the information shared between workers honoring our practice standard *Nothing About Me Without Me.*

If the Transfer Meeting must occur without the family, it is still very important that there is an opportunity for a formal transition between the initial worker and the ongoing permanency worker. It might be possible that both workers and the family are on the phone together (through three way calling function) and the transition again can occur transparently with the family.

At the very least the worker who conducted the Assessment of Safety must let the family know that a new worker will be assigned, the name and contact information of the new worker and when the family can expect to be contacted by the new worker. We NEVER want the family to receive a call from a new worker without having some type of information about the transfer.

**NOTE:** This process should occur ANY time a case is transferred from one worker to another. This means when workers leave the agency or when they are transferred or are promoted to other positions within the agency.

**Supporting Documents:**

- See County Case Data Sheet
Assessment is the process of gathering information that will support service planning and decision making regarding the safety, permanency and well-being of children, youth, and families. The assessment process begins with 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, workers must systematically gather information and continuously evaluate the needs of children and parents/caregivers as well as the ability of family members to use their strengths to address their problems.

Completing a Risk and Family Functional Assessment is a “process,” not simply the completion of a “tool.” This does not mean that tools are superfluous; they are helpful in documenting needs or in stimulating the conversation about assessment issues. It does mean, however, that the engagement of family members in a discussion that is individualized to their situation is vital.

Previously in this document we have discussed the process of assessing child safety that is initiated following the call reporting alleged abuse or neglect of a child. The assessment of safety determines if a child is unsafe due to present or impending danger. When a child is determined to be unsafe and a decision has been made to open a case for services, (regardless of whether the child is placed outside the home), a Family Risk and Functional Assessment is undertaken as part of the development of a useful service plan.

About the Assessment Process
It is important to understand that that the way we ask questions and compile information during an assessment generates an experience for the family and powerfully impacts how subsequent work unfolds.
Consider Billy, a 14-year-old boy who has been hospitalized 12 times in the last three years, and is increasingly involved in the juvenile justice system. An intake worker is collecting his previous hospitalization history and involvement in the juvenile justice system. The worker also collects all of the interventions that have been tried with the family system. As the worker methodically obtains the details of precipitating factors, treatment course, and discharge plan for each intervention, she notices Billy and his family’s presence in the room increasingly shrinking. The intake worker is only collecting information, not “intervening,” and yet is it any wonder that by the time Billy and his family describes his 11th unsuccessful hospitalization, his fifth court appearance and a string of services and interventions that their sense of sense of hope has shrunk to microscopic level?

In his Collaborative Therapy with Multi-Stressed Families author Bill Madsen describes the Smith Family’s interaction with two teams of social workers from the state child welfare system. The first team viewed the family as chronically dysfunctional, whereas the second team saw them as having tremendous coping skills and survivors of many family traumas, desperate for help but very suspicious due to a long history of previous negative experiences with helpers. As we reflect on the families’ interactions with the two different teams, several important points emerge. “Different observers ‘see’ different things in a situation. Perception is not a passive process of observation but an active drawing of distinctions.”17 The distinctions we draw as social workers are profoundly organized by our own history and our own set of cultural “shoulds and shouldn’ts”. The different views of the Smith family were shaped by the context of the social workers’ interactions with the family and the values within which those interactions were interpreted. The first team anticipated the family’s “dysfunction” and described themselves as stiffening up in anticipation of the family’s “craziness.” The second team, whose perspective emphasized the family’s resilience and commitment to one another, had a different reaction. They admired the family’s persistence in continuing to struggle to get their children back, and wanted to help the family have a different experience in their interactions with the team.

Our reactions to families are often communicated in subtle ways and, in turn, invite birth family reactions to us. The Smith family thought the first team of social workers was uneasy around them, and that the workers were critical, “uptight and judgmental.” The family responded with suspiciousness and defensiveness, and a relationship developed that was characterized by mutual mistrust, blaming, and antagonism. As the interaction became more polarized, each party became more entrenched in their negative view of the other. In contrast, the Smith family felt understood and validated by the second team and responded by sharing more of their life story and became active participants in the process of service planning and service delivery. This premise is the foundation for the Practice Standard *We Continually Examine Our Use (Misuse) of Power, Use of Self and Personal Biases.*

Our Practice Standard emphasize that when serving children and families we are respectful, strength focused and culturally responsive in the way we interact with birth families, how we understand their problems, and how we organize the information compiled assessment process.

The focus of a Risk and Family Functional Assessment is to assess the underlying causal factors for behaviors and conditions affecting children as well as contributing factors to children being

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17 Collaborative Therapy With Multi-Stressed Families: From Old Problems to New Futures. (1999)
unsafe or at risk of future harm such as family history, domestic violence, substance abuse, mental health, chronic health problems, and poverty.

In a Risk and Family Functional Assessment, the family’s strengths and protective factors are also evaluated to identify resources that can support the family’s ability to meet its needs and better protect the children. The Family Risk and Functional Assessment incorporates information collected through the assessment of safety and integrates the information into a behaviorally focused individualized service plan (ISP).

Time perspective is needed in comprehensive family assessment—what led to the current problems as well as the likely impact of both the maltreatment and the response on the child and family. The Family Risk and Functional Assessment seeks to understand history and its impact on future child safety. It involves recognizing patterns of parental behavior over time that have contributed to children being unsafe.

Gathering valid and useful information is critical for appropriate and adequate intervention with children, youth, and families who enter the child welfare system.

**If a Family Risk and Functional Assessment is not undertaken as part of developing the ISP, we often miss the opportunity to develop interventions that contribute to lasting behavior change.**

A good functional assessment completed early in the process of serving a family, increases the likelihood of that the services utilized will be targeted on addressing the real issues of the family contributing to children being unsafe.

**Completing the Risk and Family Functional Assessment**

Once a decision has been made to open a case for services, regardless of whether the child is placed outside the home, a Risk and Family Functional Assessment is undertaken as part of the development of a useful individualized service plan. *If the child welfare agency is responsible for serving the family, a functional assessment is completed.*

Additionally, over the course of a family’s involvement with OKDHS circumstances often change. These changes result from the various factors impacting the life of the child, youth, and the family as well as the effectiveness of the services provided through the service plan. Furthermore, additional information may become known to the agency and affect the plan for service delivery. As such, the Risk and Family Functional Assessment are completed at the outset of the service planning process, but also updated periodically throughout the child, youth’s and family’s involvement with the agency.
Completing the OKDHS Risk and Family Functional Assessment must include:

**Family Involvement.** An effective comprehensive family assessment must be completed in partnership with families. Family involvement in assessment fosters engagement by enhancing communication between the agency and the family about how the family got to this point, what has to change, what services are needed, the expectations for who will do what by when, the time frames, and what alternative resources might exist within the extended family and social network to address the safety, permanence, and well-being of the child or youth.

**Assessment of All Caregivers and All Children.** All children and youth in the family are assessed. Parents—both mothers and fathers—custodial or non-custodial are assessed and any other in-home caregivers or those frequently in the home caring for children are assessed.

**Individualization.** Although some of the same factors may be present among families who enter the child welfare system (for example, substance abuse, mental illness, poverty), each family is unique in how these factors affect their ability to safely care for their children and protect their individual members. Workers need to be careful not to have a pre-conceived idea of the needs of individual families and look for information to confirm these ideas. All the available information should be considered to see how it fits together to describe each family.

This individualization carries through to service planning and delivery—each family as a unit (and their individual members) should receive services that address specific areas in need of change in the context of the protective factors and resources identified. Individualizing our response requires an agency commitment to distinguish between what the family needs to change behaviors or conditions that caused children to be unsafe and what the agency “generally” offers. We cannot simply give families what we have rather than what they need. It requires the child welfare agency to work with its community stakeholders to ensure that needed services are developed and made available in all the state’s jurisdictions.

**Strength Focused-Solution Focused Questions.** One of the most critical interviewing and engaging strategies during the functional assessment is how we ask questions. For example, instead of asking the birth parents about their “parenting skills” we might ask the following types of questions:

- Parenting is not something that you wake up and know how to do…it is hard for all of us. Do you ever get lost as a parent?
- On a scale of 1-10, where are you at in comparison with where would you like to be as a parent?
- When is a time when your child was very successful—what part did you play in that success?
- What is one special way that you show love to your children?
- Who taught you to be a parent? Who is your biggest influence as a parent?
From these questions, the strengths and the protective capacities of the parent often emerge. If for example, the birth parents can recall good memories of times they have had with their child, if they make clear verbal statements of their love for their child, or if they can laugh and find humor in areas where their children cause them frustration, these are indications of the strength of the parent-child relationship. If the parent made certain that the child ate regular meals, or required that the child check in on a frequent basis, these are examples of protective capacities of caregivers.

**Assessment of Protective Capacities.** Comprehensive family assessments identify individual and family strengths and protective factors. The continuous exploration of 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 the needs identified, mobilizing and or expanding the resources that the family can use to help meet their needs.

**Strengths** are those positive qualities or resources present in every family. **Protective Capacities** are personal and parenting behavioral, cognitive and emotional characteristics specifically and directly associated with being protective of one’s children.

It is important to note that 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. The protective factors often have to be deliberately mobilized to play a relevant role within 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 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. When worker’s can identify protective capacities of caregivers, these can be integrated into the safety planning process. The chart below depicts the difference between a parental strength and a protective capacity—demonstrating how a protective capacity serves to protect children.

<table>
<thead>
<tr>
<th>STRENGTH</th>
<th>PROTECTIVE CAPACITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother says “I love my child”</td>
<td>Mother can identify relatives who can help her when she is stressed, is willing to call these relatives and has examples of how these relatives have helped her keep the children safe in the past.</td>
</tr>
<tr>
<td>Mother says “I want the children to have a better life than I had”</td>
<td>Mother knows the resources in the community to help her children get food and clothing when the money is tight and can talk specifically about how she has used those resources in the past to get through a tough financial period.</td>
</tr>
</tbody>
</table>
Father reads to the children at night and plays with them.

Parents like to play games with their children and have fun laughing with them.

Father brings children to his parents when Mother has been drinking—has done this in the past and his parents have kept the children safe.

Parents understand that their severe arguing presents a risk to the child and father is willing to leave when things start getting nasty. Father is able to describe specific times when he has done this in the past with success.

**Specialized Assessments When Indicated.** As information is being gathered in the process of family functional assessment, it may be useful to go beyond the assessment capabilities of the child welfare worker for specialized assessments.

These specialized assessments could be for developmental issues that seem to be impacting the child, mental health evaluations of the child, youth, and/or parents, evaluations related to the use of drugs, evaluations of the cognitive abilities of children and youth that are impacting their education, or possibly specialized evaluations of various handicapping conditions that impact parenting that could make parents eligible for support. Additionally, CAPTA requires developmental assessments/developmental screening for children under three years of age.

When the worker recognizes the need for specialized assessments, s/he should focus the attention of the specialist on the specific areas of concern and have some sense of how the specialized assessment findings would impact child welfare decision-making. The recommendations arising out of these specialized assessments should be incorporated into the individualized service plan.

**Clinical Consultation and Teaming Within and Across Internal Programs and Services**

We see today, more than any other point in our history of serving children and families the need to team within and across programs. Research teaches us that children needing child protection increasingly come from families who have multiple needs and problems and that family complexity has demanded more comprehensive assessments and service planning on the part of professionals. In order to achieve the outcomes we desire for children and families OKDHS appreciates and emphasizes the need for interdisciplinary communication and collaboration.

Research supports the need to enhance teaming skills on behalf of families. “The different orientations, vocabularies, and working styles of professional staff can pose substantial barriers to effective teamwork if not explicitly addressed. For example, numerous studies suggest that neither child welfare nor substance abuse workers are exactly sure what the others have to offer, and they tend to be wary of one another. Wariness to team not only comes from lack of knowledge, but from differing philosophies around areas such as - who the client is (parent versus child), harm reduction versus the need for total abstinence, and timelines regarding treatment interventions.”

18 Young, Gardner and Dennis. Teaming As a Way to Support Families. (1998)
Within the OKDHS Practice Model workers actively seek to learn what other programs within DHS and within the community have to offer and how we can partner effectively to serve children and families.

**Linking the Information From the Assessment of Safety and the Family Risk and Functional Assessment to the Behaviorally Based ISP**

Effective service planning is a natural byproduct of a comprehensive assessment. When families have been active parts of an assessment process that identifies how the family functions that impacts child safety, family strengths and protective capacities it is much easier to put that information to use in creating a service plan that really addresses what the family needs to safely care for their children. The least effective strategy in service planning is for the worker to develop a plan in the office and bring this plan to the families. This process communicates to the family that the worker “knows best” about what they need and minimizes the birth family’s control over their own destiny. It also negates the opportunity for the team members to actively participate in the planning. As in the process of assessment, service planning and service plan review are opportunities to build relationship and should not be short circuited.

Collecting and organizing comprehensive assessment information is not an end in itself; it must be used in focused ways in the service plan. The worker should ensure that the family members have an accurate understanding of why their situation was reported to child welfare and the specific behaviors or conditions have to change for their children to be safe. Family members should be intricately involved in the process of moving from assessment to the development of the service plan. They 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. This process should be transparent – the worker should share the tools and information being used to build the service plan. The child welfare caseworker is in an excellent position to coordinate and involve other service providers, specialized resources, and the family’s resources toward changing behaviors or conditions that caused children to be unsafe or at risk of future harm.

Who Receives a Copy of the ISP?
While in the past there may have been some confusion about who should receive a copy of the ISP, the OKDHS Practice Standards and Practice Model are very clear. All members of the team, including the Bridge Resource Family, if the child is in care, should receive a copy of the ISP.

This process of going from information to judgments is critical. There is no ready “prescription” for how these judgments are made; we must train staff to make these essential judgments.

"If we really understood and believed the concept of team, all of these questions about what the resource family should and should not know would be a moot point. I am a part of the team, my work with the team depends on my understanding of the issues the child and family are facing. The very nature of “team” implies that while I understand my specific contribution, I also understand the overarching goals as well as the challenges and barriers to achieving those goals. I am able to offer my perspective on how to overcome the barriers to success."

OKDHS
Bridge Resource Family

The visual below depicts the linkage between the learning of the safety and risk assessment, the functional assessment and the interventions within the Individualized Service Plan.

Supporting Documents:

New Risk and Functional Assessment and Individualized Service Plan
Background of Concurrent Planning Under ASFA

It is widely acknowledged that all children require security, love, acceptance, connectedness, a moral/spiritual framework and lifetime intimate relationships for their healthy growth and development. They also need stable families and supportive communities, especially in the early years of life, in order to form secure attachments so vital to positive self-esteem, meaningful relationships, positive school achievement and success in the adult world of family and work. Sadly, child welfare systems across the country have had an uneven history of meeting children’s developmental needs for stability and continuity in their family relationships.

In response to this reality, in November, 1997 Congress passed and President Clinton signed into law the Adoption and Safe Families Act (ASFA). This law radically changed the child welfare environment, requiring states to act within tighter timeframes to establish and achieve permanent placements for children in care.

The themes found in ASFA include:

- Safety as paramount throughout the life of a case.
- Foster care as a temporary service requiring timely decisions about permanency for children.
- Services are needed to support birth, foster and adoptive families.
- Accountability by moving from a focus on process to outcomes.
- Innovation to achieve more timely and positive 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.
- Children are safely adopted by relatives or other community families.
- Children are safely placed with legal guardians - relatives or other families.
Children are placed in alternative planned living arrangements.

In order to achieve these permanency outcomes, ASFA encourages the use of Concurrent Planning, and it requires that states make reasonable efforts to find permanency for children who can not return to their biological parents. It mandates states to concurrently identify, recruit, process and approve a qualified adoptive family for a child when it files or joins a petition to terminate parental rights to that child.

Thus, this legislation moved the concept and practice of concurrent planning to the forefront of child welfare practice, setting the stage for states to implement these strategies as one component of child welfare “best practice.”

About Concurrent Planning
Concurrent Planning as designed by Katz, et al supports intensifying and expediting efforts to achieve permanence for a child in a timeframe that reflects a child’s sense of the passage of time. It offers caseworkers a structured approach to moving children more quickly from the uncertainty of foster care to the stability and security of a permanent family. It is consistent with a family-centered and community-based service orientation because it is rooted in the belief that children need stable families and supportive communities for their healthy growth and development. The goals of Concurrent Planning include:

- Striving to provide children with stable, safe and permanent families in which to grow up.
- Ensuring family and community-centered practice in least restrictive placement settings.
- Ensuring culturally responsive practice.
- Facilitating an open and inclusive case planning process.
- Providing goal-focused and time-limited services.
- Conducting frequent and regular case reviews of children's status and family progress toward reaching safety, permanency and well-being goals.
- Encouraging frequent parent-child visits to increase likelihood of early reunification.

Concurrent Planning holds promise for expediting timely decision-making for children because of its dual focus on family reunification, as well as planning for alternative permanency options. Effective use of Concurrent Planning includes the respectful involvement of parents and family members early in the planning process, as well as identification of "red flags" that might serve as barriers to timely reunification or another permanency outcome.

**Effective implementation of concurrent planning requires that all components of the OKDHS Practice Model be implemented as highlighted below:**

- Frequent visitation with birth parents as long as children's safety can be assured. This is an integral aspect of the BRIDGE component of the Practice Model.

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• Full disclosure of information to birth families early in the planning process regarding the importance of their regular involvement in planning for the return of the child, their rights and responsibilities, and the legal consequences if they are unable to safely make the changes necessary for their child's return. **This is also part of BRIDGE and fully reflects our Practice Standard “Nothing About Me Without Me.”**

• Aggressive search for absent fathers, non-custodial parents, and relatives occurs initially and throughout the placement process. **This begins in the Standardized Intake and Screening process.**

• Immediate attention to all Indian Child Welfare Act requirements when applicable.

• Assessment of Child Safety and Safety Planning as represented in the **Child Safety Assessment.**

• Assessment of how the family functions in the following areas: kinship and community supports, medical needs, mental health issues, substance use, family violence, parenting skills, parent’s history of abuse and neglect, housing, food and basic needs that may be contributing to children being unsafe or at risk. **This is included in the Family Risk and Functional Assessment.**

• Provision of focused, intensive services to the birth family to assist in making the behavioral changes identified. **This is represented in the ISP.**

• Ongoing assessment of family success in achieving behavioral changes that may result in an initiation of Concurrent Planning. **This is part of the Ongoing Assessment component of the Practice Model.**

• Appropriate use of family meetings, targeted case review and mediation services to support early involvement of families in case planning and decision making. **Family Meetings are a critical component of the Practice Model.**

• Use of options counseling' when reunification seems unlikely, to carefully counsel parents about relinquishment options and any possibilities of open or cooperative adoption arrangements. **This is part of the BRIDGE component of the Practice Model.**

Concurrent Planning safeguards childhood attachments by safely building a stronger bond between the child and birth parent through reunification, or by preserving the tie between the child and the permanency planning parents through adoption. Concurrent Planning also supports finding alternate options to permanency such as relative care. Concurrent Planning brings families, child welfare agencies and the courts together to focus on child development and attachment, integrating into our practice what we know about children's urgent needs.

Concurrent Planning encourages the adults who care about the child to become collaborators rather than adversaries, to take the risk as opposed to the child bearing the risk, as they care for and plan where the child will grow up.

(Katz, L., Spoonemore, N. and Robinson, C. Lutheran Social Services. 1994)

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**Poor Prognosis Indicators**
Implementing Concurrent Planning in Oklahoma means that workers must understand and continually assess Poor Prognosis Indicators for reunification. *(See Concurrent Planning Tool Addendum E for a complete list of Poor Prognosis Indicators).*

*Concurrent Planning can be initiated at the following junctures in the case flow process:*

- During the initial safety assessment phase when it is determined that one or more poor prognosis indicators exist for reunification.
- During the functional assessment phase, 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 progress and there is an assessment that one or more of poor prognosis indicator 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. It is not sufficient to simply identify that the concurrent plan is either legal guardianship or adoption. The plan must specify the steps the worker and other members of the team will make to identify the permanent caregiver, engage the permanent caregiver, assess the caregiver’s willingness and ability and involve the individual in the Bridge program to prepare for legal guardianship or adoption.

**Supporting Documentation**
- Concurrent Planning Tool (Addendum E)
Once the initial service plan is complete and service delivery is in process, the resource family is in the position to support the birth family in carrying out the plan, and in evaluating its efficacy. The service plan is only the team’s best hypothesis about the supports needed to help the child and family live together safely. Once developed it needs to be tested for its efficacy in changing the behavior of parents identified in the safety assessment that caused children to be unsafe.

The Adoption and Safe Families Act of 1997 (ASFA) provided very tight timeframes for achieving permanency for children. Time cannot be lost providing services that have little to no chance of addressing the concerns in the family. If after the service plan is enacted, and services are put in place, and after a few weeks it is clear that certain components of the plan are not working, a meeting should be called and the plan should be evaluated to determine if it needs to be modified to better meet the needs of the family.

This model of an ongoing assessment requires that team members take an active role in determining the efficacy of plan and bringing any issues to the team for problem resolution. Progress reviews are based in part on talking with and observing the family, talking with other key case participants (extended family, providers), and review of progress reports from service providers. There are several strategies that can facilitate discussion about progress include using scaling questions (for example, comparing levels of concern from one time to another), timelines, “temperature” gauge charts (measuring progress to a goal), and other behaviorally oriented graphics.  

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Rationale for Ongoing Assessment

In a safety intervention system, case planning is focused on change that reduces safety threats and increases parental protective capacities so that parents can resume the protective function for the family. Therefore, these two areas form the core of case planning. All case plans must be related to change in these areas, and there must be a rational relationship between them and the goals, tasks, interventions and services that comprise the case plan. Intervention is not the “friendly visitor” approach, or the “catch them doing bad” approach but is precisely focused on assisting parents/caregivers identify, understand and change issues related to safety threats and protective capacities. The approach is one of mutuality and shared discovery for both parent(s)/caregiver(s) and the worker. Case plans are focused, time limited, behaviorally specific, attainable, relevant, and understandable to all and agreed to by the parent(s). Agreement is defined by the parent(s)’ true understanding of the areas for change, a demonstrated readiness for change, an understanding of the behavioral change needed and how the interventions will help accomplish this change. Case plans provide the basis for understanding when the work is completed so that CPS involvement is no longer required. Conversely, they provide the basis for deciding that sufficient change has not occurred so that permanency goals may be justified and pursued.

The reason to continually evaluate the efficacy of the plan is that family service/intervention needs change as families make progress or face setbacks.

For example, it may be that the intervention required to help the parent change behaviors that caused their children to be unsafe was be some form of intensive mental health intervention to stabilize Mom’s day to day life and her use of medications. If successful in this first phase of intervention, Mom may no longer need intensive treatment but instead need less intensive out-patient follow-up. If some form of “relapse” occurs, they may need treatment that is more intensive.

Sometimes new information provides new insight into existing needs. For example, a parent may reveal a history of child trauma or show signs of depression related to this, thus indicating a need to cope with the effects of these experiences. There are also times when family circumstances change, such as a parent moving back into the home or a grandparent moving out, etc. There may be times when we thought that parenting classes would benefit, for example very young parents. We did not know that the parents do not learn well in a group setting, learned this in the first weeks of the parenting classes. Upon this learning, the ISP should be changed to have the teaching occur instead in the birth family’s home, with the Bridge resource family (for example) serving as the teacher. There are also times when parents have been successful in achieving some of their behavior changes required to keep their children safe. Dad might have changed jobs so that the children are not left alone at night, or Mom might have demonstrated her ability to parent without the use of physical force. When these changes occur the ISP should be modified to reflect the progress. The diagram below provides a visual of effective service planning and ongoing assessment of service efficacy and family progress in changing behaviors or conditions that caused children to be unsafe.
Assessment
Service Planning
Service Delivery
Assessment of Progress/Need
ISP Modification
ISP reflects a mix and match of services that are tailored to meet the actual needs of the family. The Plan should not be “cookie cutter” but individualized to the child and family.

Data compilation

Whenever possible, the Family Team Meeting forum that was used to create the ISP is the same forum that should be used initially to assess progress and potential modifications to the plan. However, all contacts with family members and service providers provide opportunities to gather information about a family’s progress and needs. These activities should not be left only to formal meetings; sometimes meaningful information is more readily shared at less-formal times and when it seems most relevant.

Supporting Documentation

Case Plan Review Tool that is part of the Risk and Family Functional Assessment
To some in the child welfare arena, the term permanency has become synonymous with adoption or legal guardianship. Yet it is very important that child welfare social workers understand that permanence in the life of a child can take on several forms including remaining with their family at home, returning the child back to the birth family, adoption or legal guardianship and if all other plans are ruled out, another planned permanent living arrangement (APPLA) such as living in an apartment with supports.

Making decisions regarding child permanency is by far one of the most challenging of the child welfare system. Short and long term safety concerns, abandonment and loss issues, and long term supports that will be required all must be evaluated and decisions reached that result in the best interest of the child.

**Reunification**

All agree that it is tremendously rewarding when efforts at reunification are successful. When the reunification efforts were supported by resource families, birth parents and resource families are quick to discuss how the support offered by resource families carries over to when the child is returned home. This serves to strengthen the parental caregiving as well as to ensure that the child is able to maintain connections with the resource family if they so choose. Many birth parents who have successfully reunited with their children credit resource families who were available to help with problems, give advice or simply be there as a shoulder to lean on.

Ongoing contact between the resource family and the birth family also ensures that the child does not experience another loss. Children placed in out-of-home care experience many emotions including loss, fear and abandonment. Each time a child moves these feelings resurface. If a child can return to the birth family, but maintain their relationship with the resource family, it will ease the strain of transition for the child.
Adoption
Of course there will also be times when none of the efforts to reunify the child with his/her birth family are effective and the permanency goal must shift from reunification to adoption. This is a moment in the process where the relationship between the resource family and the birth family may reap tremendous benefits for the child. If the resource family and the birth family have developed a strong partnership, it is possible that the birth parent may consider voluntary relinquishment if the resource family agrees to be the adoptive parent or legal guardian for the child. Several resource families who have developed strong relationships with birth families told stories of parents being willing to allow their children to be adopted “as long as it is to you.”

One birth Mom whose first child was adopted by the child’s foster parent told this story:

“I tried as hard as I could to get it right...but I was just too hooked on drugs and involved in bad relationships to be a good Mom to my kids. Jenny [the foster Mom] knew that. But she didn’t shove it down my throat, she just let me come to it on my own. When I was visiting my kids one day I just broke down and started to cry. I loved my kids but knew that they would be screwed up if they came back home...heck I didn’t even really have a steady place to live.

I looked at her and said...would you take them? I knew that if she took care of my kids that I could see them every once in awhile...I knew this because I felt like Jenny didn’t just love my kids, she loved me too. Jenny adopted my girls. But they know who I am, and I visit them. Jenny makes sure that I have pictures and am invited to holidays and birthday parties. The kids know who I am, and I think they still love me too.”

Even if voluntary relinquishment does not occur, at least the Bridge Resource family, the birth family and agency staff can honestly discuss ways in which the child can stay connected to his/her birth parents after the Termination of Parental Rights (TPR) occurs and the child is adopted by the resource family. When Bridge Resource Families and birth families have worked together and created a bond that is based on their mutual love for the child, it changes the dynamic of the termination of parental rights process. The Bridge Resource Family understands that while the TPR is a legal determination that needs to occur so that the child can live with a permanent family, it does not sever the emotional bond between parent and child. Termination of parental rights is a legal distinction, not an emotional one. Bridge Resource Families who have adopted children after developing close relationships with their parents are emphatic about the long term benefit of maintaining the child’s connections with his/her birth family.

Planned Alternative Permanency Options
Because there are times when the birth family is unable to care for the child safely on a full time basis and the resource family is unable to adopt the child, planned alternative permanency options must be identified. It is always best if these options are considered early in the process—so that birth families and resource families can be engaged in the process of identifying individuals who might be interested in adopting the child.

Too many children languish in foster care with no permanent and legal connections to adults who care about them. All too often the child welfare system settles for the permanency plan of
Planned Alternative Permanency Options when other options could have been available if we searched hard enough—and engaged the child’s kin, resource family, teachers, friends and neighbors in the process. Planned Alternative Permanency Options should only be considered in cases where OKDHS has documented to the court a compelling reason for determining that it would not be in the best interests of the child to return home, be referred for termination of parental rights, or be placed for adoption, with a fit and willing relative, or with a legal guardian. It is important for every member of the system to understand that there are only a few compelling reasons cited under the Adoption and Safe Families Act for allowing a child’s permanency plan to be a Planned Alternative Permanency Option:  

- An older teen who specifically requests that emancipation be established as his/her permanency plan;
  - NOTE: There are some units who ask children to specifically describe why they do not want to be adopted in writing...to their worker...this allows the worker to have a conversation with the child.
- The case of a parent and child who have a significant bond but the parent is unable to care for the child because of an emotional or physical disability and the child’s foster parents have committed to raising him/her to the age of majority and to facilitate visitation with the disabled parent; or
- The Tribe has identified another planned permanent living arrangement for the child.

Because a Planned Alternative Permanency Option may end up being a catchall for those children for whom adoption or legal guardianship did not work, it is important to consider some of the key aspects of this type of permanency plan.

**First the arrangement is intended, designed, considered, premeditated, or deliberate.**

“Permanent” means enduring, lasting, or stable; an environment that is by design temporary such as a group care environment is not intended to be permanent and is not an acceptable permanent option for a child.

A Planned Alternative Permanent Placement has by definition the following characteristics:

- **Permanent physical placement of the child**
- **Quality of care**
- **Supervision and adult support of the youth**
- **Nurture and teaching.**

**Permanency Pacts**

FosterClub.org\(^23\) is an organization that was developed for children in care or aging out of care by children in care or aging out of care. One of their most powerful suggestions is the development of Permanency Pacts for children leaving care without a permanent, legal family.

*What’s a Permanency Pact?* A pledge by a supportive adult to provide specific supports to a young person in foster care with a goal of establishing a lifelong, kin-like relationship.

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\(^{22}\) This information can be found on the NRFCPPP Website www.nrfcppp.org  
\(^{23}\) Fosterclub.org
Youth transitioning from foster care are often unsure about who they can count on for ongoing support. Many of their significant relationships with adults have been based on professional connections which will terminate once the transition from care is completed. It is critical to the youth's success to identify those adults who will continue to provide various supports through and beyond the transition from care. Clarifying exactly what the various supports will include can help to avoid gaps in the youth's safety net and misunderstandings between the youth and the supportive adult.

**A Permanency Pact Creates:**

- A formalized, facilitated process to connect youth in foster care with a supportive adult.
- The process of bringing the supportive adult together with youth and developing a pledge or “Permanency Pact” has proven successful in clarifying the relationship and identifying mutual expectations.
- A committed, caring adult may provide a lifeline for a youth, particularly those who are preparing to transition out of foster care to life on their own.

In addition to the two primary parties in a Permanency Pact (the youth and the supportive adult), it is recommended that a Facilitator assist in developing the Pact.

The *Facilitator* may be a Case Worker, Independent Living Provider or other adult who:
- is knowledgeable in facilitating Permanency Pacts*
- is familiar with the youth, and
- can provide insight into the general needs of the youth transitioning from care

The *Supportive Adult* is an adult who:
- has been identified by the youth
- has a relationship with the youth
- is willing to commit to a life-long relationship with the youth
- is a positive role-model and
- is able to provide the youth with specific support on an on-going basis

The first step is to engage the youth to identify the supports they want or need as they prepare for the transition out of foster care into adulthood. Together with the youth, the Facilitator can then begin to develop a list of adults who may be able to provide some of those supports. This list may include current relationships or adults with whom the youth has had a previous connection to which they wish to reestablish.

The Facilitator then:
- obtains necessary releases of information
- makes initial contact with the identified adult(s)
- updates them regarding the youth’s current situation
- gauges their level of interest
- assists the adult in identifying possible supports they will provide, and
- schedules and facilitates the Permanency Pact meeting
The discussion involves identifying the kinds of supports adults are willing to provide to the youth leaving care. The youth and Supportive Adult sign the Pact and the Facilitator provides a witness signature. Copies of the Permanency Pact are provided to the youth, the Supportive Adult and maintained in the case record as part of the youth's Transition Plan. All other members of the youth's Transition Team, including foster parents, CASA, judge, etc. should also receive copies of the Permanency Pact.

Taking a step toward trusting a relationship is often a very great accomplishment for a youth with a background where relationships are broken, promises are often not kept, and disappointment in caretakers prevails. The gift that a Supportive Adult contributes by making a life-long commitment to the relationship is heroic. The impact of the forged relationship may be profound to all parties. To symbolize the importance of the commitment, it is recommended that a Permanency Pact be held in conjunction with some sort of ceremony or celebration.

### Some examples of Permanency Pacts include:

<table>
<thead>
<tr>
<th>Place to do laundry</th>
<th>Use of Phone or Computer</th>
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<tbody>
<tr>
<td>Emergency Place to Stay</td>
<td>Help when moving into an apartment</td>
</tr>
<tr>
<td>Food/Occasional Meals</td>
<td>Cooking lessons</td>
</tr>
<tr>
<td>Care Packages at College</td>
<td>Help with reading complex documents</td>
</tr>
<tr>
<td>Job Search Assistance</td>
<td>Regular Check in</td>
</tr>
<tr>
<td>Career Counseling</td>
<td>Assistance with Management of bills/money management</td>
</tr>
<tr>
<td>Support with the housing hunt</td>
<td>Mechanical Assistance (house., car)</td>
</tr>
<tr>
<td>Recreational Activities</td>
<td>Help with housekeeping or home decorating</td>
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<tr>
<td>Transportation</td>
<td>Help with Voting</td>
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<tr>
<td>Mentor</td>
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<tr>
<td>Educational Assistance/Advocacy</td>
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<tr>
<td>Storage</td>
<td></td>
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<tr>
<td>Clothing</td>
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<tr>
<td>Help with Legal Troubles</td>
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**Supporting Documentation**

- Permanency Pact Certificate
- Permanency Pact Guide
Addendum A

STATE OF OKLAHOMA DHS
CHILD WELFARE PRACTICE STANDARDS

1. We Continually Examine our Use (Misuse) of Power, Use of Self and Personal Biases
   ✈️ We must be aware of and recognize how we use the power of the position.
   ✈️ Our use of team supports the process of examining personal biases and use of self.
   ✈️ We believe in the importance of hearing all voices—whether we disagree or not.
   ✈️ We continually assess our personal biases and styles, ensuring that they do not interfere with our ability to partner with families; at the same time we will regularly enter into discussions/mentoring with our supervisor (at all levels) about personal biases and the way they are impacting our work.
   ✈️ We allow ourselves to imagine and feel the experiences of families, using our brains and our heart in our work to assist families in accomplishing their goals.
   ✈️ It is critical that families see and believe that we are genuine and that we care.

2. We Respect and Honor The Families We Serve
   ✈️ We separate what parents have done from who they are.
   ✈️ We address the issues instead of judging.
   ✈️ We behave as if we are a guest in the family’s home—a guest with a purpose.
   ✈️ We learn about their life demands and value their time.
   ✈️ We are humble understanding that “any given day” it could be us.
   ✈️ We hold a belief that people can change—with the right tools and resources.

3. We Listen to the Voice of Children
   ✈️ We have frequent and meaningful conversations with children about what they need to feel safe, using language and making decisions that respects their love for their family and their need for connection to their culture.
   ✈️ We ensure that children have accurate information and understand what is happening in their lives.
   ✈️ We actively find ways for children to contribute and have an influence and a sense of control on the decisions made about their lives; being honest about their options and choices.
   ✈️ We frequently engage children in conversations about how to improve our system.
4. **We Actively and Continuously Seek to Learn Who Families Are and What They Need**

- We do not make assumptions about families. They are the expert of their own lives and often have solutions to their own problems. We create an environment where families can teach us about who they are and what they need.
- We communicate with families in their primary language in order to understand their experiences, their culture and how they make parenting decisions.
- We are students of the culture, race and ethnicity of the families we serve—and we actively use this information as we join with families in planning and decision making.
- We have an attitude that we can make a difference—there are the informal supports and resources if we look hard enough and partner effectively with the family and community.

5. **We Believe in the Value of “Nothing About Us Without Us”**

- When we interact with family, we engage in a conversation that builds relationship, we ask strength-focused questions, we listen and the learning allows us to develop effective service plans.
- The family, the worker and community partners develop common goals—that acknowledges the families perspectives and the child’s need for safety, permanency and well being of children.
- We are transparent with one another to ensure clarity regarding what we are thinking, our concerns and why we are focusing on certain areas of safety and permanency.
- We actively find ways for families to contribute and have control over their own lives.
- We actively engage BRIDGE families in the process of teaming, information sharing and decision making.

6. **We Maintain A Childs’ Permanent Connection to their Kin, Culture and Community**

- Young adults need to be informed about their choices, they need to understand what happens to them, and they need to consistently maintain contact with their worker.
- Visitation between a child and their family is a child’s right.
- Families belong together and we maintain optimal connection between a child, their family and their culture.
- We seek to place siblings together; and if we cannot we create frequent opportunities for them to see one another.
- As we make decisions about placement, we consider all of the implications for the child…understanding that every time when we remove a child, there is emotional harm.

7. **We Conduct Our Work With Integrity At All Levels Of The Agency**
There is a standard of excellence and cooperation that permeates the work of the agency.

We are compassionate with one another and we have the difficult conversations about the pain and complexity of this work.

We formally provide support, an opportunity for debriefing and stress relief for our workers and supervisors so that they can continue to do the work well.

We communicate honestly and we do what we say we are going to do.

We actively educate other systems about the needs of children and families and about best practices in child welfare.

We hold one another accountable to being respectful and courteous, valuing and supporting each other—letting go of territorial issues and working together to accomplish our collective goals.
Addendum B

State of Oklahoma
Department of Human Services

CPS Intake
Prompter Questions When Interviewing a Reporter

The prompter questions below are designed to assist the CPS Intake social worker in obtaining careful, detailed, and thorough information from the reporter, which lays the foundation for making well-informed screening decisions. These questions are grouped into categories. The first six categories [What, When, Where, How, Caregiver Strengths/Protective Capacity, and Additional Information] contain general questions that correlate with the current KIDS Referral Screens and should be asked of every reporter. Categories seven through twenty contain additional questions that are intended as a guide specific to the type of child abuse or neglect alleged by the reporter.

<table>
<thead>
<tr>
<th>Area of Exploration</th>
<th>Content Discussion/Possible Questions to Ask</th>
</tr>
</thead>
</table>
| 1. What             | What are the details of abuse/neglect of the child(ren)?  
  Rephrase: Please explain what makes you believe the child(ren) are abused or neglected?  
  - What happened to the child(ren), in simple terms?  
  - Did you see physical evidence of the abuse or neglect? If yes, please describe.  
  - What did the parent/child(ren) say about how this happened?  
  - How does this affect the child(ren)?  
  - Is there anything that makes you believe the child(ren) is in danger right now?  
  Does the child(ren) have injuries, now? If so, please describe injuries?  
  Rephrase: Does the child(ren) have any injuries? If so, please describe.  
  - Is the child(ren) in need of immediate attention?  
  - Has the child(ren) already received medical treatment for the injuries? |
| 2. When             | When was the child(ren) last seen and by whom?  
  Rephrase: When is the last time you saw the child(ren)? Were they in good condition?  
  - When did the incident occur? |
<table>
<thead>
<tr>
<th>Area of Exploration</th>
<th>Content Discussion/Possible Questions to Ask</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Is this an ongoing pattern with the family?</td>
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<tr>
<td></td>
<td><strong>Who else was told or knows of this situation?</strong></td>
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<tr>
<td></td>
<td>• Have these people witnessed the CA/N or incident?</td>
</tr>
</tbody>
</table>

3. **Why**

<table>
<thead>
<tr>
<th>Why are you calling today?</th>
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<tbody>
<tr>
<td><em>Rephrase: Has anything happened recently that prompted you to call today?</em></td>
</tr>
<tr>
<td>• What do you think or hope that OKDHS can do for the family?</td>
</tr>
<tr>
<td>• Is there anything you can do to help the family?</td>
</tr>
</tbody>
</table>

4. **How**

| How did you learn about the incident or situation? |
| • How long has this been going on? |

5. **Caregiver Strengths/Protective Capacity**

| Are there people or placed the family turns to for help or support? |
| • What positive interaction have you seen between the parents and child(ren)? |
| • Can you tell me something good about the family? |
| • Do the parents seem willing or able to keep their child(ren) safe? |
| • What strengths do you think the parents have? |
| • What efforts have the parents made to correct this problem? |
| • What good things do the parents do for the child(ren)? |

6. **Additional Information**

<table>
<thead>
<tr>
<th>Safety Factors</th>
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</thead>
<tbody>
<tr>
<td><em>What are the risk factors in the home, such domestic violence, safety hazards, and physically or mentally disabled victim?</em></td>
</tr>
<tr>
<td><em>Rephrase: Are you aware of any safety problems with a social worker going to the home?</em></td>
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<tr>
<td>• To your knowledge, are there guns or other weapons in the home?</td>
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<tr>
<td>• Is anyone in the home likely to be violent or dangerous?</td>
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<tr>
<td>• Are there large dogs or guard dogs in or around the home?</td>
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<td>• Are there any gates, codes, fences, isolated locations that prevent entry to the residence?</td>
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<tr>
<th>Special Circumstances</th>
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<tbody>
<tr>
<td><em>Are there special circumstances, such as cultural or language barriers?</em></td>
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<tr>
<td>• Is English the primary language? If not, what is?</td>
</tr>
<tr>
<td>• Do the parents or child(ren) have any issues that would make it difficult for the social worker to communicate well with them? (Deafness, mental illness, limited mental capacity, etc.)</td>
</tr>
<tr>
<td>• Is there something important about the family’s culture we need</td>
</tr>
<tr>
<td>Area of Exploration</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
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<tr>
<td>7. Physical Abuse/Inappropriate Discipline</td>
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<td>8. Sexual Abuse/Exploitation/Inappropriate Sexual Acting Out</td>
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<tr>
<td>9. Mental Injury/Emotional Abuse/Suicidal Child(ren)</td>
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<tr>
<td>Area of Exploration</td>
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<td>---------------------</td>
</tr>
<tr>
<td><strong>10. Domestic Violence</strong></td>
</tr>
</tbody>
</table>
  - Has anyone in the family been hurt? If so, who has been hurt? Describe the injuries specifically.  
  - Could you describe what “fighting” or “arguing” means?  
  - Could you explain what “dispute” or “domestic” means?  
  - Was the child(ren) present during the incident/violence?  
  - Was the child(ren) hurt during the incident?  
  - What was the child(ren) doing or where was the child(ren) during the incident?  
  - Are there any weapons in the home?  
  - How does the “yelling” affect the child(ren)?  
  - How does the violence affect the child(ren)?  
  - Who is caring for and protecting the child(ren) right now?  
  - What is the battered parent/caretaker’s ability to protect self and the child(ren)? |
| **11. Drug or Alcohol Abuse** |  
  - How does the parent’s drug or alcohol use affect the child(ren)?  
  - Are the child(ren) present during the drug or alcohol use?  
  - How does this affect the ability of the parent/caregiver to provide for the basic needs of the child(ren)?  
  - Are the drugs or alcohol kept within the reach of the child(ren)?  
  - How does this affect their ability to supervise the child(ren)?  
  - Do you have knowledge that there is selling or manufacturing in the home? |
| **12. Abandonment** |  
  - Did the parent arrange with someone else to care for the child(ren)?  
  - If so, are they willing and able to provide for the child(ren)?  
  - Does the caretaker know how to contact or the location of the parent?  
  - Can the child(ren) remain with the caretaker or is immediate intervention needed right now?  
  - Did the parent say when or if they would return for the child(ren)? |
| **13. Drug or Alcohol Exposed Newborn** |  
  - When is the newborn expected to be discharged?  
  - Are there any known siblings? If so, where are they located?  
  - Are there any concerns about the mother’s interaction with the newborn?  
  - Does the newborn have any medical or other special needs that require extra care?  
  - Are you aware of any other previous drug or alcohol exposed... |
<table>
<thead>
<tr>
<th>Area of Exploration</th>
<th>Content Discussion/Possible Questions to Ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>newborns delivered by this mother?</td>
<td>• What was the mother’s explanation for the positive drug or alcohol screen?</td>
</tr>
</tbody>
</table>
| **14. Lack of Supervision** | • Is the child(ren) alone right now?  
• Do you know where the parent’s are and/or how to locate them?  
• How much longer do you expect the child(ren) to be unsupervised before an adult arrives home?  
• Is the child(ren) capable of taking care of him/herself during the time left unsupervised?  
• Is the child(ren) responsible for caring for other younger child(ren)?  
• Does the child(ren) have access to a phone?  
• Is there anything about the home environment that raises the level of concern, i.e. pool, unsecured weapons, dangerous neighborhood, etc.?  
• Does the child(ren) have any physical, mental, emotional or psychological limitations that require constant supervision?  
• Do the child(ren) have access to another adult?  
• What times and how long are the child(ren) left unsupervised? |
| **15. Inadequate and Dangerous Shelter** | • Could you describe what “filthy or “dirty” means?  
• Does the child(ren) have access to the safety hazards you described?  
• What affect does the lack of utility have on the child(ren)?  
• What present safety concerns are in the environment?  
• When is the last time you were in the home?  
• What is it in the environment that makes it unsafe for the child(ren)? |
| **16. Medical/Dental Neglect** | • Is the child(ren) in need of immediate medical attention?  
• Does the child(ren) require ongoing medical supervision, medication, or treatment?  
• How are these concerns affecting the child(ren)?  
• Is the parent aware of issue, understand the child(ren)’s condition, or the need for treatment?  
• Has the parent tried to get medical care for the child(ren)?  
• What will happen to the child(ren) if they not receive this medical care, medication, intervention, etc?  
• Does the parent have a mental or physical limitation prohibiting them from seeking treatment for the child(ren)? |
<table>
<thead>
<tr>
<th>Area of Exploration</th>
<th>Content Discussion/Possible Questions to Ask</th>
</tr>
</thead>
</table>
| 17. Inadequate Physical Care | - Is the lack of hygiene affecting the child(ren)’s health?  
- Is the child(ren) made fun of because of lack of hygiene?  
- Are the untreated head lice resulting in extended absence from school?  
- Are the untreated or reoccurring head lice resulting in scabs, sores, or infections?  
- Have any resources been provided to the family?  
- What steps have the family taken to address these issues?  
- How is the delay in changing the baby’s diapers affecting the baby? (severe diaper rash, infection, etc) |
| 18. Inadequate Clothing | - Is the child(ren) exposed to elements that would endanger his/her health?  
- Is the child(ren) repeatedly ill due to exposure?  
- Does the child(ren)’s clothing generally match the weather conditions?  
- What effect does the lack of clothing have on the child(ren)? |
| 19. Educational Neglect | - What reasons has the parent given for the child(ren) missing school?  
- How many consecutive days has the child(ren) missed?  
- Does the child(ren) want to go to school and the parent will not assist?  
- Are the child(ren)’s absences due to illness?  
- What steps have been taken to engage the parent to address the problem?  
- Has the parent been referred to truancy court?  
- What impact will this have on the child(ren)’s academic success? |
| 20. Inadequate Nutrition | - What makes you think the child(ren) is not getting enough food?  
- Is there a medical reason why the child(ren) is failure to thrive or malnourished?  
- You said the child(ren) only eats junk food. Is the child(ren) fed every day?  
- Do you know how often and the last time the child(ren) ate?  
- Does the child(ren) attend a child(ren) care or school where they get food?  
- Does the child(ren) appear malnourished?  
- What food have you observed in the home? |
Addendum C

State of Oklahoma
Department of Human Services

ASSESSMENT OF CHILD SAFETY

<table>
<thead>
<tr>
<th>Family Name:</th>
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<thead>
<tr>
<th>Children</th>
<th>Referral #</th>
<th>Case #</th>
</tr>
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</table>

<table>
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<tr>
<th>Individuals Involved in the Assessment Process:</th>
</tr>
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</table>

I. DEFINITIONS

**Safe:** A child is in an environment without any safety threats or if there are immediate and/or impending threats of serious harm, a responsible adult in a caregiver role demonstrates sufficient capacity to protect the child.

**Unsafe:** A condition in which the threat of serious harm is present or imminent and the protective capacities of the family are not sufficient to protect the child. A child is considered unsafe if present danger or impending danger exists.

**Present Danger:** An immediate, significant and clearly observable family condition occurring in the present tense, already endangering or threatening to endanger a child (occurring now).

**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 (i.e., next several days), and is likely to have severe effects.

**Note:** *Children three years of age or younger and/or children with diminished mental or physical capacity should be considered more vulnerable.*
II. IMMEDIATE PROTECTIVE ACTION PLAN

Directions: When Present Danger was/is identified, document the following:

The Present Danger was/is __________________________________________________________

The immediate action to protect the child(ren) was/is ______________________________

III. SIX KEY QUESTIONS IN GATHERING INFORMATION

Directions: The space available following each question is expandable according to the need of the CW worker using this tool.

1. MALTREATMENT: What is the extent of the maltreatment?

Assess for all types of maltreatment. Describe all symptoms, events, circumstances and severity related to the current report of maltreatment, the location and condition of the reported child(ren) and if there is a pattern of maltreatment.

2. CIRCUMSTANCES: What surrounding circumstances accompany the maltreatment?

Include analysis of previous maltreatment and the major influences that led to the maltreatment occurring, e.g. depression, substance use, domestic violence, isolation, etc., history and duration, chronicity, parent explanation for events/injuries and responses to CPS.

3. CHILD FUNCTIONING: How does every child in the home function on a daily basis?

Include pervasive behaviors, feelings, intellect, physical capacity and temperament. Describe vulnerability, special needs, physical and emotional health, child developmental status, school performance, peer/social/sibling relationships, attachment with parent, mood and behavior, age appropriate functioning, response to CPS intervention, fearfulness, supports, sleeping arrangements, any sexual reactive or acting out behavior, and verbal and social skills.

4. PARENTING – DISCIPLINE: What are the disciplinary approaches used by the parent(s) and under what circumstances?

Describe types of discipline used, frequency, parent view of purpose of discipline, range of options parent knows and uses, emotional state of parent when disciplining, awareness of child’s perception of discipline methods, parental agreement on disciplines, is disciplined based on reasonable expectations for the child?

5. PARENTING – GENERAL: What are the overall, typical, pervasive parenting practices used by the parent(s)? (Do not include discipline)
Discuss overall parenting styles, perception of child, tolerance as parent, interaction patterns with child, ability to put child’s needs before own, ability to meet child’s basic and emotional needs, support/concern for child, awareness of child’s needs, ability to protect, parenting knowledge and skill, perception of child, etc.

6. **ADULT FUNCTIONING** for all caretaking members of the family: How does the adult(s) function with respect to daily life management and general adaptation? Describe overall pattern of adult’s approach to life, including overall mood, impulse control, coping styles, stress management, substance use, mental health issues, problem awareness, and problem solving skills, maturity, dependability, employment patterns, income, resource management, ability to meet own needs in healthy ways, relationship and social skills/supports, quality of family relationships.

**IV. IDENTIFYING SAFETY THREATS**

Directions: Through analysis of the above information, assess the presence or absence of the following safety factors.

1. Child is fearful of Person(s) Responsible for the Child (PRFC(s)), other family or household members or other persons having access to the home.

   Some examples of this may include the following:
   - Child cries, cowers, cringes, trembles, or otherwise exhibits fear in the presence of certain individuals or verbalizes such fear.
   - Child exhibits severe anxiety (i.e. nightmares, insomnia related to situation(s) associated with a person(s) in the home.
   - Child has reasonable fears of retribution or retaliation from PRFC.
   - Other: _______________________________________

   □ Yes    □ No

   Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:

   ______________________________________________________

2. PRFC(s) has not, will not, or cannot provide supervision necessary to protect

   Some examples of this may include the following:
   - PRFC does not attend to the child to such an extent that the need for care goes unnoticed or unmet (i.e. although PRFC is present, child wanders outdoors alone, plays with dangerous objects, plays on unprotected window ledge, has unsupervised access to uncovered pools, etc. or is exposed to other serious hazards).
• PRFC leaves child alone (time period varies with age and development stage).
• PRFC makes inadequate and/or inappropriate babysitting or childcare arrangements or demonstrates very poor planning for child’s care
• Parent’s whereabouts are unknown.
• Other: ________________________________________________________________

☐ Yes    ☐ No

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:

_____________________________________________________________________

3. PRFC(s) describes or acts toward child in predominantly negative terms and/or the PRFC has extremely unrealistic expectations for the child’s behavior. Some examples of this may include the following:
• Describes child as evil, stupid, ugly, or in some other demeaning or degrading manner.
• Curses and/or repeatedly puts child down.
• Scapegoats a particular child in the family.
• Expects a child to form or act in a way that is impossible or improbable for the child’s age (i.e. babies and young children expected to be toilet trained or eat neatly, expected to care for younger siblings, expected to stay alone).
• Child is seen by either parent as responsible for the parent’s problem.
• Uses sexualized language to describe child or in name-calling (i.e. whore, slut, etc.).
• Other: ________________________________________________________________

☐ Yes    ☐ No

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:

_____________________________________________________________________

4. PRFC(s) current behavior is violent or out-of-control.
   Some examples of this may include the following:
   • Extreme physical or verbal, angry or hostile outbursts at child.
   • Use of brutal or bizarre punishment (e.g. scalding w/ hot water, burning w/ cigarettes, forced feeding).
   • Domestic violence that interferes with supervision, care, and/or physical safety of child.
   • Use of guns, knives, or other instruments in a violent way.
   • Shakes or chokes baby or young child to stop a particular behavior.
   • Behavior that seems out of touch with reality, fanatical, or bizarre.
   • Behavior that seems to indicate a serious lack of self-control (reckless, unstable, raving, explosive).
• Other: ____________________________________________________________

☐ Yes  ☐ No

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:
_____________________________________________________________________

5. PRFC(s) has caused serious harm to the child or has made a believable threat to cause serious harm to the child.

Some examples of this may include the following:

• PRFC caused serious non-accidental abuse or injury (i.e. fractures, poisoning, suffocating, shooting, burns, severe bruises, welts, bite marks, choke marks, etc.).
• An action, inaction, or threat that would result in serious harm (i.e. kill, starve, lock out of home, etc.).
• Plans to retaliate against child for CPS assessment.
• PRFC has used torture or physical force that bears no resemblance to reasonable discipline or punished child beyond the child’s endurance.
• One or both parent’s fear they will maltreat child and/or request placement.
• Other: __________________________________________________________

☐ Yes  ☐ No

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:
_____________________________________________________________________

6. PRFC(s) refuses access to the child, or there is reason to believe that the family is about to flee, or the child’s whereabouts cannot be ascertained.

Some examples of this may include the following:

• Family has previously fled in response to a CPS Assessment.
• Family has removed child from a hospital against medical advice.
• Family has history of keeping child at home, away from peers, school, or other outsiders for extended periods.
• Other: __________________________________________________________

☐ Yes  ☐ No

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:
_____________________________________________________________________

7. PRFC(s) is unwilling or unable to meet the child’s immediate needs for food, clothing, shelter, and/or medical or mental health care and the lack of these threaten the child.

Some examples of this may include the following:

• No food provided/available to child, or child starved/deprived of food/drink for prolonged periods.
• Child without minimally warm clothing in cold months.
• No housing or emergency shelter; child must or is forced to sleep in the street, car, etc.; housing is unsafe, without heat, etc.
• PRFC does not seek treatment for child’s immediate and dangerous medical condition(s) or does not follow prescribed treatment for such condition(s).
• Child appears malnourished.
• Child has exceptional needs which parent cannot/will not meet.
• Child is suicidal and parent will not take protective action.
• Child shows effects of maltreatment, such as serious emotional symptoms and lack of behavior control or serious physical symptoms.
• Other: _____________________________________________________

□ Yes □ No

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:
____________________________________________________________________________

8. PRFC(s) or other person(s) living in or having access to the home previously harmed or endangered a child and circumstances indicate the person is a present danger to the child.

Some examples of this may include the following:
• Previous maltreatment that was serious enough to cause or could have caused severe injury or harm.
• PRFC has retaliated or threatened retribution against child for past incidents.
• Escalating pattern of maltreatment.
• PRFC does not acknowledge or take responsibility for prior inflicted harm to the child or explains incident(s) as justified.
• Both parents cannot/do not explain injuries and/or conditions.
• Other: _____________________________________________________.

□ Yes □ No

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:
____________________________________________________________________________

9. Child sexual abuse is suspected and circumstances suggest that sexual abuse is an immediate concern.

Some examples of this may include the following:
• Access by possible or confirmed perpetrator to child continues to exist.
• It appears that PRFC or other person has committed rape, sodomy, or has had other sexual contact with child.
• PRFC or others have forced or encouraged child to engage in sexual performances or activities.
• Other: _____________________________________________________.

□ Yes □ No

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:
____________________________________________________________________________

10. Physical conditions in the home are hazardous and immediately threaten the child’s safety and the PRFC(s) cannot, will not, or are unable to seek outside resources.

Some examples of this may include the following:
• Leaking gas from stove or heating unit. Dangerous substances or objects stored in unlocked lower shelves or cabinets, under sink or in open.
• Lack of water or utilities (heat, plumbing, and electricity) and no alternative provisions made or alternate provisions are inappropriate (i.e. stove, unsafe space heaters for heat).
• Open/broken/missing windows.
• Exposed electrical wires.
• Excessive garbage or rotted or spoiled food that threatens health.
• Serious illness or significant injury has occurred due to living conditions and these conditions still exist (i.e. lead poisoning, rat bites).
• Evidence of human or animal waste throughout living quarters.
• Guns and other weapons are not locked and can be accessed by children.
• Other: ______________________________________________________________

□ Yes  □ No
Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor

11. Other (specify)
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Some examples of this may include the following:
• Child’s behavior likely to provoke PRFC to harm the child.
• The behavior of a child living in the home threatens immediate harm to him/her self or to others and the PRFC cannot control the behavior.
• Unexplained injuries
• PRFC(s) explanation for the child’s injury or physical condition is inconsistent with the observed or diagnosed injury or condition
• Abuse or neglect related to child death, or unexplained child death.
• Serious allegations with significant discrepancies or contradictions by PRFC or between PRFC, and collateral contacts.
• PRFC refuses to cooperate or is evasive.
• Criminal behavior occurring in the presence of the child or the child is forced to commit a crime(s) or engage in criminal behavior.
• PRFC(s) inappropriately disciplined child.

□ Yes  □ No
Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor
V. SAFETY DECISION

Directions: If no safety threats are identified, the child(ren) is considered SAFE. If any of the safety threats are identified, the child(ren) is to be considered UNSAFE. Check the box(es) that applies and enter the name(s) of the child(ren) associated with either decision.

Child(ren):

☐ Safe  __________, __________, __________, __________

☐ Unsafe __________, __________, __________, __________

☞ If child(ren) are safe, the Assessment of Child Safety is completed. Stop here and sign below.

☞ If child(ren) are unsafe, continue on to next page.

Comments:
Required CW Worker Signature     Date     Required CW Supervisor
Signature     Date

Routing:  Original – CW Case record
VI. PROTECTIVE CAPACITIES OF Person(s) Responsible for the Child (PRFC(s))

If safety threats are identified, the protective capacities of adults in the household must be assessed before determining the most appropriate safety response. Below is a list of possible protective capacities. It is not intended to be an all-inconclusive list. Identify which protective capacities are present within the family. They can be displayed by any PRFC. Check all that apply and indicate specifically to which PRFC it applies.

□ ______________________ has demonstrated or can describe times when he/she deferred his/her own needs in order to meet the child's needs;

□ ______________________ displays a desire and capability to prevent future harm to a child;

□ ______________________ accepts and demonstrates the responsibility and skills to nurture and provide for the basic needs of the child;

□ ______________________ has the motivation and physical ability to intervene and chooses to intervene to protect the child from others;

□ ______________________ demonstrates ability and motivation to control negative impulses and unsafe behavior. (The worker needs to explain specifically the behavior of the PRFC and consider patterns of behavior. It also requires that information be gathered from other individuals/sources);

□ ______________________ demonstrates healthy attachment to the child (one or both PRFCs);

□ ______________________ perceives the child in predominantly positive or realistic terms (at least one PRFC);

□ ______________________ is facilitating CPS access to the child;

□ ______________________ is receptive to intervention;

□ ______________________ can readily identify actions necessary to protect the child from serious harm;

□ ______________________ demonstrates readiness to change in areas related to child safety;

□ ______________________ extended family members or social supports are readily accessible, capable and can perform a protective role;

□ ______________________ has resources necessary to assure the child's safety;

□ ______________________ has skills necessary to meet the child's safety needs and chooses to do so;

□ Other. Please explain: _____________________________________________
Conclusions about the enhanced or diminished PRFC(s) protective capacities:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________.

VII. SAFETY RESPONSE

Directions: For each identified safety threat consider the resources available in the family and the community that may keep the child(ren) safe. Check each step to be taken to protect the child and develop the attached Voluntary Safety Plan.

☐ Use family resources, neighbors or other individuals in the community to keep the child safe.
☐ Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.
☐ Have the non-maltreating PRFC/caregiver move to a safe environment with the child.
☐ The PRFC/caregiver places the child outside the home in a safe arrangement.
☐ Legal action must be taken to place the children outside of the home.
☐ Other: ________________________________________________________________

VIII. VOLUNTARY SAFETY PLAN

Directions: A Voluntary Safety Plan (see next page) is developed when a decision of “unsafe” has been made and the worker, with supervisory approval, determine that without the plan the child(ren) must be removed from the home.

______________________________________________________________________

Required CW Worker Signature Date Required CW Supervisor Signature Date

Routing: Original – CW Case record
Family Name:

<table>
<thead>
<tr>
<th>Children:</th>
<th>Referral #</th>
<th>Case #</th>
</tr>
</thead>
</table>

1) What is the specific safety threat?

___________________________________________________________________
___________________________________________________________________

2) What actions have or will be taken to protect each child in relation to current safety concerns?

___________________________________________________________________

3) Who is responsible for implementing each plan component?

___________________________________________________________________
___________________________________________________________________

4) How will the plan be monitored and by whom?

___________________________________________________________________

Safety Plan Termination

1) What must happen in order to terminate the plan?

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

2) What time frames have been imposed by this plan?

___________________________________________________________________
___________________________________________________________________
SIGNATURES AND DATES FOR VOLUNTARY SAFETY PLAN

I have discussed the Voluntary Safety Plan with the parents/caregivers and all those who are responsible for carrying out the plan. I have their agreement to fully participate in this plan to keep the child(ren) safe.

Child Welfare Worker __________________________________ Date
______________ (Signature)

CW Worker’s Phone Number: ____________________________

Supervisor’s Name and Phone Number: ____________________________

I/we have discussed the voluntary safety plan with the child welfare worker, we understand its contents and that it is voluntary, and agree to fully participate in this plan to keep the child(ren) safe. If something happens which prevents us from carrying out the plan we will immediately notify the child welfare worker. If the child welfare worker is unavailable, we will notify the supervisor.

PRFC __________________________________ Date
______________ (Signature)

Other PRFC __________________________________ Date
________________ (if more than one in home) (Signature)

Other Safety Plan Participants:
Name: ___________________ Relationship _______________ Date _______

Name: ___________________ Relationship _______________ Date _______

Name: ___________________ Relationship _______________ Date _______

Name: ___________________ Relationship _______________ Date _______

Safety Plan Monitor

Name: ___________________ Relationship _______________ Date _______

Supervisory Approval of Safety Plan

☐ Supervisor gave verbal approval by phone
   Name of Supervisor ____________________________
   Date_______ Time_________
□ Supervisor’s Approval of written plan

Date_______ Time_______

(Signature)

Supervisor’s Phone: ________________________________

Distribution: Original to Case file; Copy to PRFC(s); Copy to Person
Addendum D

State of Oklahoma
Department of Human Services

SAMPLE
ASSESSMENT OF CHILD SAFETY

<table>
<thead>
<tr>
<th>Family Name:</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Crystal Smith</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Children:</th>
<th>Referral #</th>
<th>Case #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carley (age 10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian (age 4)</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Individuals Involved in the Assessment Process:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grandmother: Sheila Smith</td>
</tr>
<tr>
<td>Mother: Crystal Smith</td>
</tr>
<tr>
<td>Boyfriend: Colin Jones</td>
</tr>
<tr>
<td>Child: Carley Smith</td>
</tr>
<tr>
<td>Maternal Uncle: Brian Smith</td>
</tr>
<tr>
<td>Pastor: Mr. Reed</td>
</tr>
</tbody>
</table>

I. DEFINITIONS

Safe: A child is in an environment without any safety threats or if there are immediate and/or impending threats of serious harm, a responsible adult in a caregiver role demonstrates sufficient capacity to protect the child.

Unsafe: A condition in which the threat of serious harm is present or imminent and the protective capacities of the family are not sufficient to protect the child.

In this tool we assess that a child is unsafe if one of the two following conditions exist:

Present Danger: An immediate, significant and clearly observable family condition occurring in the present tense, already endangering or threatening to endanger a child (occurring now).

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 (i.e., next several days), and is likely to have severe effects.

Note: Children three years of age or younger and/or children with diminished mental or physical capacity should be considered more vulnerable.
II. IMMEDIATE PROTECTIVE ACTION PLAN

Directions: When Present Danger was/is identified, document the following:

The Present Danger is: ____________________________________________
_________________________________________________________________

The immediate action to protect the child(ren) is:
_________________________________________________________________
_________________________________________________________________

III. SIX KEY QUESTIONS IN GATHERING INFORMATION

PART I: INITIAL ASSESSMENT/INVESTIGATION INFORMATION

1. Discussion of the EXTENT of Current Maltreatment

The report from the maternal grandmother alleged that Crystal left her children unsupervised for several hours last night.

Carley (age 10) was frightened and called her grandmother. Following Carley’s call, the maternal grandmother went to the home and found that the children were unsupervised. The mother had left the children by themselves so that she could go out on the town. Both of the children reported being fearful for their safety and the safety of their mother. During the CPS interview, the mother indicated that she did not return home that evening until approximately 4:00 a.m. The children were left alone from as early as 8:00 or 9:00 p.m. to 4:00 a.m. (After finding the children home alone, unsupervised, the grandmother took them to her house). [Interviews with children, mother, boyfriend and grandmother.]

2. Discuss the CIRCUMSTANCES surrounding the maltreatment.

Based on the interviews with the children, grandmother and the mother, it appears that the children have repeatedly been left alone by the mother. Although not confirmed, the grandmother indicates that the children may be left alone as often as 3 – 5 times a week both day and night. The mother admits to having a significant substance abuse problem. (She uses alcohol and crack cocaine approximately 4 – 5 times per week.) The mother’s substance abuse appears to be affecting the mother’s ability to adequately supervise the children as well as consistently meet their basic needs. The mother does not deny that the children were left alone but minimizes the severity of the concerns. [Interviews with children, mother, boyfriend and grandmother.]

3. Discuss CHILD FUNCTIONING of every child living in the household: How does the child function on a daily basis? Include pervasive behaviors, feelings, intellect, physical capacity and temperament.
Carley (age 10) appears to be bright and is very articulate. She is sociable, pleasant to talk with. She indicates that she has many friends. She reportedly does well in school. She is developmentally appropriate, appears to be physically health. She accepts responsibility by taking on the caretaker role for both her mother and brother. She appears to be emotionally and intellectually mature for her age. She is somewhat preoccupied with her family’s situation, concerned for the welfare of her mother, protective of her young brother. Expresses fear of being alone, afraid of the neighborhood. [Interviews with children, mother, boyfriend and grandmother and Carley’s teacher.]

Christian (age 4) appears to be physically healthy. He is not very talkative, but shy and withdrawn. He participates in age-appropriate activities, indicates having friends. He appears to be somewhat clingy to Carley. [Interviews with children, mother, boyfriend and grandmother.]

4. Discuss the DISCIPLINARY PRACTICES in the Family: What are the disciplinary approaches used by the parent and under what circumstances?

Crystal is primarily responsible for the discipline of the children. She rarely allows Colin Jones (her boyfriend) any leverage in disciplining the children (e.g. “No conflict over the kids because he’s (Colin) not their father.”) The mother denies physically disciplining the children. Disciplinary approaches may be inconsistent or passive as a result of the mother’s substance abuse and her frequent absences from the home. (e.g. Carley indicated that Crystal and Colin are gone almost every night.)

Colin does not take an active role in disciplining the children. He expresses some frustration about Crystal not letting him have more of a “parental” role with respect to guiding and/or redirecting the kids. [Interviews with children, mother, boyfriend and grandmother.]

5. Discussion of PARENTING PRACTICES in the Family: What are the overall, typical, pervasive parenting practices used by the parent? (Do not include discipline.)

Crystal speaks very fondly of the children and appears to be proud of them. She sees Carley as being very much like her when she was that age. She feels that both of her children are exceptional. When talking about Carley, she indicated that “she is going to be somebody.” Based on interviews with the children, Crystal and Colin, there appear to be strong attachments between the mother and the children. She clearly has aspirations for the children to make something out of their lives and believes that they have the potential to do so. However, she has difficulty translating these feeling into positive and consistent parenting practices. Her substance abuse problem frequently results in her being unresponsive to the needs of the kids, both emotionally and physically. Her expectations of the kids are inappropriate, which often means that Carley is required to take on a great deal of responsibility for maintaining the household. Crystal readily admits that Carley “takes care of a lot of things,” and she refers to Carley as “my big girl.” Given that Carley is 10 years old, Crystal indicated that she did not feel that it was inappropriate for Carley to take care of Christian by herself. However, the mother’s questionable parenting practices appear to be more related to the mother’s substance abuse problem, rather than a lack of knowledge and/or skill. Parenting decisions are often impulsive and are influenced by her urges to satisfy the drug dependency. [Interviews with children, mother, boyfriend and grandmother.]

Colin speaks positively of the kids (e.g. “good kids,” “I love the kids”, ” the kids are special to me”). He appears to enjoy spending time with them (e.g. takes them to the park, takes them to get something to eat). The relationship between the children and him seems to be more like a big brother than a father figure. Although on a couple of occasions he referred to Carley and Christian as “his kids,”
Carley indicated that she gets along with him but does not see him as a father figure. Generally, Colin seems uncertain about his role as a parent. This is partially related to the way that Crystal undermines his role or standing with the children. Also, it appears that Colin is yet to make a firm commitment to the family. He is frequently in and out of the home and subsequently that affects his degree of involvement with the kids. Beyond talking about “babysitting,” it appears that Colin may not view the supervision and/or general welfare of the children as his direct responsibility.

[Interviews with children, mother, boyfriend and grandmother.]

6. Discuss the ADULT FUNCTIONING for all caretaking members of the family: How does the adult function with respect to daily life management and general adaptation? What mental health functioning and/or substance use is apparent on a daily basis?

Crystal (28 years old) appears to be intelligent, articulate, and sociable. She is able to communicate her needs but has difficulty meeting those needs in adaptive ways. She has limited ability to solve problems (particularly long-term problem solving). She expresses having a positive vision for her future (e.g. get out of the “projects”). However, her ideas and thoughts about changing her current circumstances are not planned out. Crystal has difficulty managing stress. She has feelings of insecurity and becomes easily threatened. Crystal lacks self-control (e.g. substance abuse, leaving the kids unattended). She appears to have poor self-esteem. She has a significant substance abuse problem (e.g. regularly uses alcohol and crack cocaine). There may be some dependency issues as evident in her history of failed relationships with men. Also, she appears to frequently rely on others to get her needs met (e.g. Colin, Carley, her mother). While she is somewhat open about her drug usage, she remains guarded. Crystal expressed feeling “guilty” about some of the choices that she has made in her life. At some level, she remains in denial about the significance of individual problems and tends to blame others.

[Interviews with mother, boyfriend and grandmother.] Crystal works outside the home, has kept the job for over three years. She maintains a nice apartment where she has lived for several years. The apartment is reasonably clean.

Colin (30 years old) is clearly able to communicate needs, feelings and perceptions regarding the family situation, but generally keeps the conversation at a superficial level. He appears somewhat guarded, distrustful and does not talk much about himself. He tends to remove himself from any direct responsibility for family problems by focusing attention toward Crystal. He is controlled and seems thoughtful. He appears to be resourceful and intelligent. Colin denies selling drugs but is vague about his employment. He avoids conflict (e.g. prefers to leave the home during conflict.) Colin has no apparent mental health issues or substance usage. He presents as emotionally controlled and stable.

[Interviews with mother, boyfriend and grandmother.]

Safety Threats
Indicate the presence or absence of safety threats in a family by giving consideration to all 18 threats, utilizing all the information that is collected about the family.

A “yes” indication is a conclusion that the safety threat exists; it is observable; it can be described. It is a conclusion, not a suspicion, and can only be indicated when sufficient credible, reasonable, believable information supports the conclusion. Indicating “yes” means that the safety threat meets all of the safety threshold criteria: severe effects, out of control, and imminent. If a “yes” box is indicated, there is space provided beneath each safety threat so that a fuller case-specific description of how the threat is actually occurring in the family can be explained and justified.
A “no” box is indicated when the conclusion is reached that the safety threat does not exist, or at the time of the safety assessment, the information available did not reveal the safety threat. If a negative family condition does not meet all of the safety threshold criteria, then “No” must be indicated.

IV. IDENTIFYING SAFETY THREATS

Directions: Through analysis of the above information, assess the presence or absence of the following safety factors.

1. Child is fearful of Person(s) Responsible for the Child PRFC(s), other family or household members or other persons having access to the home.

Some examples of this may include the following:
- Child cries, cowers, cringes, trembles, or otherwise exhibits fear in the presence of certain individuals or verbalizes such fear.
- Child exhibits severe anxiety (i.e. nightmares, insomnia related to situation(s) associated with a person(s) in the home.
- Child has reasonable fears of retribution or retaliation from PRFC.
- Other: _____________________________________________________

□ Yes  XXNo

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:

2. PRFC(s) has not, will not, or cannot provide supervision necessary to protect

Some examples of this may include the following:
- PRFC does not attend to the child to such an extent that the need for care goes unnoticed or unmet (i.e. although PRFC is present, child wanders outdoors alone, plays with dangerous objects, plays on unprotected window ledge, has unsupervised access to uncovered pools, etc. or is exposed to other serious hazards).
- PRFC leaves child alone (time period varies with age and development stage).
- PRFC makes inadequate and/or inappropriate babysitting or childcare arrangements or demonstrates very poor planning for child’s care
- Parent’s whereabouts are unknown.
- Other: _____________________________________________________

XXYes  □ No

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor: Crystal does not provide adequate supervision. The children are left in the home alone at night (often all night long) from 4 to 5 times per week; Carley is expected to care for herself and Christian.

3. PRFC(s) describes or acts toward child in predominantly negative terms and/or the PRFC has extremely unrealistic expectations for the child’s behavior.

Some examples of this may include the following:
- Describes child as evil, stupid, ugly, or in some other demeaning or degrading manner.
• Curses and/or repeatedly puts child down.
• Scapegoats a particular child in the family.
• Expects a child to form or act in a way that is impossible or improbable for the child’s age (i.e. babies and young children expected to be toilet trained or eat neatly, expected to care for younger siblings, expected to stay alone).
• Child is seen by either parent as responsible for the parent’s problem.
• Uses sexualized language to describe child or in name-calling (i.e. whore, slut, etc.).
• Other: _____________________________________________________

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor: Carley in particular, are afraid to be alone and are highly anxious for fear of where their mother is and if she is okay. Carley appears to feel overwhelmed with being left in charge and expected to be responsible for her younger

4. PRFC(s) current behavior is violent or out-of-control.

Some examples of this may include the following:

• Extreme physical or verbal, angry or hostile outbursts at child.
• Use of brutal or bizarre punishment (e.g. scalding w/ hot water, burning w/ cigarettes, forced feeding).
• Domestic violence that interferes with supervision, care, and/or physical safety of child.
• Use of guns, knives, or other instruments in a violent way.
• Shakes or chokes baby or young child to stop a particular behavior.
• Behavior that seems out of touch with reality, fanatical, or bizarre.
• Behavior that seems to indicate a serious lack of self-control (reckless, unstable, raving, explosive).
• Other: _____________________________________________________

□ Yes  XXNo

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:

5. PRFC(s) has caused serious harm to the child or has made a believable threat to cause serious harm to the child.

Some examples of this may include the following:

• PRFC caused serious non-accidental abuse or injury (i.e. fractures, poisoning, suffocating, shooting, burns, severe bruises, welts, bite marks, choke marks, etc.).

• An action, inaction, or threat that would result in serious harm (i.e. kill, starve, lock out of home, etc.).
• Plans to retaliate against child for CPS assessment.
• PRFC has used torture or physical force that bears no resemblance to reasonable discipline or punished child beyond the child’s endurance.
• One or both parent’s fear they will maltreat child and/or request placement.
• Other: _____________________________________________________.

□ Yes  XXNo

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:
6. **PRFC(s) refuses access to the child, or there is reason to believe that the family is about to flee, or the child’s whereabouts cannot be ascertained.**

Some examples of this may include the following:
- Family has previously fled in response to a CPS Assessment.
- Family has removed child from a hospital against medical advice.
- Family has history of keeping child at home, away from peers, school, or other outsiders for extended periods.
- Other: _____________________________________________________.

☐ Yes    XXNo

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor.

7. **PRFC(s) is unwilling or unable to meet the child’s immediate needs for food, clothing, shelter, and/or medical or mental health care and the lack of these threaten the child.**

Some examples of this may include the following:
- No food provided/available to child, or child starved/deprived of food/drink for prolonged periods.
- Child without minimally warm clothing in cold months.
- No housing or emergency shelter; child must or is forced to sleep in the street, car, etc.; housing is unsafe, without heat, etc.
- PRFC does not seek treatment for child’s immediate and dangerous medical condition(s) or does not follow prescribed treatment for such condition(s).
- Child appears malnourished.
- Child has exceptional needs which parent cannot/will not meet.
- Child is suicidal and parent will not take protective action.
- Child shows effects of maltreatment, such as serious emotional symptoms and lack of behavior control or serious physical symptoms.
- Other: Substance use impacts her ability to care for her child.

XXYes    ☐ No

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor: *Crystal has a significant substance abuse problem which is directly affecting her parenting, her lack of protectiveness, her perceptions about child safety, and her judgment. She is impulsive and frequently leaves the home (4 to 5 times per week) to acquire and use drugs.*

*Crystal’s motivation is focused on getting and using drugs; her substance abuse is affecting all aspects of her parenting including meeting the child’s basic needs. There are times when Grandma comes to the home and there is little food for the children. Crystal is in denial about the seriousness of what she is doing and the danger the children are in. Indications are such that this behavior will continue without outside influence.*

7. **PRFC(s) or other person(s) living in or having access to the home previously harmed or endangered a child and circumstances indicate the person is a danger to the child.**

Some examples of this may include the following:
- Previous maltreatment that was serious enough to cause or could have caused severe injury or harm.
- PRFC has retaliated or threatened retribution against child for past incidents.
- Escalating pattern of maltreatment.
• PRFC does not acknowledge or take responsibility for prior inflicted harm to the child or explains incident(s) as justified.
• Both parents cannot/do not explain injuries and/or conditions.
• Other: _____________________________________________________.

☐ Yes  XXNo
Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:

9. Child sexual abuse is suspected and circumstances suggest that sexual abuse is an immediate concern.

Some examples of this may include the following:
• Access by possible or confirmed perpetrator to child continues to exist.
• It appears that PRFC or other person has committed rape, sodomy, or has had other sexual contact with child.
• PRFC or others have forced or encouraged child to engage in sexual performances or activities.
• Other: _____________________________________________________.

☐ Yes  XXNo
Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:

10. Physical conditions in the home are hazardous and immediately threaten the child’s safety and the PRFC(s) cannot, will not, or are unable to seek outside resources.

Some examples of this may include the following:
• Leaking gas from stove or heating unit. Dangerous substances or objects stored in unlocked lower shelves or cabinets, under sink or in open.
• Lack of water or utilities (heat, plumbing, and electricity) and no alternative provisions made or alternate provisions are inappropriate (i.e. stove, unsafe space heaters for heat).
• Open/broken/missing windows.
• Exposed electrical wires.
• Excessive garbage or rotten or spoiled food that threatens health.
• Serious illness or significant injury has occurred due to living conditions and these conditions still exist (i.e. lead poisoning, rat bites).
• Evidence of human or animal waste throughout living quarters.
• Guns and other weapons are not locked and can be accessed by children.
• Other:

☐ Yes  XXNo
Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:

11. Other (specify):

Some examples of this may include the following:
• Child’s behavior likely to provoke PRFC to harm the child.
• The behavior of a child living in the home threatens immediate harm to him/her self or to others and the PRFC cannot control the behavior.
• Unexplained injuries
• PRFC(s) explanation for the child’s injury or physical condition is inconsistent with the observed or diagnosed injury or condition
• Abuse or neglect related to child death, or unexplained child death.
- Serious allegations with significant discrepancies or contradictions by PRFC or between PRFC, and collateral contacts.
- PRFC refuses to cooperate or is evasive.
- Criminal behavior occurring in the presence of the child or the child is forced to commit a crime(s) or engage in criminal behavior.
- PRFC(s) inappropriately disciplined child.

□ Yes  ☒ No

Identify PRFC(s)/caretaker(s) and child(ren) associated with this safety factor:

V. SAFETY DECISION

Directions: If no safety threats are identified, the child(ren) is considered SAFE. If any of the safety threats are identified, the child(ren) is to be considered UNSAFE. Check the box(es) that applies and enter the name(s) of the child(ren) associated with either decision.

Child(ren):

□ Safe  ,  ,  ,  

XX Unsafe  Carley, Christian

If child(ren) are safe, the Assessment of Child Safety is completed. Stop here and sign below. If child(ren) are unsafe, continue on to next page.

Comments:

Required CW worker signature  Date  Required CW Supervisor Signature  Date

Routing: Original – CW Case record

VI. PROTECTIVE CAPACITIES OF Person(s) Responsible for the Child (PRFC(s))

If safety threats are identified, the protective capacities of adults in the household must be assessed before determining the most appropriate safety response. Below is a list of possible protective capacities. It is not intended to be an all-inclusive list. Identify which protective capacities are present within the family. They can be displayed by any PRFC. Check all that apply and indicate specifically to which PRFC it applies.

□  has demonstrated or can describe times when he/she deferred his/her own needs in order to meet the child's needs;

□  displays a desire and capability to prevent future harm to a child;
□ _______________ accepts and demonstrates the responsibility and skills to nurture and provide for the basic needs of the child;

□ _______________ has the motivation and physical ability to intervene and chooses to intervene to protect the child from others;

□ _______________ demonstrates ability and motivation to control negative impulses and unsafe behavior. (The worker needs to explain specifically the behavior of the PRFC and consider patterns of behavior. It also requires that information be gathered from other individuals/sources);

☑ Crystal and Colin demonstrates healthy attachment to the child (one or both PRFCs);

☑ Crystal and Colin perceive the child in predominantly positive or realistic terms (at least one PRFC);

☑ Crystal and Colin are facilitating CPS access to the child;

☑ Crystal and Colin are receptive to intervention;

□ _______________ can readily identify actions necessary to protect the child from serious harm;

☑ Crystal and Colin demonstrates readiness to change in areas related to child safety;

☑ Sheila Smith extended family members or social supports are readily accessible, capable and can perform a protective role;

□ _______________ ___ has resources necessary to assure the child's safety;

□ _______________ has skills necessary to meet the child's safety needs and chooses to do so;

□ Other. Please explain: _________________________________

Conclusions about the enhanced or diminished PRFC(s) protective capacities: ___

While Crystal and Colin are attached to the children, speak in positive terms about the children and are willing to have the system intervene, they do not possess protective capacities enough to safely care for the children without support.

VII. SAFETY RESPONSE

Directions: For each identified safety threat consider the resources available in the family and the community that may keep the child(ren) safe. Check each step to be taken to protect the child and develop the attached Voluntary Safety Plan.

☑ Use family resources, neighbors or other individuals in the community to keep the child safe.

☑ Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.

☑ Have the non-maltreating PRFC/caregiver move to a safe environment with the child.

☑ The PRFC/caregiver places the child outside the home in a safe arrangement.

☑ Legal action must be taken to place the children outside of the home.

☑ Other: _________________________________.
VIII. VOLUNTARY SAFETY PLAN

Directions: A Voluntary Safety Plan (attached) is developed when a decision of "unsafe" has been made and the worker, with supervisory approval, determine that without the plan the child(ren) must be removed from the home.

<table>
<thead>
<tr>
<th>Required CW worker signature/Date</th>
<th>Required CW Supervisor Signature/Date</th>
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Routing: Original – CW Case record
Family Name: Smith, Crystal

<table>
<thead>
<tr>
<th>Children:</th>
<th>Referral #</th>
<th>Case #</th>
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<tbody>
<tr>
<td>Carely and Christian</td>
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1) What is the specific safety threat?

Lack of supervision and basic needs are not being met consistently.

2) What actions have or will be taken to protect each child in relation to current safety concerns?

Carley and Christian have been staying with Sheila Smith, maternal grandmother, in her home on an emergency basis while the investigation was completed and a longer term safety plan developed. **Carley and Christian will now be returned home and Ms. Smith will stay in the family’s home in the evening and overnight to make sure the children are not left unsupervised. This will occur Sunday through Thursday.** Ms. Smith will also be able to provide emotional support and encouragement for Crystal Smith and encourage support and continued commitment from Colin.

Child Care. Christian will attend pre-school/child care daily at the First Baptist Church. Carley will go to the child care center every afternoon after she gets out of school. Sheila Smith will transport the children to school and child care every morning and will pick them up from child care every afternoon, except Fridays. (Brian Smith, maternal uncle, will pick the children up on Fridays.) Pastor Reed will make arrangements for Christian and Carley to attend the child care program and will monitor their adjustment to the program. Child care for Christian is Monday – Friday from 9 a.m. to 5 p.m. while Carley is in school. Carley will attend the child care center after school from 3:30 to 5 p.m.

3) Who is responsible for implementing each plan component? **Sheila Smith is the maternal grandmother. Ms. Smith has a close attachment and bonding with the children and they with her. Ms. Smith acted and continues to act in a protective manner on behalf of the children. She responded to the home after the children called her to report they were left home alone and took the children to her home. The children were interviewed in her home; it was appropriate and will meet all the needs of the children. Ms. Smith was present and active in the development of this plan. Background checks were completed on this date; there was no A/N or criminal history. In-home supervision by Ms. Smith will begin immediately. Ms. Smith will provide supervision during the evening hours and will remain in the home overnight.**

Pastor Reed, First Baptist Church. He is Sheila Smith's pastor and he has known her for almost 30 years. He was present in the development of the safety plan and is in agreement with his role. **Sheila Smith is the maternal grandmother; her confirmation and suitability are described above. Pastor Reed will assist with the coordination of the child care/after school program and will provide transportation on an as-needed basis.**
Brian Smith, maternal uncle, will provide respite care every weekend. Brian lives in a suburb approximately 45 minutes from Crystal’s home. Crystal and Colin will be invited to spend weekends at Brian’s house, as well, if they so choose. Brian will pick the children up from child care at 5 p.m. on Friday afternoon and will take them home to get whatever clothes and other items they need for the weekend. He will talk to Crystal at that time to see if she wants to accompany them for the weekend. Brian will return Carley and Christian home at 5 p.m. on Sunday. He will make sure that Sheila Smith is at the house and ready to assume responsibility for supervision before he leaves.

4) How will the plan be monitored and by whom?

Mike Lucas, caseworker, will have telephone contact with Ms. Smith a minimum of once a week to support the plan; Ms. Smith will/can call with any concerns. The caseworker will also meet in-person with both Crystal and Sheila Smith once a week.

Brian Smith is the maternal uncle. He is an Associate Professor at Mount Vernon Community College. He was present in the development of the safety plan; is in agreement with his role; and understands the need for a plan for protection of the children. Background checks were completed on this date; there was no A/N or criminal history.

Pastor Reed, First Baptist Church. Background checks was completed on this date; there was no A/N or criminal history.

Safety Plan Termination

1) What must happen in order to terminate the plan?

Crystal and Colin must demonstrate that they are able to put the children’s need for supervision ahead of their own needs. This means identifying child care providers, assuring that they will provide safe care, specifically arranging for care when they leave (even when Grandmother is in the home to demonstrate behavior). This also means demonstrating an understanding of why Carley should not be left alone or left to supervise Christian.

2) What time frames have been imposed by this plan?

This plan will be reviewed after three weeks.
SIGNATURES AND DATES FOR VOLUNTARY SAFETY PLAN

I have discussed the Voluntary Safety Plan with the parents/caregivers and all those who are responsible for carrying out the plan. I have their agreement to fully participate in this plan to keep the child(ren) safe.

Child Welfare Worker ________________________________ Date __________ (Signature)

CW Worker’s Phone Number: ____________________________

Supervisor’s Name and Phone Number: ________________________________

I/we have discussed the voluntary safety plan with the child welfare worker, we understand its contents and that it is voluntary, and agree to fully participate in this plan to keep the child(ren) safe. If something happens which prevents us from carrying out the plan we will immediately notify the child welfare worker. If the child welfare worker is unavailable, we will notify the supervisor.

PRFC ________________________________ Date __________ (Signature)

Other PRFC ________________________________ Date __________ (if more than one in home) (Signature)

Other Safety Plan Participants:

Name: ___________________________ Relationship __________________ Date _________

Name: ___________________________ Relationship __________________ Date _________

Name: ___________________________ Relationship __________________ Date _________

Name: ___________________________ Relationship __________________ Date _________

Safety Plan Monitor

Name: ___________________________ Relationship __________________ Date _________

Supervisory Approval of Safety Plan

☐ Supervisor gave verbal approval by phone
   Name of Supervisor ___________________________ Date _________
   Time _________

☐ Supervisor’s Approval of written plan ______________ Date _________
   Time _________
   (Signature)
   Supervisor’s Phone: ________________________________

Distribution: Original to Case file; Copy to PRFC(s); Copy to Person most responsible if other than PRF.
A concurrent plan is initiated when:

- any of the factors in A or B apply to both parents, legal guardian(s), or custodian(s) with whom reunification is being considered; or
- one parent meets one of the criteria listed and the other parent is absent, deceased, or unable to be located despite ongoing diligent search efforts.

**A. If a termination of parental rights request was not included in the initial deprived petition, do any of these indicators exist for parents, legal guardians, or custodians?**

- Parent, legal guardian, or custodian has inflicted chronic abuse, neglect, or torture on the child, a sibling, or another child within the household where the child resides.
- Parent, legal guardian, or custodian has been convicted in the murder or voluntary manslaughter of any child, or aided or abetted, attempted, conspired, or solicited to commit murder or voluntary manslaughter of any child.
- Parent, legal guardian, or custodian has deserted the child and such desertion continues for a period of at least six months immediately prior to the filing of:
  - a petition alleging the child deprived; or
  - a petition to terminate parental rights.
- Child has experienced severe physical or sexual abuse in infancy.
- Child was conceived as a result of a rape. This applies only to the parent who committed the rape and whose child(ren) has been placed outside the home.
- Parental rights to another child have been terminated following a period of service delivery to the parent and no significant change to correct the original conditions has occurred since.
- Parent, legal guardian, or custodian has a recent history of criminal activity and has been incarcerated. The continuation of parental rights would result in harm to the child based on consideration of:
  - the duration of the incarceration and its detrimental effect on the parent/child relationship;
  - the age of the child;
  - the current parent/child relationship; and
  - the manner in which the parent, legal guardian, or custodian has exercised parental rights and duties in the past.
- A judicial finding that reasonable efforts to reunite are not required.
B. During the safety analysis, family functional assessment, or ongoing work with family, were any of these poor prognosis indicators identified?

- There have been three or more child protective services reports of a serious nature, indicating a chronic pattern of abuse or severe neglect.
- Child has been in out-of-home placement for over six months, or there have been repeated removals, with no significant improvement in parent's behavior, or of conditions that caused the child to be unsafe.
- Child has been abandoned for at least three months, despite repeated attempts by the worker to facilitate contact.
- The parent, legal guardian, or custodian fails to establish or maintain visitation while the child is in out-of-home care.
- Parent is under the age of 16 with no parenting support systems, and placement of the child and parent together has failed due to parent's conduct.
- Parent, legal guardian, or custodian has asked to relinquish parental rights.
- Child has resided out of the child's home under court supervision for a cumulative period of more than one year within a three year period following a deprived adjudication.
- Parent, legal guardian, or custodian is not actively, or is irregular or sporadic in, working the plan and no correction of conditions has occurred regardless of intensive interventions and supports provided by Child Welfare.
- Parent, legal guardian, or custodian, has been at any time, subject to the registration requirements of the Oklahoma Sex Offenders Registration Act or any similar act in any other state, or has been convicted of a sexual felony offense.
- Parent, legal guardian, or custodian has a history of extensive, abusive, and chronic use of drugs or alcohol and has resisted treatment for this problem during a three year period immediately prior to the filing of the deprived petition.
- The child was returned home and removed again for safety reasons.
- Indications of maltreatment during unsupervised visitation are reported.
- Reunification has been the permanency plan for at least six months and the risk to the child's safety in the home has not been sufficiently reduced.
- A judicial finding that reasonable efforts have been made and failed.
- A judicial finding that reasonable efforts are not required.
c. **Concurrent plan:**

- Adoption
- Legal guardianship

<table>
<thead>
<tr>
<th>To do</th>
<th>Responsible party</th>
<th>Timeframe</th>
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</table>
1. **Standard Intake Process**
   - Use Prompter Questions and Screening Guide when receiving and screening reports of child abuse and neglect.

2. **Assign MAJORITY as CPS Assessments in KIDS**
   - Exceptions:
     - Criminal prosecution is expected
     - Deprived petition is expected
     - Child Care
     - Resource Home (any type of foster home or trial adoptive home)

3. **Complete CPS Assessment with family using the DRAFT Assessment of Child Safety**
   - Use electronic version that you have stored on your tablet desktop, or
   - Use manual version

4. **Documenting CPS Assessment in KIDS**
   - Complete ASSESS/INTERVIEW/FAMILY/CONTACT INFO screen in KIDS the same as you currently do
   - Store DRAFT Assessment of Child Safety in KIDS File Cabinet
     - If DRAFT Assessment of Child Safety is completed electronically, scan version with signature to KIDS File Cabinet
     - If DRAFT Assessment of Child Safety is completed manually, scan manual document and save scanned document to KIDS File Cabinet

***Contact KIDS Help Desk if you need assistance in saving either the WORD document or the Scanned document to the KIDS File Cabinet***
• Assess/Safety Screen
  o Only need to go to **Safety Decision** Tab and select Unsafe or Safe, AND
  o Make notation in Text Box titled **“Child is Safe or Conditionally Safe due to”** as seen below
    ▪ Note: Planned enhancement to KIDS application in January release will allow you to click on a box rather than having to type this statement
If "Unsafe" is selected as the Safety Decision, proceed to the Initial Safety Plan screen. Select "Other" and make a notation in the "Explain" field as seen below.

<table>
<thead>
<tr>
<th>Child Factors</th>
<th>PRFC Factors</th>
<th>Severity/Chronicity</th>
<th>Environment/Family</th>
<th>Summary</th>
<th>Safety Decision</th>
<th>Initial Safety Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of family or community resource, neighbor, or other person or service</td>
<td>Protecting PRFC will ensure child's safety</td>
<td>PRFC will voluntarily make arrangements for child to temporarily stay outside the home</td>
<td>Court action recommended, child to remain in own home</td>
<td>Protective or emergency custody not recommended, court action initiated</td>
<td>Protective or emergency custody recommended, check all that apply</td>
<td>Remove or recommend removal of child from out-of-home placement</td>
</tr>
<tr>
<td>Other</td>
<td>Explain: [See Assessment of Child Safety stored in KIDS File Cabinet]</td>
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For each condition identified in the Safety assessment, consider available resources in the family and community that may help keep the child safe. Check each step taken to protect the child and explain below. Indicate all safety interventions taken or immediately planned and explain how each intervention protects each child. The steps in the safety plan are documented on Forms CWS-KIDS-3 and DOFS-75.
Documenting Information from SIX KEY QUESTIONS in completing the KIDS CPS Assessment Screens:

ALLEGATIONS TAB

Question 2. CIRCUMSTANCES: What surrounding circumstances accompany the maltreatment?
Include analysis of previous maltreatment and the major influences that led to the maltreatment occurring, e.g. depression, substance use, domestic violence, isolation, etc., history and duration, chronicity, parent explanation for events/injuries and responses to CPS.

- If Draft Assessment of Child Safety was completed on the electronic version, merely copy and paste text from question 2 to area below
- If Draft Assessment of Child Safety was completed on the manual version, type responses below
SOCIAL HISTORY TAB

**Question 6.** ADULT FUNCTIONING for *all caretaking members* of the family. How does the adult(s) function with respect to daily life management and general adaptation? What mental health functioning and/or substance use is apparent on a daily basis?

Describe overall pattern of adult’s approach to life, including overall mood, impulse control, coping styles, stress management, substance use, mental health issues, problem awareness, and problem solving skills, maturity, dependability, employment patterns, income, resource management, ability to meet own needs in healthy ways, relationship and social skills/supports, quality of family relationships.

- If Draft Assessment of Child Safety was completed on the electronic version, merely **copy and paste text from question 6 to area below**
- If Draft Assessment of Child Safety was completed on the manual version, type responses below

**Question 5.** PARENTING – GENERAL: What are the overall, typical pervasive parenting practices used by the parent(s)? (Do not include discipline)

Discuss overall parenting styles, perception of child, tolerance as parent, interaction patterns with child, ability to put child’s needs before own, ability to meet child’s basic and emotional needs, support/concern for child, awareness of child’s needs, ability to protect, parenting knowledge and skill, perception of child, etc.

- If Draft Assessment of Child Safety was completed on the electronic version, merely **copy and paste text from question 5 to area below**
- If Draft Assessment of Child Safety was completed on the manual version, type responses below

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**Social History Details**

Discuss medical and mental health history, marital history, life changes, cultural issues, alcohol/drug use (past and present), education, and employment and military history.

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**Support Systems:**
STRENGTHS AND CAUSES TAB

- Complete ASSESS/INTERVIEW/FAMILY/ASSESS screen, STRENGTHS and CAUSES tab in KIDS the same as you currently do.
Question 4. PARENTING – DISCIPLINE: What are the disciplinary approaches used by the parent(s) and under what circumstances?
Describe types of discipline used, frequency, parent view of purpose of discipline, range of options parent knows and uses, emotional state of parent when disciplining, awareness of child’s perception of discipline methods, parental agreement on disciplines, is disciplined based on reasonable expectations for the child?
- If Draft Assessment of Child Safety was completed on the electronic version, merely **copy and paste text from question 4 to area below**
- If Draft Assessment of Child Safety was completed on the manual version, type responses below

Question 1. MALTREATMENT: What is the extent of the maltreatment?
Assess for all types of maltreatment. Describe all symptoms, events, circumstances and severity related to the current report of maltreatment, the location and condition of the reported child(ren) and if there is a pattern of maltreatment.
- If Draft Assessment of Child Safety was completed on the electronic version, merely **copy and paste text from question 1 to area below**
- If Draft Assessment of Child Safety was completed on the manual version, type responses below

Question 3. CHILD FUNCTIONING: How does every child in the home function on a daily basis? Include pervasive behaviors, feelings, intellect, physical capacity and temperament.
Describe vulnerability, special needs, physical and emotional health, child developmental status, school performance, peer/social/sibling relationships, attachment with parent, mood and behavior, age appropriate functioning, response to CPS intervention, fearfulness, supports, sleeping arrangements, any sexual reactive or acting out behavior, and verbal and social skills.
- If Draft Assessment of Child Safety was completed on the electronic version, merely **copy and paste text from question 3 to area below**
- If Draft Assessment of Child Safety was completed on the manual version, type responses below
CONCLUSIONS TAB

- Complete ASSESS/INTERVIEW/FAMILY/ASSESS screen, CONCLUSIONS tab in KIDS the same as you currently do.